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Participation of Tanzanian Nurses and Midwives in the Implementation of Millennium Development Goals 4 (Reduction of Child Mortality) and 5 (Improvement of Maternal Health): A Case Study

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PARTICIPATION OF TANZANIAN NURSES AND MIDWIVES IN THE IMPLEMENTATION OF MILLENNIUM DEVELOPMENT GOALS 4 (*REDUCTION OF CHILD MORTALITY*) AND 5 (*IMPROVEMENT OF MATERNAL HEALTH*): A CASE STUDY

A Thesis Submitted in fulfilment of the requirements for the award of Degree of Doctor of Philosophy.

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Contents

Declaration of Authorship

This thesis is the candidate's own work and contains no material that has been

accepted for the award of any degree or diploma in any other institution.

To the best of my knowledge, the thesis contains no material

previously published or written by another person, except where due reference is

made in the text of the thesis.

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PETER TARATARA   **NOVEMBER 2022**

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Dedication

This Thesis is dedicated to my three beautiful children Moucho Taratara, Samvura Taratara and Tuyisabe Taratara. May they always remember that pursuit of ambitions, hard work, persistence, and courage are virtues.

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List of Abbreviations

AFR: African Region

AMO: Assistant Medical Officer

AMR: Region of the Americas

ANO: Assistant Nursing Officer

ANP: Advanced Nursing Practice

CST: Critical Social Theory

EMR: Eastern Mediterranean Region

EN: Enrolled Nurse

EPC: Interprofessional Education

EUR: European Region

FBO: Faith Based Organisations

GDP: Gross Domestic Product

GHWA: Global Health Workforce Alliance

HKMU: Hubert Kairuki Memorial University

HSSP: Health Sector reforms and Strategic Plans

ICA: Inductive Content Analysis

ICM: International Confederation of Midwives

ICN: International Council of Nursing

IMF: International Monetary Fund

IPC: Interprofessional Cooperation

KH: Kairuki Hospital

KSN: Kairuki School of Nursing

LFC: Leadership for Change

LMIC: Low- and Middle-Income Countries

MDGs: Millennium Development Goals

MKUKUTA:	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
MMR:	Maternal Mortality Ratio
MNT:	Nursing and Management Theory
MOHCDGEC:	Ministry of Health, Community Development, Gender, Elderly and Children
MOHSW:	Ministry of Health and Social Welfare
MUHAS:	Muhimbili University of Health and Allied Sciences
NGO:	Non-Governmental Organisation
NIMR:	National Institute for Medical Research
NO:	Nursing Officer
PHC:	Primary health Care
PMO-RALG:	Prime Minister's Office–Regional Administration and Local Government
SAPs:	Structural Adjustment Programs
SDGs:	Sustainable Development Goals
SEAR:	Southeast Asian Region
SIT:	Social Identity Theory
TAMA:	Tanzania Midwives Association
TAMWA:	Tanzania Media Women's Association
TNC:	Tanzania Nurses Council
TNMC:	Tanzania Nurses and Midwifery Council
TNMC:	Tanzania Nursing and Midwifery Council
U5MR:	Under five Mortality Ratio
UN:	United Nations
USA:	United States of America
USAID:	United States Agency for International Development
UWT:	Umoja wa Wanawake Tanzania

VBL:	Value Based Leadership
VHW:	Village Health Worker
WA:	Western Australia
WB:	World Bank
WHO:	World Health Organization
WPR:	West Pacific Region
WWI:	First World War
WWII:	Second World War

Abstract

In 2000, the United Nations (UN) developed the Millennium Development Goals (MDGs) as an international framework to address poverty, promote sustainable development, and improve global health. The framework was translated into 8 goals with goals 4 and 5 targeting the reduction of child mortality and the improvement of maternal health. The UN and the World Health Organization (WHO) encouraged nurses and midwives to participate in the implementation process of the MDGs, and each country had the responsibility of formulating its own implementation policies and plans. The encouragement to participate was from the understanding that nurses and midwives are the backbone of the health care system. In South Africa, for example, nurses in the public sector make 60% of the total health care workforce and are responsible for serving up to 82% of the South African population; and globally, nurses and midwives make about half of the workforce in the health care industry. Nurses and midwives are also part of the global network of the health care professionals, and therefore their frontline involvement in the implementation of health-related goals would be essential if those goals were to be attained. Maternal and child mortality and morbidity rates, whilst declining in developed countries, have been slower to reduce in developing countries such as Tanzania, especially regarding various health determining factors that disadvantage women.

The aim of this study was to investigate and describe factors that enabled or inhibited the participation of Tanzanian nurses and midwives in the implementing of MDGs 4/5, including the call from the UN and WHO to support Tanzanian nurses and midwives in the strategies to implement those goals. The study was taken with view that since nurses and midwives would be instrumental in participating in the Sustainable Development Goals (SDGs), it would therefore be important to investigate their awareness and participation in the MDGs to see if there are lessons to be learnt in that would lead to developing strategies for actions targeting improved participation in future health goals.

The study used the case study design, and data were collected by using survey, interviews, and focus group discussions from five hospitals in Tanzania. Three of the five hospitals involved in the study were public hospitals, and two were private hospitals. Closed-ended data were analysed by using descriptive analysis, while open-responses were analysed by using Inductive Content Analysis. The study results were presented in five phases in relation

to the research questions, and each phase of data presentation was built on the previous phase to ensure consistency and logical flow of the study findings.

This study has proposed the framework for future nursing and midwives' participation in the achievement of future health care goals. The framework was developed from analysing the Tanzanian cultural context, and participant's awareness in the implementation of the MDGs 4 & 5. The Framework, therefore proposes strategies for improved participation in future national or global health care goals. The conclusion in the study encourages the nursing and midwifery leadership in Tanzania, including the National Nursing and Midwifery Associations to play a leading role in mobilising their members to take a leading role in optimising the Tanzanian public health, and a leading role in the implementation processes of the current SDGs and future national and global health goals.

Chapter 1: Introduction and Background to the Study

1.0: Introduction

The Millennium Development Goals constituted a set of eight goals and associated targets that were promulgated through the Millennium Declaration at the United Nation's Millennium Summit that took place in the year 2000. The MDGs were to be implemented by 2015, and they represented an ambitious Millennium global consensus and commitment by 189 Heads of States and Governments that took place in New York. The eight goals were: Eradicate extreme poverty and hunger; Achieve universal primary education; Promote gender equality and empower women; Reduce child mortality; Improve maternal health; Combat HIV/Aids, Malaria, and other diseases; Ensure environmental sustainability; Develop a global partnership for development. This chapter presents the background information on MDGs and the research problem. It then covers the research purpose leading into research questions, and the significance of the study. The chapter summary is provided at the end.

1.1: The background to MDGs

Prior to the declaration of MDGs in 2000, the world had other human development agendas that guided the quest to break through the human shackles of poverty and inequality. One may say that MDGs were a continuation of the popular philosophy termed "health for all by the year 2000" which became a world agenda as part of the Alma-Ata Declaration in 1978 (Child Mortality Coordination, 2006). They were also formulated from development ideas that were part of the World Development campaigns of the 1980s and 1990s such that in 2000, they were officially proclaimed as a product of the United Nation's Summit (Lozano et al., 2011).

In the early 1990s global leaders discussed the need to improve human population and development during the Cairo (Egypt) International Conference. This conference was followed in 1995 by the 4th World Conference on Women and Development that was held in Beijing (Campbell-White & Merrick, 2006). During the Beijing conference, the delegates focused on twelve key issues that affected women:

> Poverty, education and training; health care and related services; violence against women; effects of armed or other kinds of conflict on women; economic structures and policies; power and decision making; human rights; media stereotyping;

environment and natural resources safeguarding; and the rights of the girl child

(Larson, 1996, p. 695)

Despite being referred to as overambitious, the Beijing conference was another opportunity to remind the world about the content of the UN Charter and therefore the obligation to put into practice the Universal Declaration of Human Rights (UDHR), in particular the elimination of all forms of discrimination against women (Larson, 1996). In line with the UDHR, MDGs were declared in 2000. One unique feature of the MDGs were their ability to mobilise global political consensus by the 189 Heads of Governments and States and also their ability to transform this political consensus into economic and health improvement actions in all countries of the world (Clements, Nshimirimanda, & Gasasira, 2008). Following their promulgation, high level meetings and implementation plans were drawn, including a wide call to key world institutions, Non-Government Organisations (NGOs), businesses and foundations and individual countries to support their implementation and achievement by 2015. As the most ambitious, comprehensive, and widely supported initiative the world has ever had (Lozano et al., 2011) its monitoring and implementation success was highly anticipated. The next section looks at the research problem.

1.2: Millennium Development Goals 4 & 5

In September 2000, the United Nations (UN) declared 8 Millennium Development Goals (MDGs) to be achieved by 2015. MDGs 4 and 5 were aimed at reducing child mortality and improving maternal health. Child mortality refers to the probability of a child dying between birth and exactly 5 years of age, expressed per 1,000 live births (Wakefield et al., 2019), and maternal death is defined as the:

death of a woman while pregnant or within 42 days of termination of

pregnancy, irrespective of the duration and site of the pregnancy, from

any cause related to or aggravated by the pregnancy or its

management but not accident or accidental cause (Tayler-Smith et al.,

2013, p. 168).

Following the Millennium Declaration in 2000, the UN and the World Health Organisation (WHO) affirmed their commitment to achieving the MDGs by releasing two important documents entitled "The UN global strategy for women and children's health", and "the WHO's strategic directions for strengthening nursing and midwifery services" (Amieva &

Ferguson, 2012, p. 55). The documents encouraged nurses and midwives to become actively involved in the implementation process of MDGs 4 and 5, as they recognised the indispensable role nurses and midwives could play in strengthening a country's health care system (Amieva & Ferguson, 2012). The documents were viewed as assisting in empowering nurses and midwives and in strengthening health care services in various countries.

Empowerment was interpreted as a system, or organizational support, to improve competency, self-determination and to influence behaviors with positive organisational impact (Montani, Courcy, Giorgi, & Boilard, 2015). Each country was responsible for implementing the goals based on local conditions (Waage, et al., 2010).

The UN and WHO recommended that various stakeholders collaborate throughout the process of providing care and they encouraged nurses and midwives to participate in continuing education programs. Although the concept "stake holders" is widely contested, this study adopts the widely accepted definition of stake holders as given by Freeman (1984) which states that a stake holder "is any group or individual who can affect or is affected by the achievement of the organisations' objectives" (Miles, 2011, p. 293). This definition is preferred since it carries a notion of people who have vested interests in the affairs of the organisation, and whose decisions or actions have an effect on the organisation. Operationally, "stake holders" as used in this study refers to professionals or groups of employees that are part of the decision-making process of an organisation that supports the health care sector in achieving the envisaged goals.

One activity in the successful implementation of MDGs 4 & 5 as stated by the UN and WHO was the recording and tracking of maternal and child mortality rates (Amieva & Ferguson, 2012). Child mortality is a vital indicator of the child's and mother's health and also an indicator of the overall wellbeing of the people in a given country (Appunni & Hamisi, 2013). Whereas MDG 4 aimed at reducing by two-thirds the under-five mortality rate (U5MR), MDG 5 targeted three quarters reduction in maternal mortality ratio (MMR) and universal access to reproductive health by 2015 (Cohen, Bishai, Alfonso, Kuruvilla, & Schweitzer, 2014; Gaps, 2011).

Maternal Mortality is the death of a woman during the process of child bearing, or during the first 42 days of the birth of a child (Hogan et al., 2010); and is expressed by a number of deaths per 100, 000 live births (Cohen et al., 2014).

Besides being implementation focused, MDGs were also focused on the success and progress in monitoring of its targets. Close to 2015, the monitoring showed inequalities in achieving the goals across world regions and individual countries (Lomazzi, Borisch, & Laaser, 2014a). In developing countries, the success story has not been encouraging due to inability to meet the targets (Bank & World, 2015). More child mortalities were reported mainly in Low- and Middle-Income Countries (LMIC), particularly in Sub-Saharan Africa, and in South Asia. Malaria, malnutrition, diarrhea, and pneumonia were reported to be the leading causes of child fatalities, accounting up to 30% of the mortality rates (Bryce, Black, & Victora, 2013).

Tanzania falls under the category of LMIC and is found in Sub-Saharan African region. The country experienced some challenges in attaining MDG 4 which is about reducing child mortality (Cohen et al., 2014), and also challenges in attaining MDG 5 (Ruhago, Ngalesoni, & Norheim, 2012). Those challenges, included inconsistent targets in the area of Reproductive, Maternal, Newborn, and Child Health (RMNCH); inconsistent policy implementation strategies; the absence of follow-up home visits to mothers who deliver in hospitals, and who get discharged early (Afnan-Holmes, Magoma, John, & Levira, 2015). Other reported challenges were inadequate family planning programs; inadequate high impact intervention programs, low utilization of skilled birth attendants (SBA), low health workforce density and specialist cadres (5.5 doctors, nurses and midwives per 10 000 people) which is way below what is recommended by WHO (Afnan-Holmes et al., 2015). WHO recommends 23 doctors, nurses and midwives per 10 000 people (Afnan-Holmes et al., 2015). Yet more challenges were attributed to insufficient funding, disparities between rural and urban areas in terms of health workforce density as well as gaps in utilization of national maternal reproductive health policies.

As regards MDG 4, the U5MR for Tanzania remained higher than that of the world's average such that in 2009, Tanzania had a 27th ranking on U5MR (Appunni & Hamisi, 2013). in 2013, the country had only reduced undernourishment among the children below the age of 5 years by 2% between 1990 and 2012, and undernutrition is understood to be an important indicator of a child's health, which accounts for 45% of the children's deaths before the age of 5 years (Semali, Tengia-Kessy, Mmbaga, & Leyna, 2015).

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The majority of U5MR was accounted for by neonatal deaths caused by sepsis and pneumonia or lower respiratory illnesses, pre-term birth, and intrapartum complications (Bryce et al., 2013). The protection against pneumonia by using pneumococcal vaccine was reported to be ineffective, and this was the same for antibiotics treatment due to antibiotics resistance. Diarrhea was another threat to children's lives, and the vaccine as well as the use of oral rehydration salts (ORS) were ineffective. Other factors which accounted for high U5MR as well as maternal deaths in Tanzania were high prevalence of HIV/AID, and malaria (Appunni & Hamisi, 2013). Lack of long-lasting insecticide-treated nets to protect the children against malaria (6 months to 3 years or more) and undernutrition prevalent among the majority of Tanzanian children especially in rural areas were the main causes of child mortality (Bryce et al., 2013).

At present, MMR of 70 per 100 000; Neonatal Mortality Ratio (NMR) of 12 per 1000 live births; and U5MR of 25 per 1000 live births by 2030 constitute the global target (Cohen et al., 2014). NMR refers to the number of deaths of new born children during the first 28 days of life (Afnan-Holmes et al., 2015). The assessment and maintenance of records on child mortality and maternal health are important features for any country's effort to attaining these global goals.

Tanzania was also off target with its MDG 5 targets (Cohen et al., 2014). By around 2013, MMR for Tanzania stood at 410 deaths per 100,000 livebirths (Afnan-Holmes et al., 2015). In general, attaining MDGs targets by 2015 has not only been difficult for Tanzania, but this remains a challenge for the Sub-Saharan region even by 2030. For example:
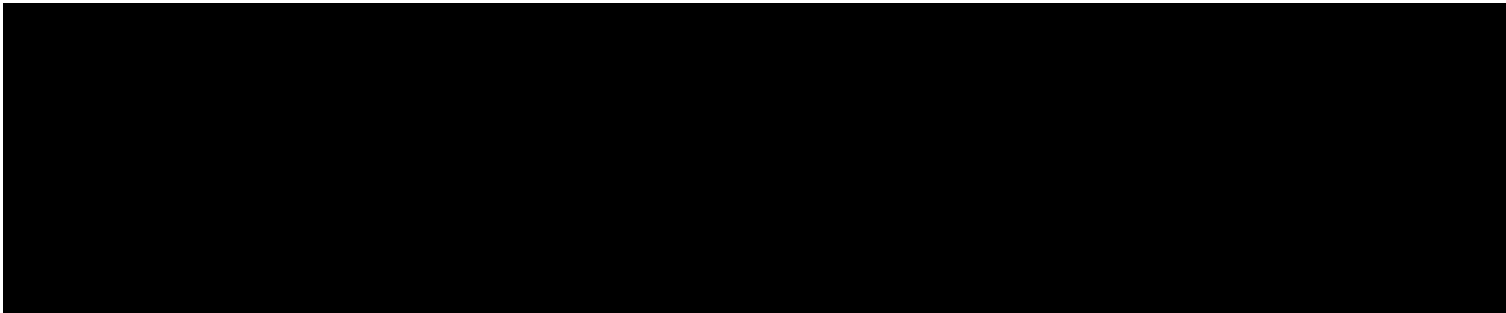
> Gabon would have to improve more than seven times on its present MMR annual rate of decline of 0·8%—compared with Eritrea's 6·3%—to reach an MMR of 70 per 100 000 livebirths in 2030. If a country such as Chad, with an MMR of 1100 per 100 000 livebirths in 2010, improved its MMR at 6·3% annually from 2010 to 2030, its MMR in 2030 would still be 300 per 100,000 livebirths (WHO, 2015 p.374)

The attainment of MDG 5 has also not been possible for parts of Asia (Fotso & Fogarty, 2015). Although South-East Asia made good progress, MMR in the region stood at 190 per 100,000; with a skilled birth attendance (SBA) of around 51% (Fotso & Fogarty, 2015). SBA is an important indicator of maternal health in a given population (Fotso & Fogarty, 2015); and it refers to the process where women are provided with care during pregnancy, during

childbirth and the period after child birth by a trained or accredited health professional (Munabi-Babigumira, Nabudere, Asiimwe, Fretheim, & Sandberg, 2019).

While low to middle income countries struggled to attain health related goals (MDGs 4 and 5), high income regions and countries have done well, owing to already existing strong health care systems, high income and funding of health activities, synergy in health related policies, access to high skilled birth attendants and equitable access to services (Fotso & Fogarty, 2015). The table below shows achievement progress on goal 4 and 5. Table 1 offers a summary of progress towards attaining MDGs 4 and 5 targets.

Table 1.1: Global and Regional Progress on MDGs 4 and 5.

("WHO publishes 2015 World Health Statistics," 2015, p. 12)

In December 2015, the WHO terminated the MDGs project, but again the UN acknowledged that world poverty was far from being eradiated. A new initiative called Sustainable Development Goals (SDG), was designed to address the deficits. Although these new goals did not include child and maternal morbidity and mortality, they were embedded in Goal 3 which aspires to ensure healthy lives and promoting well-being of the people for all ages' (Sachs, 2012).

Anecdotal evidence indicates that nurses and midwives had a low level of participation in the implementation of the MDGs in developing countries. It has been argued that barriers such as lack of knowledge and confidence; lack of opportunities; lack of enabling structures in the health care systems; and the negative image of the nursing profession, have prevented nurse leaders from effectively participating in healthcare policy development in East African countries (Shariff, 2014).

1.3: The research problem

Tanzanian nurses, like all nurses, have knowledge and competencies that are useful in strengthening their country's health care system. Anecdotal evidence indicates that nurses and midwives had a low level of participation in the implementation of the MDGs in developing countries. It has been argued that barriers such as lack of knowledge and confidence; lack of opportunities; lack of enabling structures in the health care systems; and the negative image of the nursing profession, have prevented nurse leaders from effectively participating in healthcare policy development in East African countries (Shariff, 2014).
Despite the knowledge and competencies, Tanzanian nurses and midwives may have been faced with unique factors that have limited their participation in implementing MDGs 4 and 5. The question then to be asked is: could the same factors or similar factors as those mentioned above have limited Tanzanian nurses and midwives from fully participating, and being key players in the implementation process of the MDGs 4 and 5? Can lessons be learnt to empower nurses and midwives in the implementation of the SDGs now that the MDGs have expired? These questions necessitated the need to investigate such factors to enable formulation of strategies to improve nurses and midwives' participation and to empower them so that they can have more impact in the implementation and attainment of SDGs by 2030, particularly Goal 3 (Good Health and Well-being).

1.4: The purpose of the study

The purpose of this study was to investigate and describe the factors that enabled or inhibited Tanzanian nurses and midwives from participating in the implementation of MDGs 4 and 5. A clear understanding of these factors would lead to recommending strategies for better participation, implementation, and attainment of SDGs by 2030.

1.5: Research questions

The interconnectedness of the research problem and purpose led to the following five research questions:

1. How were the nurses and midwives in Tanzania made aware of the MDGs 4 and 5?
2. How did the nurses and midwives in Tanzania participate in implementing the MDGs 4 and 5?
3. What are the factors that enabled or impeded Tanzanian nurses and midwives from participating in the implementation of MDGs 4 and 5?
4. How did the Ministry of Health and Social Welfare (MOHSW), hospital administrators in Muhimbili Referral Hospital, Hubet Kairuki and Kabanga respond to the UN's and WHO's call to support the nurses and midwives in implementing MDGs 4 and 5?
5. What lessons can be learned from nurses and midwives' participation in MDGs that will assist in formulating strategies for participation in future health care goals such as the SDGs?

1.6: Significance of the study

As nurses and midwives are recognised to be instrumental in the implementation of the MDGs (Amieva & Ferguson, 2012), it was important to investigate the enabling and inhibiting factors that influenced their participation in the MDGs to see if lessons could be learnt for the future. The enabling and inhibiting factors enabled recommendations to be made for nurses' and midwives' participation in SDGs, including strategies for strengthening the nursing and midwifery services and the health care system in Tanzania. This study identified gaps in the Tanzanian health care system, particularly those related to implementation processes of MDGs. The study will therefore come up with details on how these identified inhibiting factors may be mitigated to give confidence to nurses and midwives and to improve their participation in future health care goals including SDGs. Similarly, this study will give details on how identified enabling factors may be maintained and enhanced to reduce child mortality and to improve maternal health in Tanzania.

Finally, there is insufficient literature that describe the influence of the UN's and the WHO's effort to encourage nurses and midwives' participation in implementing the MDGs in Tanzania. This study intends to fill this gap adding to a more comprehensive understanding

of Tanzanian nurses' and midwives' participation in addressing health care goals, principally those associated with child and maternal wellbeing.

1.7: Researcher positionality statement

Qualitative research brings together the researcher and participant in an interaction that shapes the research and affects the extent to which data is collected and interpreted. The depth of information collected during data collection is subject to the researcher's personal attributes, the rapport he/she builds with the participants as well as self-disclosure (Flurey, 2015).

The researcher as "instrument" in qualitative research means that he/she is an active being who uses their sensory self to shape the data collection, interpretation, and presentation (Cumming-Potvin, 2013) . Thus, the paragraph below describes my location within the study. I developed a desire to look at the participation of the nurses and midwives in Tanzania in MDGs 4 and 5, being aware that their participation was essential in achieving those global health goals.

I am a male registered nurse who undertook my nursing studies in Western Australia where I have been working both in clinical and management areas for about 22 years. I grew up and received my initial, secondary and university education in Tanzania prior to moving to Australia. Although I have not worked in the Tanzanian health care system, I have a fair understanding of the health care setting from literature, regular social contacts in Tanzania and from using the hospital services. During my 22 years in Australia, I visited my family and friends in Tanzania almost every year. This therefore gave me an opportunity to keep in touch with the socio-economic changes and developments in the country. I speak Kiswahili and I am culturally competent within Tanzanian society. Being culturally competent means having both awareness about Tanzanian cultural practices in general, and also being sensitive to those practices. Literature supports the view that cultural competency is composed of both the knowledge or cultural awareness and the skills to use that knowledge in different cultural settings (Rittle, 2015). I declared my background to participants of this study in order to let them know who I was, and how I could relate to them professionally. I assured participants that despite my Eurocentric nursing background, I still shared with them the social norms, values and culture. I built good rapport with participants, and my personal attributes during data collection were described as supportive and affirmative. My co-supervisor who was also a Tanzanian played a supportive role.

1.8: Chapter One Summary

Chapter one has introduced essential parts of the first chapter. The introduction and background to the study have been discussed, covering the advent of MDGs. The importance for nurses and midwives to be actively involved in MDGs as proposed by the UN and WHO was highlighted. MDGs 4 & 5 were discussed, including the challenges in terms of their realisation in Tanzania. The research problem, purpose, research questions, and study significance were discussed. The researcher's positionality was presented, and the researcher's connection to Tanzania was covered. The next chapter discusses the literature review.

Chapter 2: Literature Review

2.0 Introduction

This study examines the participation by nurses and midwives in Tanzania during the implementation phase of Millennium Development Goals (MDGs) between 2000 and 2015. The World Health Organization (WHO) has an expectation that nurses and midwives were part of the network in a country's health care system involved in decisions and interventions geared towards improving population health and wellbeing (Gonzales & Boswell, 2021). According to WHO, the participation of nurses and midwives should not only be limited to implementing clinical interventions related to maternal and child health, but rather, they should be actively involved in enacting policies, making plans and evaluating those interventions. The overall intention was to learn from their participation in MDGs to ensure better participation in the current global development agenda (2016 – 2030) named Sustainable Development Goals (SDGs), potentially leading to further reductions in child mortality and improvement of maternal health.

The literature review for this study aimed at locating materials that were considered relevant to the context (Tanzania), and the subject matter (MDGs/SDGs). The literature review located and discussed MDGs and SDGs as the subject matter for the study. Other concepts reviewed are the context of care in Tanzania; nursing education including Inter-professional Collaboration, and Inter-Professional Education (IPE); nursing empowerment; and Critical Social Theory (CST). These concepts and theories were essential in describing the subject matter, and they provide a good link and synthesis between the phenomenon being studied (participation) and the context. There is an observed relationship between nurses' empowerment, and their confidence to participate in health care policy formulation (Hajizadeh, Zamanzadeh, & Khodayari-Zarnaq, 2021). The World Health Organization also recognises the importance of IPE for the nursing profession in effecting their participation in health services delivery through collaborative practice (Lim & Noble-Jones, 2018).

During the literature review process, a combination of methods such as the use of key words was used to access materials from electronic data bases such as ProQuest, PsycInfo, Medline, Wiley Online Library, ScienceDirect and other credible websites. The data bases facilitated

the access to credible scholarly publications and journals relevant to the study topic. Some of the key words used in the search included:

"UN Millennium Summit in New York 2000"; "Precursor to MDGs"; "MDGs implementation in Tanzania"; "MDGs for Sub-Saharan Africa"; "The context of health care in Tanzania"; "Primary Health Care in Tanzania"; "Tanzania, access to health care"; "Inter-Professional Collaboration"; "Interprofessional Practice"; "Interprofessional Education"; "Education for professional groups in Tanzania"; "Leadership in nursing"; "A nurse Leader"; "Nursing and MDGs"; "nursing leadership and challenges"; "Women empowerment"; "Education for change", "Tanzania and women empowerment"; "Nursing Theories", Critical Theory'; "Critical Social Theory in nursing". "Critical Social Theory and education".

In-text references (through paraphrasing or direct quotes) that seemed to be of interest were tracked through the reference list for specific material, and in data bases. Once the referenced material was found, it was read as whole publication. Besides articles, relevant textbooks, and books published online were also reviewed. The search for literature on MDGs was for materials published between 2000 and 2016, and the search for information on SDGs was for publications dating from 2014 to 2022. This is because the literature on MDGs became available from the time of their declaration and implementation (2000 to 2015), and the literature on SDGs became available mainly from 2016. No timeframes were used for other literature that offered the background, the context, and theoretical constructs to the study.

This proposed study is unique in that there has not been a lot of literature and studies describing nurses or midwives' participation in the implementation of MDGs in Tanzania, and other countries in Africa. The literature review on MDG implementation and related subject matter is therefore an attempt to provide enough background and orientation to this study. Scholarly literature was continuously gathered from the time of submitting the research proposal for approval right through to data collection, analysis, presentation of findings and dissertation writing. In other words, the literature review continued throughout the research and writing process.

2.1: The literature review framework

Following on from the previous section where the search for literature was explained, the concepts that were reflected repeatedly in the literature were included as part of the framework used in this chapter. This framework was developed in order to provide a

systematic process for understanding the background, the discussion, the syntheses, and study recommendations. The framework was therefore shaped by the literature review which was iterative in nature and reflected my personal view of reality, the phenomenon being studied and my professional experience as an Australian registered nurse who understands the context of Tanzanian nursing. The concepts which were identified repeatedly in the literature enabled the framework and influenced the structuring of the chapter. Key concepts in this chapter therefore included: MDGs and SDGs; the context of care in Tanzania, Inter-Professional Collaboration (IPC); Inter-Professional Education (IPE); nursing leadership; women's empowerment in Tanzania; Critical Social Theory, and Social Identity Theory.

The concepts used in the literature review framework are diagrammatically represented below.

Figure 2.1: The Concepts for Literature Review framework
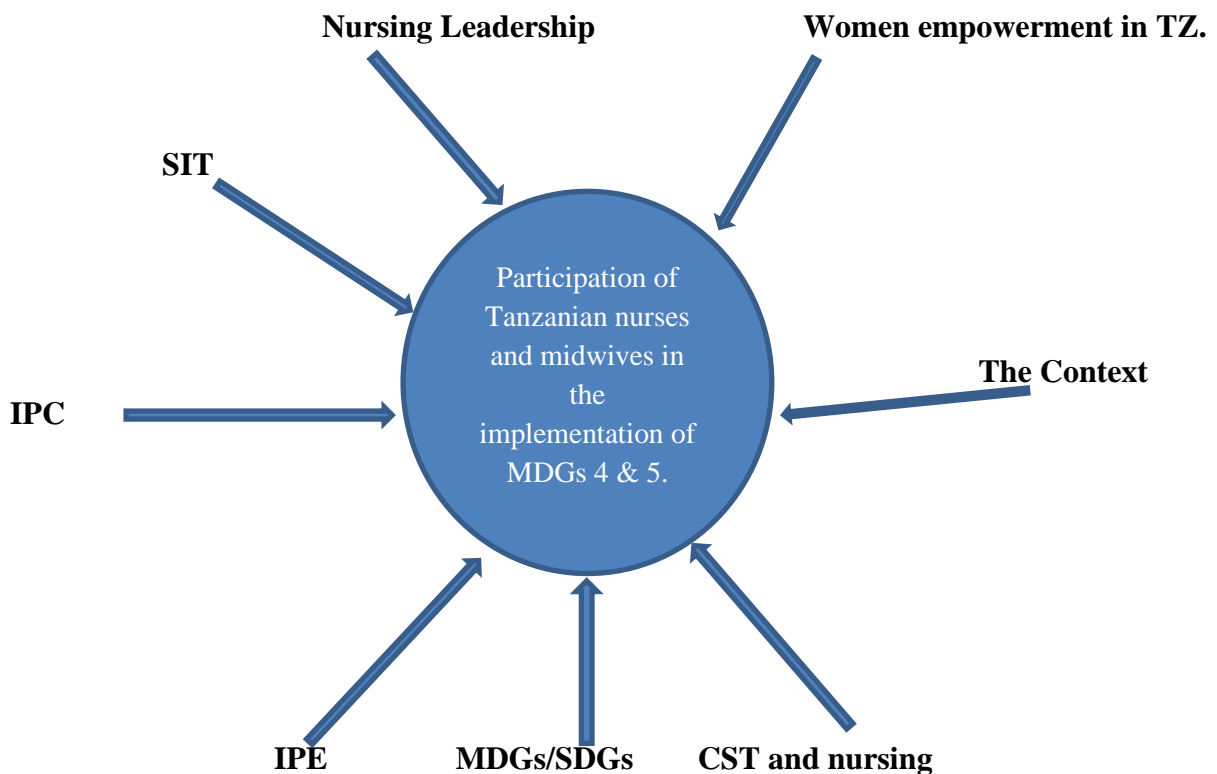
2.2: The Millennium Development Goals (MDGs)

The MDGs arose from the declaration made by world Heads of Governments and States who gathered in New York in 2000. One of the visions for MDGs (embedded in Goals 4 and 5) was to reduce inequity and improve access to health care. In the years leading to the declaration of MDGs, the vision of 'health for all by the year 2000' became the catch cry across the globe (Child Mortality Coordination, 2006), and the MDGs therefore included a set of eight goals and eighteen associated sub-goals and targets to be achieved by 2015.

The MDGs represented a commitment by 189 Heads of Governments and States to tackle poverty and hunger; achieve universal education; address gender inequality; reduce child mortality; improve maternal health; combat HIV/AIDS, tuberculosis and malaria; improve the natural environment, access to clean water, sanitation and housing; and improve global partnership for sustainable development (Mutasa & Paterson, 2015).

The 2000 millennium development framework was a unique strategy for global development. One of the key elements of the MDGs was their ability to mobilise the global political consensus through the UN summit including rich and poor countries, the world's key international institutions, international Non-Governmental organisations (NGOs), and their potential to transform this consensus into economic and health improvement actions, in all countries across the globe (Mutasa & Paterson, 2015). The advent of MDGs created a unique momentum for socioeconomic change, especially for countries in Africa. On the one hand, MDGs were expressing basic human rights, because they advocated for basic human needs. On the other hand, the MDGs aimed at portraying a broader view of the development narrative beyond individual countries' efforts (Mutasa & Paterson, 2015). A summary of the advantages and value noted in MDGs is offered as follows: "The MDGs are claimed to be the first global development vision that combines a global political endorsement with a clear focus on, and means to engage directly with, the world's poor people" (Waage et al., 2010a, p. 995).

MDGs were signed by 53 African countries, and these countries were convinced about the development narrative that MDGs portrayed at the time of their inception. Despite Africa

making some progress in the attainment of MDGs, literature has clearly exposed obvious setbacks to attaining these goals, particularly those related to reduction of child mortality, and improvement of maternal health. Scholars have expressed concerns related to hidden ideological underpinnings in the development of MDGs. Samir Amin (2010), quoted in Mutasa & Paterson, 2015, was critical of how MDGs were undemocratically crafted. Other scholars have also expressed how the rich countries including the United States, Europe, and partner countries such as Japan and Canada crafted MDGs to reflect the western hegemony in such a way that Ted Gordon, a known CIA consultant, was involved in the drafting of the MDGs. Exclusion and inequality have not only been echoed in the formulation of MDGs, but also in its funding and implementation strategies. Literature shows that countries with well-resourced health care systems such as Australia, Canada, Norway, and others, made tremendous steps in reducing child mortality (MDG 4) and they met targets for improvement of maternal health (MDG 5). Countries south of the Sahara and in south Asia and India, on the contrary, have either not made substantive progress or have not fully achieved the targets (Prachitha, Dhume, & Subramanian, 2019; Shrivastava, Shrivastava, & Ramasamy, 2016; Wager, 2010). For example, about 50% of all maternal deaths in the world occurred in six countries, namely India, Pakistan, Democratic Republic of the Congo, Nigeria, Afghanistan, and Ethiopia (Zimmerman, DiClemente, Andrus, Hosein, & Society for Public Health, 2016). Out of the 181 that were surveyed for attainment of Maternal Mortality Ratio (MMR) only 23 countries were close to attaining 75% of the target by 2015 (Zimmerman et al., 2016). Egypt, China and Bolivia are the three countries noted to have made tremendous steps towards cutting the maternal mortality ratio (Zimmerman et al., 2016).

Generally, targets for MDGs 4 and 5, set against the benchmark for developed economies, were considered ambitious for developing countries (Clements et al., 2008). The first MDG 4 target, which aimed to reduce the mortality rate by two-thirds in children aged below 5 years, was set as though all countries had a similar mortality rate. Given this background, it has been challenging for countries south of the Sahara to effectively meet this target, since there is an inherent high child mortality rate in those countries (Clements et al., 2008). For example, U5MR in Tanzania stood at 118 per 1000 in 2005 (World, 2009); and the rater for Denmark was 33 per 1000 around 2004 (Friborg, Koch, Stenz, Wohlfahrt, & Melbye, 2004). Looking at the high child mortality rate in Tanzania compared to that in Denmark, it would be difficult for Tanzania to be at the same child mortality rate with Denmark by 2015.

Despite the MDG initiative being ushered in with enthusiasm as part of the millennium cerebrations, analysts like Amin (2006) and Waage et al. (2010) offer a critique of the goals, starting from how the goals were drafted or constructed, how they were defined and who the beneficiaries of the goals were. Amin for example, does not agree that MDGs were a result of consultation summits made in the 1990s; instead, he states that Ted Gordon who was a CIA consultant drafted the MDGs as part of the plan for global advancement of imperialism, capitalism, and liberalism. Amin further states "Instead of forming a genuine committee for the purpose of discussing the document, a draft was prepared in the backroom of some obscure agency" (Amin, 2006, p. 2). Amin further contends that MDGs were vague in their definition. For example, he mentions clear difficulties in global poverty reduction without first analysing the policies and practices that have contributed to poverty in poor countries; and lack of this analysis has contributed to poor implementation and attainment of these goals.

Waage et al. (2010) also argue that among other challenges that MDGs faced related to how the goals were constructed and that this had a bearing on the goals' execution. Given the goals' background, it was obvious that their global implementation was considered disjointed (Waage et al., 2010a); and a closer look at the implementation framework revealed a different picture from that which was initially portrayed during the MDGs promulgation. It has been argued that targets set on levels reached by development countries have undermined the attainment of the MDGs by developing countries (Waage et al., 2010a). This is to say that MDG targets set without taking into consideration individual countries' local context, inter-country differences as well as financial capabilities were likely to fail, particularly in developing countries, and as a result, overall implementation of MDGs in developing countries was described as slow. The slowness was associated with socio-economic, cultural, administrative, and logistical factors (Wamala, Chamberlain, & Nabachwa, 2012).

Other challenges and setbacks for attaining MDG targets have included: poor leadership, corruption, lack of clear national and international implementation policies, disjointed programs for MDG implementation and lack of ownership of MDG implementation strategies, both globally and at an individual country level (Waage et al., 2010b). In this context, "ownership" refers to the control of plans and MDG implementation strategies (Waage et al., 2010a). Although multilateral agencies such as the UN, the WHO, the World Bank, together with many other non-government Organisations, were heavily involved in

developing MDGs and financing their implementation, they had no control over the MDG implementation plans and strategies. Developing countries, on the other hand, had control of the planned strategies to implement the goals, but had no control of the financing mechanisms needed to support such accomplishments (Waage et al., 2010a).

At country levels (for ub-Saharan countries) there seemed to be little evidence of a shared vision for MDGs 4 and 5 across various health care professional communities and other interest groups (Waage et al., 2010a). The absence of a shared vision seemingly resulted in an uncoordinated effort and the sharing of responsibility for implementation strategies (Waage et al., 2010a). Overall, the implementation of the MDGs has been described as being patchy and uneven, with insufficient progress to meet the targets being made, particularly in African countries (Waage et al., 2010a). This lack of progress has resulted in the adoption of a new set of goals (Sustainable Development Goals) to be implemented between 2016 and 2030.

2.3: The shift from MDGs to SDGs

Millennium Development Goals which were introduced and implemented for 15 years expired in 2015. In September 2016, Sustainable Development Goals (SDGs) were declared by the United Nations General Assembly as part of the 2030 sustainable development agenda. As such SDGs were considered as extension of MDGs, given that many countries, particularly those in the category of Low and Middle-Income Countries, were unable to reach the MDG targets. The decision to declare SDGs was preceded by a number of criticisms that were levelled against MDGs. These criticisms included among other things, the MDGs' narrow focus on the concept "development" which was merely taken to refer to economic and GDP growth, instead of being human-focused (Briant Carant, 2017). Also, analysts reported the fact that MDGs were disjointed, they lacked clear linkages, and they had a narrow focus on gender equality and rights (Briant Carant, 2017).

The declaration and adoption of SDGs was therefore understood to be unfinished business of the MDGs (Kumar, Kumar, & Vivekadhish, 2016). The Sustainable Development Goals that were declared for all countries to be achieved by 2030 are different from MDGs in that they are broader, with 17 goals and 169 targets, and many national governments were involved in their design (Niklasson, 2019). Sustainable Development Goals also encompass a much wider public vision, including environmental concerns, good health and wellbeing in areas of

physical and mental health, life expectancy, and universal health cover (UN, 2015). Another noticeable feature of the SDGs was that each country was charged with setting its targets within the context of its cultural, social, and economic environment, in order to enhance the health care system (Kumar et al., 2016).

Under SDGs, Goal 3 aims at improving the health and wellbeing of the people, and this goal encompasses all aspects of health from primary to tertiary health services. Although SDGs do not include a goal specifically devoted to primary health care (PHC), programs to promote family planning, maternal and child health, sexual health, and the fight against epidemic and transmissible diseases are viewed as primary health care concepts and are being promoted under Goal 3 (UN, 2015). It can therefore be seen that PHC still has a central role in achieving SDGs (Pettigrew et al., 2015), and PHC has been presented as an important part of the context of the Tanzanian health care system. The effective implementation and attainment of the targets under SDGs will therefore depend on the evaluation and assessment of how the implementation of MDGs was carried out, and this is what this study aims to do. SDGs are considered to be an opportunity to correct the problems encountered during MDG era. The nursing and midwifery profession has to position itself and effectively collaborate with other key stake holders in making sure that the 2030 development agenda is attained.

2.4: The context of care

The context of care in Tanzania is driven by the country's health care policy, which focuses at improving the health conditions of most Tanzanians who are found in rural areas. The health care system is also built on the Arusha Declaration, a blueprint of 1967 which laid a foundation for African socialism. The Arusha Declaration puts emphasis on social values, social justice, and rural development (Radcliffe, Scott, Werner, & Radcliffe, 2014). According to the Arusha Declaration, the focus of development and provision of essential health care services was to be directed to rural areas, and this was in line with the process of providing primary health care services.

Primary health care entails the first line of programs and treatment provided by physicians, nurses, paramedics, dentists and other health care professionals in clinics or health care centers (McMurray & Clendon, 2011). It refers to combined health care activities such as health education, health promotion, immunization, nutrition and other health care programs

(McMurray & Clendon, 2011). PHC is a social model of health, puts emphasis on holistic care, community participation and inter-sectorial approaches in areas of policy, housing, water, education, nutrition and others (Bramall, 2018). The Arusha Declaration aimed at increasing awareness and empowering people to control and improve their own health through participative and capacity building initiatives at the local levels. It is understood that the government of Tanzania has had a longstanding aim of directing more health resources to rural areas of Tanzania, where about 70 percent of the population live, and where health care professionals are in short supply (Leshabari et al., 2012).

Nurses and midwives in Tanzania and across the globe play an essential role in promoting PHC and in implementing various health activities in the community; they spread messages and campaigns on preventative and curative measures for diseases; they provide education on good life style choices, they are involved in sharing information in such areas as nutrition, vaccination as well as promoting various health care programs (Wills, 2014). Nurses and midwives have a mandate to ensure that communities respond positively to PHC programs that aim at improving health for all. They also help people and communities to be aware of social circumstances and economic conditions that affect their health. Nurses and midwives possess the knowledge and abilities to enhance good health in communities through education on determinants of good health (McMurray & Clendon, 2011). The success in implementing health care services in Tanzania requires cooperation and the sharing of responsibilities among health care professionals through the process of Inter-Professional Education, and inter-professional collaboration for better health outcome (Petri, 2010).

2.5: Nursing and midwifery education

Nursing and midwifery education in Tanzania, like in many other countries, is geared towards preparing nurses and midwives to meet the health care needs within the country; to ensure safe practice, integrate theoretical knowledge into practice, and use evidence-based practice (Mboineki & Zhang, 2018). Nurses and midwives are the backbone of Tanzanian health care system given that they form 60% of the total health care work force (Klopper, Uys, & Sigma Theta Tau, 2012). Nurses and midwives work in various settings, and they occupy positions throughout the health care system. This group of health care workers has the

knowledge and skills to carry out nursing and midwifery functions at primary health care, hospital care and tertiary referral health care institutions.

Nurses and midwives' qualifications in Tanzania may not be like those in Australia or other developed countries and therefore, they need to be defined in terms of the context of the proposed study. In general, the nursing qualifications recognised in Tanzania are enrolled nurses and registered nurses. Nurses are "enrolled" when they have completed certificate level education, which is the lowest educational level in nursing, and they are "registered" upon completion of a diploma or any level of degree program (Mboineki & Zhang, 2018). In most cases, enrolled nurses are those that have had two years of general nursing training. A nurse in Tanzania may also be classified as Assistant Nursing Officer (ANO) and Nursing Officer (NO).

Assistant Nursing Officers complete a three-year Diploma in General Nursing. This qualification includes an integration of both general nursing and midwifery competencies. Nursing Officers complete a four years (BSc) degree that also includes an integration of general nursing and midwifery competencies. Currently, the criteria for acceptance into the program is the possession of a high school leaving certificate; but nurses who possess a Diploma in General Nursing may also be accepted. Graduates from the degree program have the option to advance to a Master's degree in any chosen area (MOHSW, 2008). The Tanzania Nursing and Midwifery Council (TNMC) is the licensure and regulatory body for nurses and midwives practicing in Tanzania. TNMC was established under the Nursing and Midwifery Act 2010 to protect the public, and to ensure that only those with acceptable knowledge and competences can practice as nurses or midwives. The licensure to TNMC is by completing the required training program provided through nursing and midwifery accredited training institutions, and through passing the TNMC's licensure examination.

The Nursing and Midwifery Practice divides Advanced Nursing Practice (ANP) in four categories namely: Nurse Practitioner, Clinical Nurse Specialist, Nurse Anesthetist and Nurse Midwives. Out of the four globally recognised categories ANPs, only Nurse Midwives are practicing in Tanzania. Education in the other three ANP are not offered in Tanzania (Mboineki & Zhang, 2018). More about nursing education in Tanzania will be discussed in Chapter 4 (The context). Inter-Professional Collaboration (IPC) is discussed next.

2.6: Inter-professional collaboration

The World Health Organization (WHO) acknowledged the contribution of inter-professional collaboration (IPC) for the realisation of various health care programs including those related to achieving Millennium Development Goals (Bashatah et al., 2020). IPC refers to the act of working collaboratively among different health care professional groups who work to attain similar goals (Neysmith, 2014). "Collaboration is a process in which autonomous actors interact through formal and informal negotiation, jointly creating rules and structures governing their relationships and ways to act or decide on the issues that brough them together; it is a process involving shared norms, and mutually beneficial interactions (Smith, 2015, p. 128)", and it takes place when professional groups who are guided by shared norms work harmoniously to attain a shared goal. In a health care setting, IPC is regarded as an act of cooperation and the sharing of responsibilities between nurses and other members of the multidisciplinary health care team with the purpose of resolving consumers' health care needs (Petri, 2010).

The collaboration being envisaged through IPC may be referred to as a looser form of team work where professionals involved still maintain accountability, shared goal, autonomy, interdependence, and interdisciplinary work (Smith, 2015). In this regard, interdisciplinary work includes collaboration between groups from different but related or complementary disciplines such as nurses, midwives, doctors, physiotherapists, speech pathologists, and others. IPC, therefore includes such activities as communication through informal and formal means such as meetings, workshops, shared planning, shared decision-making, coordination, as well as joint representation (Smith, 2015).

The concept IPC also applies to collaborative actions and interactions, between agencies and organisations. Through IPC, health care organisations, institutions, departments, health care workers, patients, and families or communities work collaboratively to deliver better health care services (Bashatah et al., 2020). Inter-professional collaboration is called a window of opportunity that needs to be explored by health professionals in various settings that are unified by one goal of meeting the needs of the people they serve (Sullivan, D. Kiovsky, J.

Mason, D. Hill, & Dukes, 2015). It is argued that inter-professional and inter-disciplinary collaboration skills facilitate the sharing of vision and responsibility among health care professionals and can lead to-attainment of goals (Petri, 2010).

Although IPC is essential in realising health care goals; its application has been slowed down by competing interests and tensions between various health care professionals (Petri, 2010). It is argued that the complex nature of IPC processes comes with challenges to its application; and difficulties have been noted in areas such as: professional roles, mistrust, the sharing of information; the issue of confidentiality, and the power balance among health professionals (Zijlstra, Lo Fo Wong, Teerling, Hutschemaekers, & Lagro-Janssen, 2018). Notwithstanding these difficulties, it is globally acknowledged that IPC can improve health care outcomes, and research has demonstrated that correct and coordinated application of IPC among well managed teams is effective in realizing envisaged health care goals (Neysmith, 2014). Given the importance of IPC in improving health care outcomes, it would be suggested that being able to define roles, norms, and awareness about professional boundaries and confidentiality would help in reducing challenges related professional roles, mistrust, or the sharing of information.

A well-coordinated IPC programs produces synergy within the health care system, which in turn positively affects the implementation and realisation of shared health care outcome (Willumsen, 2008). Inter-professional collaboration requires that professionals be trained to receive knowledge required to work in health care teams. Inter-professional collaboration is therefore complemented by, and it works hand in hand with Inter-Professional Education (IPE).

2.7: Inter-professional education

Inter-professional collaboration starts with IPE and socialisation (Yancey, 2018). Inter-professional education refers to an opportunity and occasions where professionals learn from each other as they collaborate during professional practice (Khabaz Mafinejad, Ahmady, Soltani Arabshahi, & Bigdeli, 2016), and is understood to be an effective mechanism for developing and implementing collaboration among health care professionals (Sunguya, Hinthong, Jimba, & Yasuoka, 2014). The World Health Organization (WHO) defines IPE as a process by which health care professionals and related occupations acquire knowledge and skills during their training to enable them to have meaningful interactions, collaboration and

communication which is necessary to attain the goals of the health care services (Shakman, G, & Obeidat, 2013). The goal of IPE among other things, is to enhance knowledge and awareness about others' professional roles, and to reduce communication errors, observance of norms and standards and generally to improve patients' outcomes (Bashatah et al., 2020).

Inter-professional education exposes health care workers to collaborating in a noncompeting manner, promoting good understanding among peers while maintaining group dynamics (Petri, 2010). The knowledge acquired in IPE equips aspiring professionals with skills to work collaboratively with professionals in other disciplines including skills to negotiate issues that may impede IPC. Through IPE, role awareness responsibilities and contribution of team members to interpersonal relationship is acquired. Interpersonal relationship skills which include effective communication; assertive skills and conflict resolution among peers are components of IPE. Interpersonal relationships, on the other hand signifies mutual respect, trust, and collaborative skills (Petri, 2010). Commitment, responsibility, and accountability are also essential parts of IPE. Through commitment, individuals who are part of the team as well as organisational or administrative structures work collaboratively (Petri, 2010). Skills obtained from IPE and IPC enable professionals to understand the need for collaborative practice; and they can collaborate with others without relinquishing their powers, status, and responsibilities. Health care professionals who have acquired IPE and IPC knowledge are able to optimise their skills and they can improve health services delivery (Gilbert, 2010). Both IPE and IPC, not only foster the sharing of experiences and perspectives among various professional groups, but are essential in transitioning the health systems from fragmentation to stability (Yancey, 2018).

The success of IPE also depends on the support that staff receive from their respective administrative and organisational structures (Petri, 2010). Administrative structures and units create conditions and policies that guide staff interaction, cooperation, and conflict resolution. Health care Organisations are responsible for making sure that resources, guidelines, and incentives for collaborative activities are made available (Petri, 2010). This therefore means that an envisaged health outcome does not come without cost and effort which usually is to be borne by the relevant health care organisation (Sandberg, 2010).

The majority of research on IPE is on students, from such disciplines as medicine, nursing, midwifery, and allied health. Most research on IPE is carried out in developed countries, and

IPE is a relatively new concept in developing countries such as those in Africa, and the Middle Eastern Countries. (Bashatah et al., 2020; Sunguya et al., 2014). The importance and usefulness of IPE will lead to these programs being rolled out in those countries where IPE is less researched and practiced. Strong leadership in health care settings is essential in effecting IPE and IPC. It is through effective leadership that resources are provided, and conditions for health care professionals to collaborate are put in place for the realisation of organisational goals and the goals of the health care system. Research suggests that enhancing nursing leadership is a priority if nurses are to have a voice nationally and internationally (Rosser, Scammell, Bevan, & Hundley, 2017). The next part discusses IPC and IPE in Tanzania

2.8: IPC and IPE in Tanzania

In Tanzania, practicing IPC is still at a developmental stage and as such there is scarcity of literature detailing how it is practiced in the health context. Leshabari et al.(2012) offered a description of the first initiative by the main University in Tanzania (Muhimbili University of Medicine and Allied health Sciences – MUHAS). The initiative considered to be the first step of IPC involved medical students, nursing and midwifery students, Pharmacists, dentist, and environmental health officer students. This first step was of a pilot nature and was known as Inter-Professional Day (IPD) whose aim was to foster IPC competencies and inter-professional relationships (Leshabari et al., 2012). The project was developed in realising that the health care system in Tanzania experienced severe shortages of health care professionals especially in rural areas, both in terms of awareness, competencies, and numbers. Available figures in Tanzania show that "for every 10000 births, 45 women die of pregnancy-related conditions and 260 children die before reaching 1 month" (Leshabari et al., 2012, p. 140).

Kvasnicka et al. (2017) discussed a two-days conference IPC model of inter-professional partnership for global health development which took place in Iringa – Tanzania. The conference was attended by 100 medical, nursing, pharmacy, and hospital administration participants from 28 hospitals in the southern region of Tanzania. This conference was presented by faith-based health professionals from the United States in cooperation with their Tanzanian counter parts. The aim was to foster Inter-professional Education and Cooperation as one of the strategies to strengthen the health care systems in a developing country such as Tanzania.

As noted earlier, strong leadership in health care settings is essential in effecting IPE and IPC. It is through effective leadership that more IPC and IPE programs will be resourced and implemented. The implementation of IPC and IPE programs in Tanzania through the initiatives from nursing and midwifery leaders is expected to pave the way for participation in various health programs.

2.9: Nursing leadership

Leadership plays the central role in modern nursing (Rosser et al., 2017). Nurse and midwifery leaders can be sources of inspiration, they can provide motivation and innovation. Leaders can empower others to challenge the *status quo* in various health care settings (Pullen, 2016). Leadership complements management since the two are not the same (Pullen, 2016). Leadership is essential in empowering nurses and midwives in giving them opportunities, encouragement and support through education, scholarship, and professional skills. Scholarship signifies relationships with other professionals through networking, research and educational activities that are professionally and developmentally beneficial (Rosser et al., 2017).

Nursing and midwifery are faced with common and persistent issues, challenges and failures that require leadership to address those challenges. These issues are often referred to as 'wicked issues' which include staff shortage, ongoing patient deterioration and acuity, persistent cut down of resources to perform work, and challenges related to global community health care (Rosser et al., 2017). In order to address these global challenges, and to position the nursing profession in a recognisable and respected position, nurse and midwife leaders need to apply a blend of leadership styles to suit different situations and contexts. Democratic leadership styles are required to enhance nurses' participation and teamwork; and transformational leadership styles to inspire and motivate others at the same time giving them intellectual power to change the status quo and unfavorable organisation culture (Pullen, 2016). Transformational leaders critically examine contexts, and they develop strategies to change elements of the work culture that impede the attainment of health care goals. Work culture refers to shared beliefs, norms and actions considered normal in the workplace (Rosser et al., 2017). By removing those elements of unfavorable work culture, nurses and midwives feel more valued and the attainment of global health care goals is made easy.

Globalisation and global programs require that nurse and midwife leaders have a broader view of their role beyond local confines hence the necessity to understand global challenges and how to interact with other health care professionals across country borders (Shaffer, Davis, To Dutka, & Richardson, 2014). Given that there are common global challenges that nurses, and midwives are experiencing; the need for strengthening leadership in clinical and scholarship areas in individual countries is imperative through global networks (Rosser et al., 2017). It is through strong nurse leadership that the difference will be made in individual country's health care systems. For this difference to be made, nurse and midwife leaders are required to double their efforts in the areas of empowerment since empowerment remains critical in this period characterised by global competitiveness and change.

2.10: Nurses' empowerment

The concept of empowerment has evolved, and its meaning has changed over time (Rao, 2012). In the 960s, empowerment was used to signify power sharing and in the 1970's, it was used to refer to fostering human welfare; and currently the concept is used to mean confidence and ownership of generated ideas, plans, participation, responsibilities, and working in teams for efficiency and productivity in work places (Rao, 2012). In social theory, empowerment is used in relation to the concept 'oppression for "oppressed groups"; and oppressed groups may include minority ethnic groups, immigrants, women, nurses (as representatives of a female-dominated group of employees) (Kuokkanen & Leino-Kilpi, 2000).

Nurse empowerment is a process involving being provided with the support to control one's own destiny (Williamson, 2005). The origin of the empowerment construct in nursing was a result of social cultural, work force and gender related constraints that had to be addressed to make it easy for nursing practice to advance (Rao, 2012). As a result, constructs such as 'structural empowerment' and 'motivational empowerment' came to light. Structural empowerment focuses on organisational elements to support and improve nurses' image such as participation, access to information and opportunities for advancement (Rao, 2012). Motivational empowerment manifests itself in an employee's mindset (Manojlovich, 2007). It is argued that it is the mindset of the person that shapes the beliefs, behavior and values to enable the person to confidently navigate through barriers posed by the absence of structural empowerment to attain self-efficacy (Manojlovich, 2007). Motivational empowerment

enables a person to develop self-confidence and control that he/she requires to confidently perform their duties. As consequences, empowered people possess the energy of initiating and of being responsible for actions related to work plans and programs (Williamson, 2005).

Employee's empowerment must be present at three necessary levels namely individual, Organisational and social (Rao, 2012). Nurses as empowered individuals feel confident and have a sense of autonomy. Nurses' empowerment comes from self-motivation and self-confidence and from the support of knowledge they have attained through their education and training. Being exposed to opportunities, and a supportive environment, with access to information and resources builds confidence in the ability to perform the nursing role (DeVivo, Quinn Griffin, Donahue, & Fitzpatrick, 2013). There is evidence that empowerment, as a positive concept, results in growth and development. It is argued that through an empowering process, organisations, communities and services can come together for maximum impact on realizing common goals (Kuokkanen & Leino-Kilpi, 2000). The next section discusses women empowerment in Tanzania.

2.11: Women's empowerment in Tanzania

Women's empowerment is closely linked to nurses' empowerment since most nurses in Tanzania are women (Walker, 2009). The concept 'empowerment' which has evolved over time, refers to the ability for people, or a group of people to gain power required to control their own affairs including resources through participation and decisions (Parveen, 2022). The concept covers the elements of women self-confidence, those aspects related to civil, legal and professional rights in such a way that women's contribution to society may be obvious. Women's empowerment and advocacy in Tanzania came about through a feminist movement and women rights such that female and gender empowerment is at a level that has become a social norm (Madaha, 2014a). The movement dates to colonial time and is associated with oppression practices that left certain women groups socially disadvantaged. The oppression was first perpetrated by colonial masters and agents of colonialism. After independence, the oppressive acts continued due to inherent traits of the patriarchal system (Madaha, 2014a; Vyas & Henrica, 2018). In 1961, the ruling party (TANU) deliberately created conditions to weaken the feminist movement under the pretext of national unity, hence only women's movements aligned with the ruling party such as *Umoja wa Wanawake Tanganyika (UWT)* which stands for Women's Union of Tanganyika could exist.

The recent women's empowerment was encouraged through a global women's movement, participation in UN women conferences, economic forums, and the wind of political changes in Tanzania. Also, the introduction of multiparty democracy in the 1980's necessitated the launch of Tanzania Media Women's Association (TAMWA) in 1987 which became a movement created to advance women's rights through media. TAMWA filled the gap of previous women's movements that were unsuccessful in championing the interests of women. This feminist approach by TAMWA was essential in creating a framework for gender and power balance in Tanzania as it gave voice and platform for women's rights and justice (Dancer, 2018).

Since its inception, the feminist movement has asserted its presence as a professional, ethical and advocacy non-governmental organisation (NGO) that puts the interests of its members ahead of any other barriers. So far TAMWA has created a stable platform for women empowerment throughout the country. Achievements have been realised in areas such as unified voice through media dominated by men. Also, country wide women advocacy, and TAMWA was able to successfully lobby for repelling gender biased laws; hence the creation of un-biased legislations such as the Land Act of 1999 and Sexual Offenders Provision Act of 1998 (Madaha, 2014a).

Tanzania Media Women Association has also been instrumental in placing more women in essential decision-making bodies such as the National Parliament (35% of all members); has reduced discriminatory attitude towards women and a high gender equity index has been recorded (Madaha, 2014a). Despite its success, TAMWA still has a long way to go (Madaha, 2014a). The movement will need to partner with as many women empowerment stake holders as it can in order to have more impact on gender-sensitive matters that do not advantage women in Tanzania (Madaha, 2014a). Tanzania, like many other countries in Africa is a country with already established patriarchal system and control; and therefore, some aspects of women's oppression and concerns may be addressed through awareness from, and application of the critical social theory. It is already understood that "empowerment, or rather, the lack of it, is associated with the negative patriarchal and authoritarian concept of power"(Kuokkanen & Leino-Kilpi, 2000, p. 237).

2.12: Critical social theory and nursing

The proponents of CST have used terminologies such as empowerment, oppression, emancipation, liberation, marginalization, subordination, autonomy, transformation, and others. These are words commonly used in the 19th century in reference to political and social movements across various global communities.

After the Second World War (WWII), a Servicemen's Readjustment Act was passed in the USA (1944) to change nurses' training from being hospital based training to being college education (Allen, 2010). This legislative change was hailed as important educational revolution of its own kind (Ray, 1992); and the change was viewed as one step forward for nurses' liberation.

Contrary to expectation, the changes in nursing education that happened in the United States of America (USA) after the WWII, did not end nursing oppression and sub-ordination. Biomedical dominance over nursing including the continuation of the "hospital salute". A hospital salute was a ritual exercised by nurses in hospitals where nurses were expected to stand up whenever they came closer to a physician; they would offer a chair and carry charts for a medical practitioner (Allen, 2010).

According to Ray (1992), the 1944 Act did not improve the nurses' social standing as such nurses remained professionally underprivileged and lowly regarded. The expectation of the nursing college education was to develop theory and curriculum that would no longer act as a tool for conformity and environment for perpetration of nursing sub-ordination. College education was intended to expose nursing students to critical reflections and examination of realities surrounding them in view to transforming these realities through deliberate action for their own social and professional advantage (Mooney & Nolan, 2006). Exposing learners to realities within their surroundings and critical thinking is the universal goal of college and university education.

In pedagogic practice, it is important to point out that education through theory must be understood, interpreted, and used to address real life challenging situations. It is argued that

"the use of theory as framework for practice is based on the applicability of its theoretical concepts which can be integrated into daily practice" (Wilson-Thomas, 1995, p. 570) Habermas (1978) as cited by (Duchscher, 2000, p. 455) outlines three types of interests which he refers to as key to knowledge development: The Technical interest which the person acquires in order to master his environment. This set of knowledge refers to empirical competencies that aim at solving scientific and technological problems. The next is practical interest which refers to a person's communicative abilities, and abilities to interpret and clarify meaning. In short, this is the subjective knowledge as opposed to objective knowledge obtained from technical interest.

The last one is emancipatory interest. According to Habermas, emancipatory interest is a knowledge that enables a person facing social or professional constraints to use his/her abilities responsibly to free himself or herself from those constraints. Critical theory with emancipatory intent assists people experiencing oppression and marginalization to liberate themselves from those realities and become equal participants in political and social actions (Fontana, 2004)

Similar change happened in Tanzania between 1970s and 1990s. For many years nursing was delivered through apprenticeship and traditional hands-on skills until college and university education for nurses was introduced (Moyo & Mhamela, 2011a). For example, despite offering undergraduate and postgraduate nursing courses, it wasn't until 2007 that Muhimbili University of Health and Allied Sciences (MUHAS) in Tanzania gained its charter and became a full university (Mkony, 2012).

Nursing education aims at equipping learners with all three interests (including emancipatory interest) as outlined by Habermas, and not only technical or practical interest. The graduates from Tanzanian nursing Universities would be expected not only to have clinical and scientific knowledge (technical and practical interests), but also knowledge about the critical view of the context in which Tanzanian nursing is practiced; and this is emancipatory interest. Nursing oppression is rooted into feminist theories and perpetrated through patriarchal system in workplaces and the society at large (Snyder, 2014a). The nursing situation in Tanzania is no different; and the circumstances under which TAMWA came into existence help to explain the situation under which Tanzanian nursing is practiced.

Nursing theorists came up with the concept "emancipatory knowing" in the oppression and emancipatory discourse as this concept puts emphasis on liberating people from hidden or not so obvious conditions that limit the realization of individuals' potential (Snyder, 2014a). Emancipatory knowing: "is the human capacity to be aware of and critically reflect on the social, cultural, and political status quo and to determine how and why it came to be that way" (Peart & MacKinnon, 2018, p. 352). Emancipatory knowing is a call for action in ways that reduce or eliminate inequality and injustice (Peart & MacKinnon, 2018). The concept is a proposition and reminder that our professional knowledge and values are there to direct our actions and development. In nursing context, emancipatory knowing is applied through socially, responsible, and respectful manner to enhance collaborative practices and justice in the workplace (Peart & MacKinnon, 2018). The concept requires a nurse to incorporate it into his/her clinical practice in order to foster and maintaining workplace justice, equality and also justice to patients in their daily care (Snyder, 2014b).

The concepts "action and participation' as well as "emancipatory knowing" are constructs that together solicit action from the critical view and reflection around the nursing practice (Snyder, 2014b). It is argued that the current nursing education does not sufficiently prepare nurses for reflective practice and action as it should; hence a need for nurses in clinical areas and nursing students to be equipped with action-oriented knowledge (Snyder, 2014b).

The marginalization inherent in nursing practice requires that nurses and midwives first become aware of the oppression and the marginalization which they are experiencing; that they are critical about these practices; that they act on them; but not necessarily through radical means. It is emphasised that the nurses of the 21st century, are to be armed with the knowledge about the historical perspective of nursing, the health system context, and the stratification of the society within which they live and practice (Snyder, 2014a).

Through critical social theory, a critique of existing social conditions, professional relationships with other health workers, abilities to navigate Organisational and institutional hierarchy are part of the nursing theory and curriculum (Kuokkanen & Leino-Kilpi, 2000). This means that liberation concept starts with curriculum that teaches learners to appreciate, analyse and critically understand their surroundings. The critical understanding of the society in which nurses live and practice, as well as the wider surroundings are the starting point of

the nurses' pedagogy for liberation and emancipation. Nursing faculty and nursing leaders are instrumental in ensuring that knowledge and culture on emancipatory knowing are passed on to nurses as transformative tool for addressing structural inequalities, power sharing and equal opportunities (Peart & MacKinnon, 2018). Critical social theorists argue that, nurses' lack of power and visibility in hospital environments, is not only caused by overpowering doctors, but also other hospital nurse leaders who perpetrate the patriarchal authoritarian leadership style for self-development purposes (Kuokkanen & Leino-Kilpi, 2000).

2.13: The social identify theory

The Social Identity Theory (SIT) is a theory that explains how people individually and as a group represent their identities including social norms and values (Burford, 2012; Whitaker, 2019). The SIT helps to explain individual's and group construction of self, group associations or identities and emotional attachment to their groups in a given social space (Soto-Simeone & Kautonen, 2020). According to SIT, social identification has cognitive and emotional attachment; and an individuals' social identity has effect on their social esteem, and psychological wellbeing (Welbourne, Rolf, & Schlachter, 2017).

The history of SIT could be traced in the 1970s, and it was developed by Henry Tajfel and colleagues. Henry, a social psychologist used SIT to explain group processes, starting from their formation, behaviors, influences, biases and prejudices. Since then, the research on SIT has been found to be relevant and useful in explaining situations and groups in the health care environment including the relationship between the nursing and medicine professions (Burford, 2012).

SIT provides the lenses and framework through which group processes, behaviors, inter and intragroup processes can be viewed and explained. The theory therefore covers those concepts as identity salience, nested identities, and cross-cutting identities. Identity salience is about prominence and being noticeable, and this depends on the social-cultural context in which the group emerges (Willetts & Clarke, 2014). Nested identities are related to formal categorisation and organisational structuring. The structuring may therefore fall into higher-order or lower-order identities. Willetts & Clarke (2014) relate lower-order nested identities to nurses or midwives in a given clinical setting such as a hospital ward; and higher-order nested identity to a bigger organization such as Australian Health Practitioner Agency. According to Willets

& Clarke (2014), cross-cutting identities fall under the lower-order category, they tend to be unique, are proximal, exclusive and they may include members of a given committee.

The understanding of group identities and processes in a health care context is essential in that it is these groups that have effect on group professionalism, performance, motivation, efficacy, conflicts and other dynamics. The SIT for example, helps to explain as to why or how a given professional identifies itself, their behaviors, norms and attitude. For example, the social identity of the doctors or the social identity of the nurses and midwives.

The link between social identities and performance has also been studied. There is a study which linked errors made in a clinical setting to a treat of professional identity and patient safety (Burford, 2012). On the question of performance, SIT views the health care system as a structure through which employees who belong to various social identities engage in such acts as cooperation and innovations to optimise their performance. At the organisational level, the organisation stipulates the goal to be attained, standards, and norms to guide employees' performance.

Since SIT helps to explain social identities within the health care contexts including those aspects as performance, cooperation and relationships, SIT can help to explain the aspect 'participation' of nurses and midwives in implementing MDGs 4 & 5 which is the focus of this study. In order to understand nurses and midwives' participation, the Tanzanian health care, and social contexts in which nurses and midwives work must be understood, and this is described in chapter 4. Indeed, it has been observed that "there is potential for SIT to contribute to informing and describing contexts in which professional nurses undertake their work and give voice to the diversity of identities within nursing" (Willetts & Clarke, 2014, p. 167). In some countries, nurses and midwives' professional identity remains a struggle despite their hard work. It is through the guidance of SIT and CST that eventually nurses and midwives will forge a solid intra-group identity coupled with positive self-esteem for identity salience.

2.14: Chapter Two Summary

This chapter presented the approach used for literature review as well as concepts such as background for MDGs and SDGs. It also discussed other concepts including Inter-Professional Collaboration, Inter-Professional Education, Nurses empowerment and others which offer a link to the phenomenon "participation". Critical Social Theory and SIT were

used as theories to provide the framework for nurses and midwives' collective actions meant to improve their current professional and social standing. It is through an understanding of those key concepts in the literature review (IPC, IPE, and others) that will enhance nurses' empowerment. It is expected that CST and SIT will be a catalyst for emancipation from domination and from being invisible in planned national and international health care undertakings as well as a tool for maintaining nurses and midwives' identity. The CST and SIT are also expected to be a guide for collective action by Tanzanian nurses and midwives in their endeavor to improve their participation in SDGs before their expiry in 2030. The next chapter discusses the methodology used for the study.

Chapter 3: The Study Context

3.0: Introduction

The purpose of this chapter is to provide the description of the specific information about a research context. The research context refers to circumstances, environment and all the occurrences around what is being studied, be it with people, processes or organisations (Patton, 2015b). It also includes the dynamic components such as culture, relationships, systems, politics, institutional organisation or communication patterns (Patton, 2015b). The attention to context helps to apply findings that are useful to a broader set of stake holders outside the local decision-making context (Patton, 2015b). A description of the context makes it easy to orientate the reader about nursing and midwifery in Tanzania as the study setting.

The chapter presents Tanzania's geographical location, its colonial history, economy, and health care system. The details about the health care system cover such areas as the health care services including Primary Health Care (PHC), Secondary or Hospital and referral services, health care policy and funding. The history of nursing education and details about how nursing education is organised in Tanzania are also explained in this chapter.

3.1: Research setting

The United Republic of Tanzania (popularly known as Tanzania) is in East Africa and has a total land mass of 954,000km2 (WHO, 2016). It borders several countries: Kenya and Uganda to the North, Burundi and Rwanda to the Northwest, Lake Tanganyika, and the Democratic Republic of Congo (DRC) to the West, Zambia and Malawi to the Southwest, Mozambique to the South, and the Indian Ocean to the East (See Figure1).

Figure 3.1: The Geographical Position of Tanzania on the African Continent.
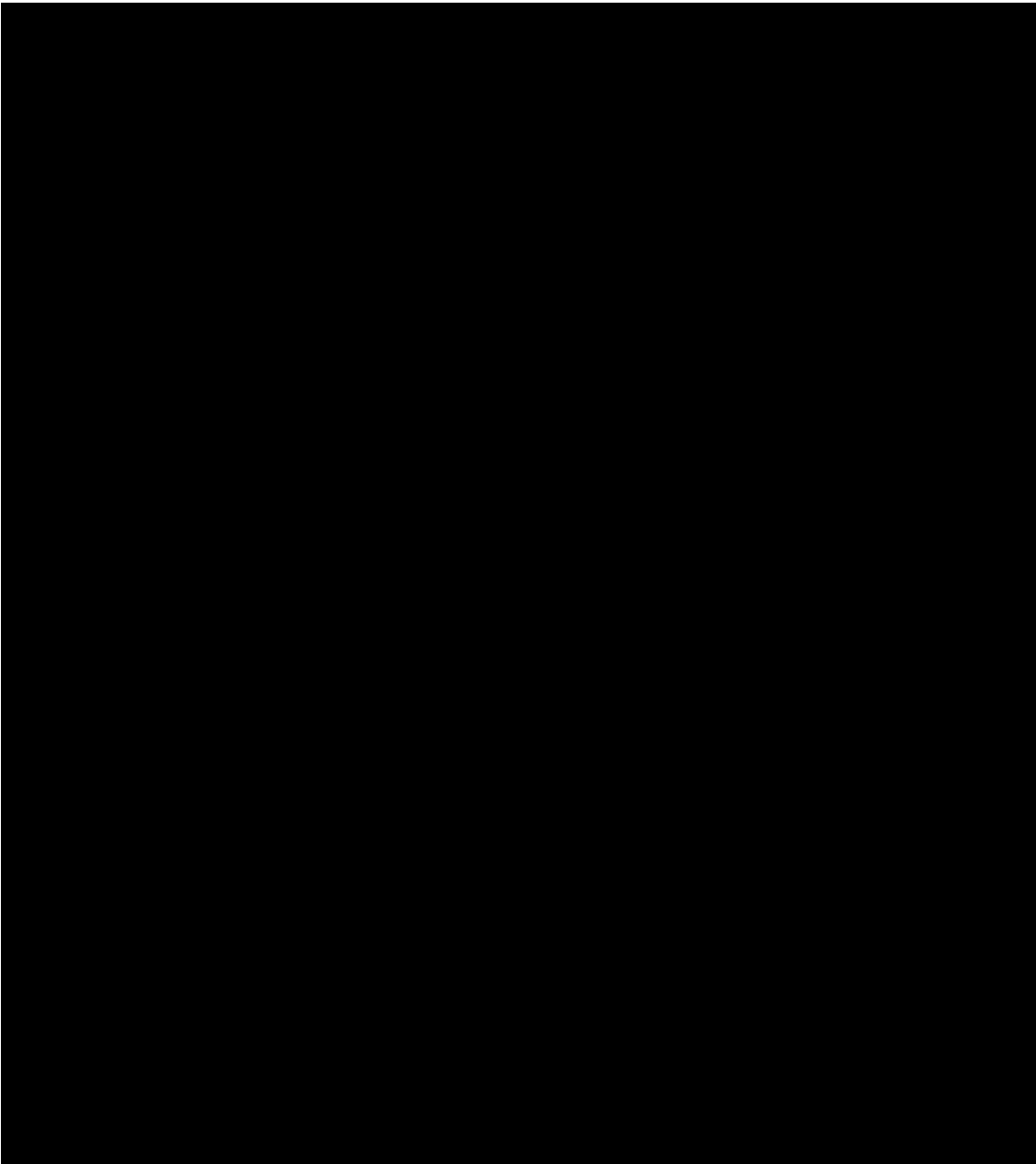
Source: World Atlas (2022)

Figure 3.2: The Political Map of Tanzania
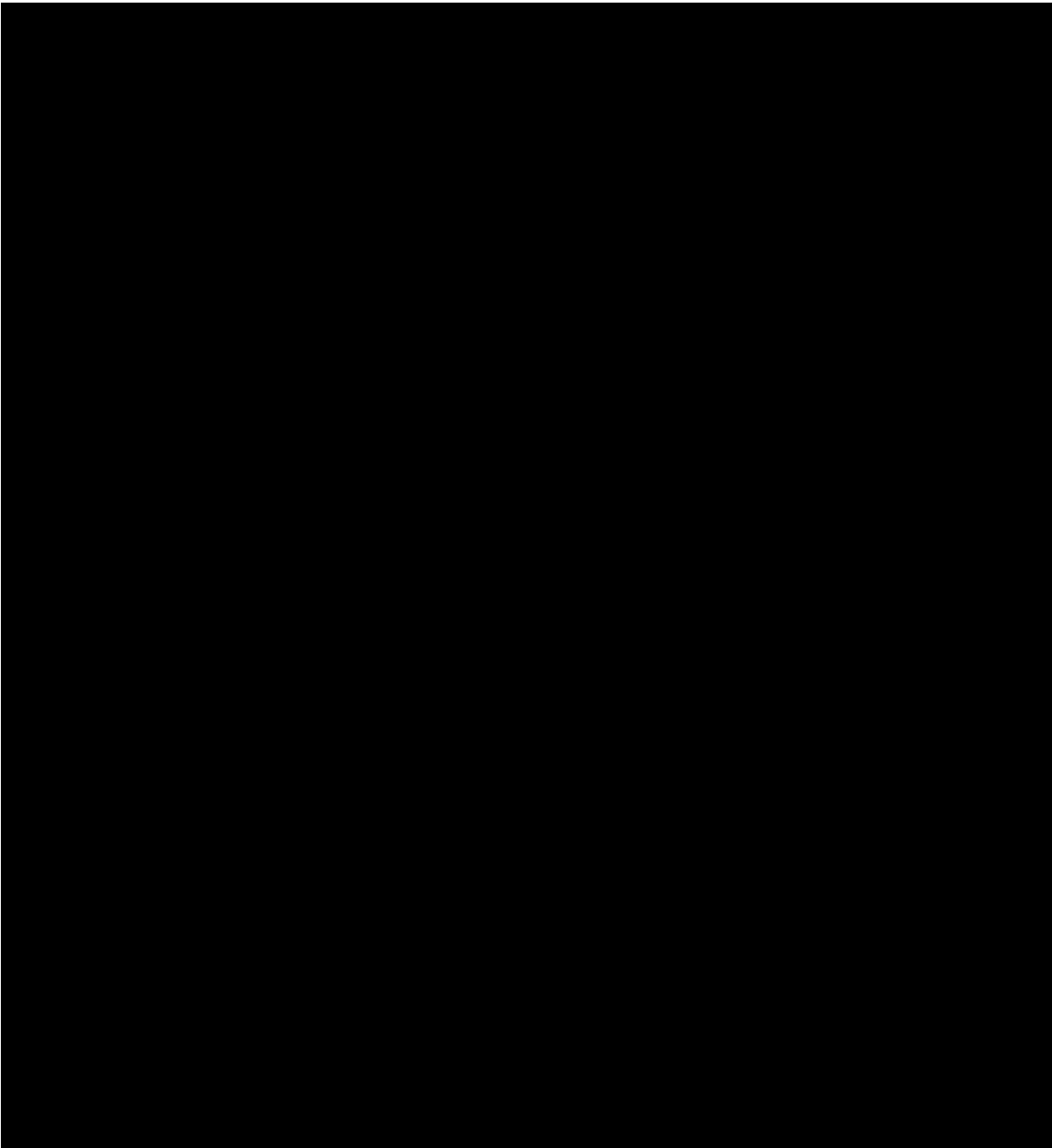
Source: World Atlas (2022)

Tanzania derived its name from the 1964 Union between the mainland Tanganyika and the Islands of Unguja and Pemba, collectively known as Zanzibar. This area comprises the archipelago in the Indian Ocean (World Bank, 2009). Tanganyika became a German colony under German East African Company towards the end of the 19th century up to the end of the World War I (WWI) in 1918. After WWI Tanzania became a British colony under the League of Nations until its independence in 1961. Swahili or Kiswahili is both a national and

official language, and English is the official language and medium of instruction in the Tanzanian education system from secondary to tertiary institutions. Kiswahili is a combination of several Bantu languages with borrowed words from Arabic and other foreign languages; and the language was molded by immigrants, settlers and traders between the East African coast, the far East, Asia, and Europe (Mugane, 2015).

The Tanzanian population almost doubled in the past two decades, it increased from 25 million in 1990 to 45 million in 2012, and about 74% of the population live in rural areas (Afnan-Holmes et al., 2015). The latest population figures stand at 55.9 million in 2019, with an annual population growth rate of 3.1% (National Bureau of Statistics 2020). Like many other developing counties, nearly half the Tanzanian population consists of children younger than 15 years. In 2019, the children under the age of 15 were 44. 2% (National Bureau of Statistics).

Figure 3.3: Percentage distribution of Total Population by Age Group and Sex; Tanzania - 2012 Census
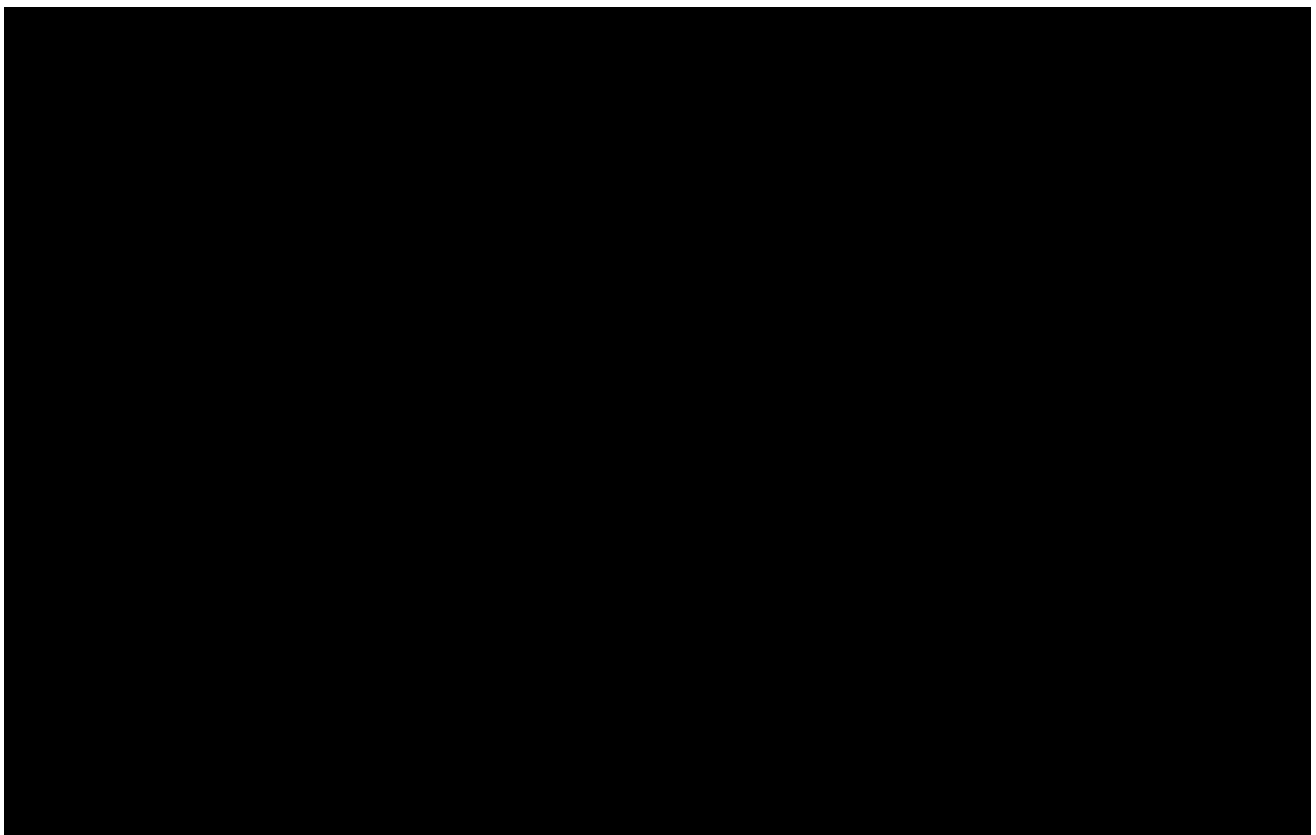
Source: Tanzania National Bureau of Statistics (2019)

Despite recent economic gains, the country has not been able to make significant and sustainable economic breakthroughs, and remains one of the developing countries in the world (World Bank, 2009). From around 2011, Tanzania has managed to improve its Gross Domestic Product (GDP) rate to about 7%; and its per capita income rose from 350 US dollars in 2006 to 950 USD in 2016 (WHO, 2016). In 2007, 25% of the population lived under the poverty line (Ministry of Health and Social Welfare, 2009). With the discovery of gas reserves and better economic management in recent years, it is suggested that Tanzania has a good chance of ascending to the position of middle-income countries in the future (WHO, 2016).

The improved annual economic performance of Tanzania in the past decade was noticed in almost all key sectors of the economy. For example, the gross domestic product (GDP) in agriculture grew at 4.8 percent per annum, manufacturing industry 7.0 per cent, services 5.9 per cent, and mining 15.2 per cent (Sustaining and Sharing Economic Growth in Tanzania, 2007); and given these figures the country is optimistic about alleviating poverty. Tanzania is likely to continue recording positive economic growth which will be necessary in addressing its economic and social challenges. However, in order to effectively address its challenges, Tanzania will require continued committed leadership and partnership with key local and international institutions such as the International Monetary Fund (IMF), the World Bank and other International Non-Government Organisations such as the United States Agency for International Development (USAID), the United Nations Development Agency (UNDP) and others which have collectively been instrumental in supporting the country's health care system. Tanzania's health care system is discussed next.

3.2: The health care system

A healthcare system consists of all activities, services, personnel and infrastructure that are intended to promote and maintain the wellbeing of the people in a given country (USAID, 2013). In Tanzania, the health care system covers institutions; workforce; financing; policies; information sharing; and technological innovation related to health care delivery. The system is comprised of primary care and secondary or hospital care, and support services such as education and funding agencies. All health services combine to make a network and multifaceted web of health care activities in the country (See Figure 4). Both the public and

private sectors are involved in delivering a range of health care activities at the ratio of 60% for the public sector, and 40% for the private sector (White, O'Hanlon, & Chee, 2013).

Figure 3.4: The Health System in the Government Context
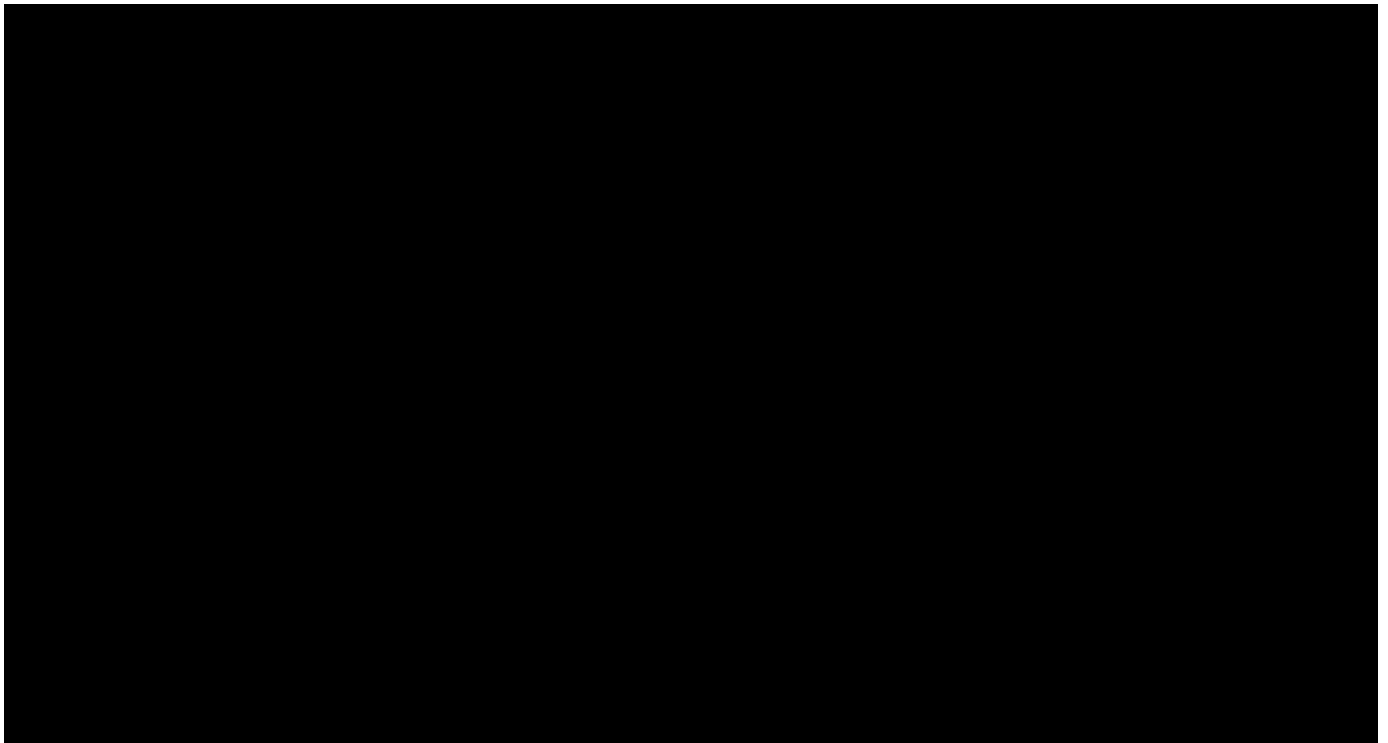
Source: USAID (2010 p.6).

The health care system in Tanzania is driven by the country's health policy that has a vision of improving the health status of its citizens, particularly in rural areas, where most people who are vulnerable to diseases live (Haazen, 2012). Various actors are involved in this important welfare sector. The Ministry of Health and Social Welfare (MOHSW) formulates the national health care policy. MOHSW also provides governance and regulatory compliances to policies and standards, regulates other health actors, oversees health related training, medical research and manages tertiary hospitals (White et al., 2013). The Prime Minister's Office–Regional Administration and Local Government (PMO-RALG) provide services through a network of dispensaries, health care centers and district hospitals across the country through decentralisation policy. Other agencies, such as the Ministry of Finance (MOF), provide funds for financing healthcare activities. Higher education and other training institutions generate knowledge through research, education and training of the health work

force, while health care facilities such as hospitals and pharmacological services provide biomedical and curative practices to needy patients (White et al., 2013). The health care system is made up of various health care services, and these are discussed below.

3.3: Health care services

The health care services are organised in a pyramid model (See Figure 5). The pyramid is made of PHC services, secondary, and tertiary health institutions. Community Health Posts, Dispensaries, Health Center Services and District hospitals constitute primary health care (WHO, 2017). Regional, zonal and specialised or national hospital facilities are secondary hospital services and are in the middle and at the apex of the pyramid (Haazen, 2012).

Figure 3.5: Hierarchy of health services provided in mainland Tanzania
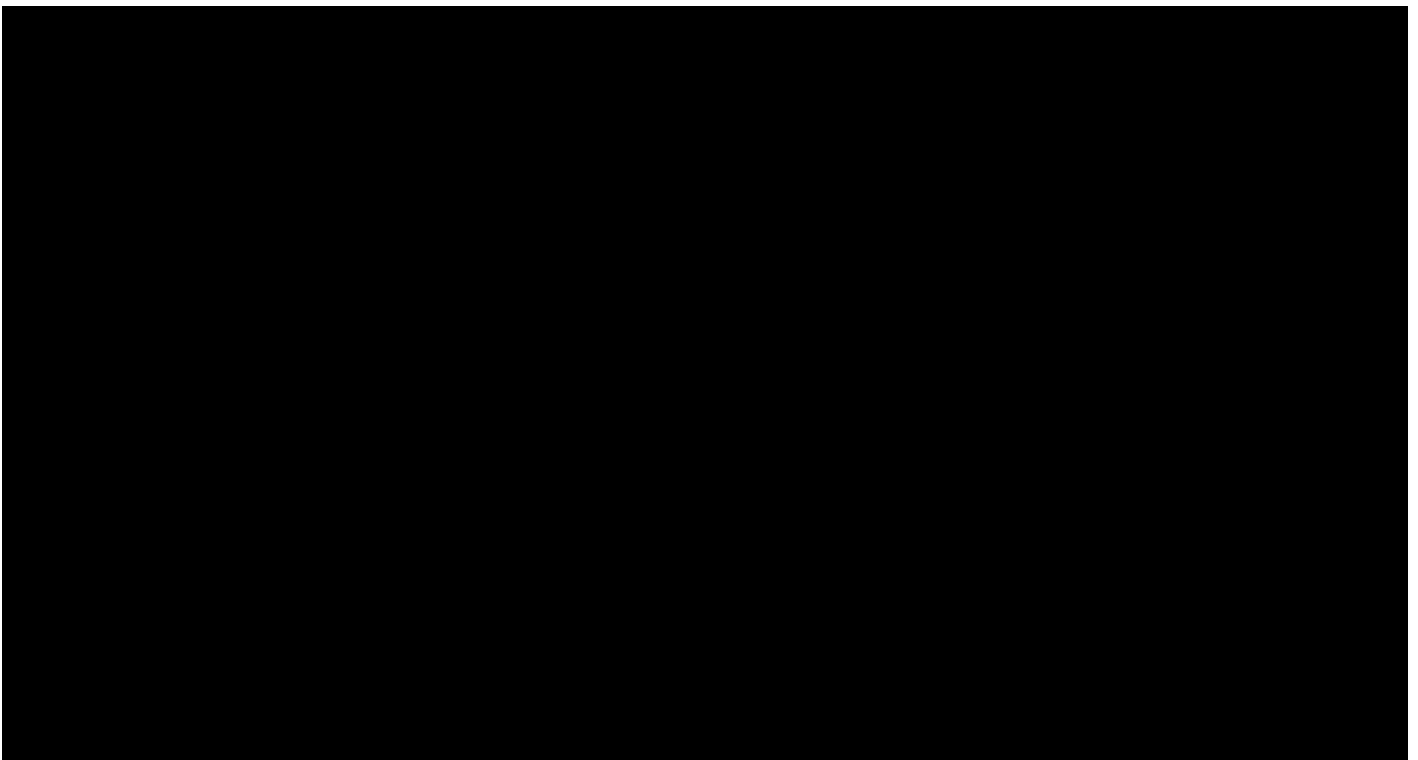
Source: Kwesigabo et al., 2012 p. 3

Although the PMO-RALG) is charged with the overall service delivery to PHC services; the planning, implementation, and evaluation of PHC services is the responsibility of the district administration. Referral institutions such as regional and tertiary hospitals are managed by the Regional and National government (WHO, 2016).

Stake holders within Tanzanian health system include the public sector, private for profit, and private not for profit at times referred to as faith-based organisations (FBO). Faith Based organisations are managed under Christians Social Council Commission; and they also include the National Muslim Council of Tanzania (White et al., 2013). Both the public and private sectors own hospitals and other health care facilities across the country. The Tanzanian health care system operates through public decentralised system whereby district level services fall under level I; regional services level II; and referral hospital services level III (Klopper et al., 2012).

Within level III services, there are four referral specialised hospitals providing clinical services in areas such as mental health, orthopedic, trauma, tuberculosis, and cancer care. Some of the private and FBO offer specialised curative services same as public referral hospital (Klopper et al., 2012).

3.4: Primary health care

Primary health care (PHC) in Tanzania is the foundation of the health care services and is depicted at the base of the pyramidal structure. The district administration is responsible for the planning and implementation of PHC services (Klopper et al., 2012). PHC services include community health posts, dispensaries, health centers, council services and district hospital facilities (MOHSW, 2009-2015) as depicted in figure 6. The effective use of the PHC facilities helps to lessen congestion in hospitals (Nartker et al., 2010).

Figure 3.6: A Simplified View of PHC in Tanzania

Administration Level

Service Level
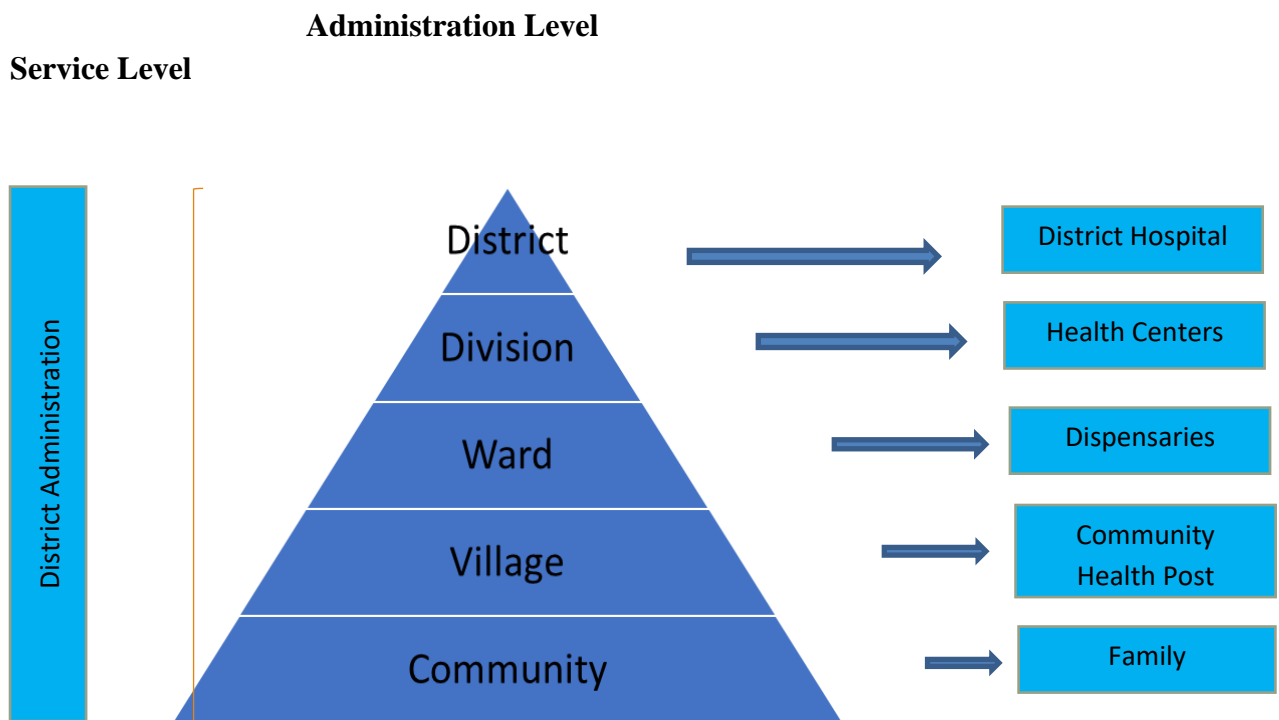
Primary health care is at the center of the health care delivery particularly for people in villages. Village population constitutes 75% of the total population of Tanzania (Nartker et al., 2010). A group of villages are served by a Community Health Post which provides basic care needs and the management of uncomplicated health problems (Kahabuka, Moland, Kvåle, & Hinderaker, 2012). These posts are managed by village health workers (VHW), who attend to simple health problems and provide community education either in the center or in homes (MOHSW, 2009-2015). VHWs may not have formal qualifications but have undergone short health related education (Kwesigabo et al., 2012).

Dispensaries are the next level in the pyramid above community health posts. They also cater for less complicated problems, and they provide education concerning reproductive and child health issues. Malaria, dysentery, tuberculosis, and normal baby deliveries are among interventions considered uncomplicated (Kwesigabo et al., 2012). Dispensaries may also provide diagnostic and dental services in a catchment area of about 6000 to 10,000 people and are commonly managed by clinical assistants. These people-attain secondary level education and two years in anatomy, physiology, hygiene, diagnostic services, primary health care services and common communicable diseases.

The next level of the pyramid comprises health centers that serve a population of up to 50,000 people. In addition to services provided by dispensaries, minor surgery and reproductive services are provided by these health centers. The facilities are serviced by assistant medical officers, who have attained three years post-secondary clinical education (Bjerrum et al., 2012). Health centers can provide in-patient nursing care for up to 20 people and are supported by enrolled nurses.

3.5: Secondary care services

Secondary care services are made up of hospitals that were established to address the population's health care needs beyond the first line primary health care centers. There are different levels of hospitals spread throughout the country. Level 1 hospitals are all district hospitals; level two are regional referral hospitals, and level three are zonal and national referral hospitals (Ishijima, Eliakimu, Takahashi, & Miyamoto, 2014).

In 2012, there were approximately 132 administrative districts in Tanzania, and each district had at least one government hospital that served a population ranging from 46,000 people in sparsely populated areas to 1.4 million people in urban centers (Kwesigabo et al., 2012). Hospitals with a district level status may be government or privately managed. The services provided by district hospitals include both in-patient and outpatient care, diagnostic services, surgical and emergency obstetric care. Assistant medical officers (AMO) are usually responsible for district hospitals and are supported by clinical officers, registered nurses, and enrolled nurses. Few districts may be grouped together to form one administrative regional area with a regional hospital. A regional hospital has similar, but expanded services compared to a district hospital. Regional hospitals are larger with more specialised services, programs, and personnel such as surgeons, physicians, specialised nurses, public health staff, and pediatricians (Kwesigabo et al., 2012).

Around eighteen regional hospitals act as referral hospitals for district hospitals (MOHSW, 2009-2015). Regional hospitals are grouped together to form four zones with each zone being served by a zonal referral hospital. These hospitals are more equipped and specialised and are recognised as teaching hospitals with two being private not for profit hospitals (Kwesigabo et al., 2012). The government owns a total of 55 district hospitals, 18 regional hospitals, and

eight teaching hospitals (Haazen, 2012). In 2019, there were a total of 294 hospitals spread throughout Tanzania mainland (Tanzania in figures, 2019).

There is only one national hospital in Tanzania called Muhimbili National Hospital (MNH) found in Dar es salaam. Prior to being a national hospital, it was called Muhimbili Hospital (MH). The hospital started as a small medical ward in 1897 by an Indian businessman known as Sewa Haji. Since 1963, MH experienced several changes, and in 1966, it became a faculty of medicine of the University of Dar es salaam. As part of the government's national health reforms, eventually MH attained the status of being a National Hospital. The reforms envisioned to transform MH into a National Hospital (MNH), a well-managed and efficient medical facility to support the primary, secondary and referral regional services in the country (Mwangu, Mbembati, Muhondwa, & Leshabari, 2008). In other words, MNH is a referral hospital for regional hospitals, and the hospital is equipped with specialised services such as medical, surgical, support, nursing, and midwifery services. MNH is not only at the apex of medical facilities in Tanzania but is also a modern medical facility in the region that supports teaching and medical research (Mwangu et al., 2008). The next section covers how Tanzania has incorporated key international health care agenda in its health care system.

3.6: Tanzania and international health care agenda

Tanzania has been part of the international health care agenda for primary health and other health care agenda spearheaded by the WHO and other international bodies. In 1978, Tanzania participated in the Alma-Ata conference, and endorsed the conference's recommendations of promoting Primary Health Care in recognising that:

> Primary Health Care (PHC) is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at the cost the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (Hall & Taylor, 2003, p. 18).

The Alma-Ata declaration, therefore, put emphasis and appealed to all countries to provide comprehensive, equitable and affordable health care services to rural communities by all countries (Hall & Taylor, 2003). Alma-Ata declaration envisioned improving societal health

in general, and not improving the health of urban population only. In this declaration's vision, societal health would mean reorienting health systems towards providing PHC services and addressing the social and environmental determinants of health as deliberate actions to enhance social justice and reduce inequalities (Hone, Macinko, & Millett, 2018).

The ideals of PHC were in line with Ujamaa Policy that Tanzania had already adopted and were enshrined in the Arusha Declaration of 1967 literally to mean African Socialism to signify equity, self-coherence and self-determination (Hunter, 2008). As such Nyerere, the then President of Tanzania used the Ujamaa Policy as a political discourse that intended to bridge the gap in terms of social amenities available mainly in urban as opposed to rural areas. Tanzania was one of the few countries in the world that were already implementing comprehensive health care services in poor rural communities by early 1970s; same as China, Sudan, and Venezuela (Hall & Taylor, 2003). Next, we look at how the implementation of PHC in Tanzania was viewed.

3.7: The impact of Alma-Ata's criticisms within Tanzanian context

Those countries that supported PHC as enshrined in the Alma-Ata Declaration, considered selective primary health targets as a narrow technocentric approach that intended to deny people at grassroot level the socio-economic development which is based on real life's social determinants of health (Cueto, 2004). On the other hand, the advocates of SAPs (WB, IMF, TNCs, NGOs) were concerned about lack of financial capability, and the skilled personnel required for effective implementation of comprehensive PHC services.

During the 1980s, many developing countries including Tanzania, were experiencing economic downturn characterised by inflation, recession, heavy foreign debts, and the introduction of new economic strategies such as Structural Adjustment Programs. SAPs were a new economic order imposed by the WB and IMF as economic recovery measures, particularly in Africa. There were a package of economic measures that were imposed on African governments, which included economic liberalisation to allow private investments as opposed to state controlled enterprises, currency devaluation, deregulation of state economies to improve management and public expenditures (Ankomah, 2004). These measures in the

end did not make any difference to African economies and no positive impact on social-economic development programs. One example of the effect of SAPs is given for Ghana where it is clearly stated "The 16 years of IMF/WB Adjustment Programs and their ramifications on the socioeconomic development for Ghana paint a dark picture, and Ghana chalked up its initial economic successes under Adjustment Programs" (Ankomah, 2004, p. 2).

It should also be remembered that the implementation of comprehensive PHC in favor of selective vertical health care interventions were being engineered by neo-liberal International Agencies, NGOs and business groups from developed countries that wanted to impose economic sanctions and financial restrictions to developing countries that fully supported comprehensive PHC (Cueto, 2004). Such measures to restrict funds to finance PHC programs negatively affected Tanzania's ability to implement government's planned PHC activities.

It has also been mentioned that comprehensive and sustainable PHC programs required obvious political commitment (Cueto, 2004); and for Tanzania, the political commitment was not questionable. Ujamaa Policy and Arusha Declaration, the manifestation of African socialism was well in favor of improving the social determinants of health in rural areas. The set back that Tanzania had was that the international agencies (IMF, the WB, the Rockefeller Foundation, and others) that were also proponents of vertical short-term PHC programs, were against the socialist ideology.

There was yet another dimension to the notion of comprehensive PHC, and this was that this new Alma-Ata outlook was meant to lessen the medical power through an emphasis on rural health and rural development. The resistance, therefore, from the medical community became apparent as this group feared losing their professional power and privileges (Cueto, 2004). Cueto (2004) further observes:

> The changing political context was also favorable for deeply ingrained conservative attitudes among health professionals. For example, most Latin American physicians were trained in medical schools that resembled the US Universities, were based in hospitals, lived in cities, received a high income by local standards, and belonged to the upper and upper-middle classes. They perceived primary health care as anti-intellectual, promoting pragmatic non-scientific solutions and demanding too many self-sacrifices (p.8).

Even those few physicians in Africa who embraced PHC principles as defined by Alma-Ata Declaration were of the view that the implementation of PHC principles should be done under the supervision of qualified medical personnel (Cueto, 2004). This was another setback for a country like Tanzania that did not have enough medical or qualified personnel to offer such supervision in rural areas.

In general, Tanzania like many other Low- and Middle-Income Countries (LMIC) was caught between the notions of the broad definition of PHC as was given by Alma-Ata Declaration in 1978, and the narrower definition that focused on selective primary care propagated by the IMF, WB and TNCs. Given insufficient financial and human resources, Tanzania was unable to implement the desired PHC services. The studies done in Tanzania, Paraguay and Indonesia showed that the quality and infrastructure of PHC were far from being adequate (Bitton et al., 2016). For many years Tanzania has been committed to the implementation of comprehensive PHC services, and the country's health care policy has reflected this commitment.

3.8: Health care policy

Since its independence in 1961, Tanzanian health policy has been geared towards addressing the health care needs of the majority of the people in the villages and smaller urban areas (Kwesigabo et al., 2012). The country's aim has been to establish a vibrant pluralistic and accountable system that has synergy with other health related sectors, such as education, water, sanitation, housing and nutrition (Juntunen & Nikkonen, 1996). Following independence, Tanzania continued the path of most countries in Africa, and it abolished the citizens' contribution towards their medical care in public hospitals (USAID Report, 2010). The Arusha Declaration of 1967 was the hallmark of the universal services to all, particularly the poor; and this was in line with the ideology of socialism (Kwesigabo et al., 2012). Before 1977, the provision of the health care services was the sole responsibility of the Tanzanian government with profit-making health care providers being prohibited. In 1977, the Private Hospitals Regulatory Act was passed giving private health care providers the ability to own and operate medical facilities (Aagard, 2005)

For some years Tanzania had sustained its path of free health for all, but this became a burden on the government in the early 1990s, owing to poor economic performance and rising health

expenditures (USAID Report, 2010). Since independence, the country has had a number of Health Sector reforms and Strategic Plans (HSSP), the latest being HSSP III inaugurated by President Kikwete in 2009 (Haazen, 2012). In recent years, a framework for economic and social development strategies were created for robust economic breakthrough. For example, in 2005, the National Strategy for Growth and Reduction of Poverty (NSGRP) popularly known in Kiswahili as the MKUKUTA (Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania) was inaugurated. MKUKUTA provides a visionary framework and commitment to mobilisation of various inter-sector resources for achieving social and economic targets such as the millennium development goals (MOHSW, 2009-2015). Mkukuta provides a Framework for rallying national efforts towards poverty reduction through emphasis on governance, fight against corruption as part of Tanzania's Vision for 2025.

The health care system and its reforms, including the strategic adjustment plans, are heavily influenced by donor bodies and agencies. The most influential of these agencies is the International Monetary Fund (IMF), which provides funds in the form of grants and loans. These contributions are provided on condition that the government accepts the implementation of structural economic adjustments that affect the financing of the health care sector (Shiner, 2003). More details about health care funding are provided below.

3.9: Health care funding

Health care funding covers the allocation, mobilisation and accumulation of the financial resources deemed necessary for the assessed health care needs of the people. It covers such activities as revenue collection from identified sources, resource allocation and interventions of health purchasing (WHO, 2000). Health care is mostly funded through the national budget, with faith based organisations being funded by various beneficiaries (Haazen, 2012).

Given its weak economy, Tanzania has not been able to fully finance all health care activities. Agencies such as the World Bank, WHO, International Monetary Fund (IMF), United States Agency for International Development (USAID) support the health care system with approximately 50% of the total health expenditure under reforms such as strategic adjustment plans (Shiner, 2003). Tanzania's total expenditure in health and other support services such as education as percentage of total government expenditure was 11.2% in 2011/2012 (Dussault et al., 2016). This expenditure is still lower than that recommended in the Abuja

Declaration for health care funding which is 15% of the total government expenditure (WHO 2017). Tanzanian nursing education as a sector to support the health care system is discussed in the next section.

3.10: Nursing education

The history of nursing and midwifery education in Tanzania has its roots in the political and colonial history of the country. Prior to colonisation, nursing practice was carried out through apprenticeship as well as hands-on care in traditional and family settings. Nursing and midwifery healing were hinged on the traditional supernatural model and traditional care of the sick. This meant that nursing and midwifery care still retained traditional care practices and was not necessarily based on contemporary nursing models (Moyo & Mhamela, 2011b). In most villages of Tanzania, people who were sick tended to go to traditional healers first before attending medical care in clinics or hospitals (Moyo & Mhamela, 2011b).

From mid-19th Century, missionaries became agents of the colonial rule and main health care practitioners. With the arrival of Bertha Wilke (the first nursing sister) in 1888 from the Evangelical Lutheran Missionary Society and the subsequent arrival of more missionary nurses, the German Colonial Government embarked on a malarial control program in the then Dutch East Africa that included Tanganyika, Burundi, and Rwanda. With the takeover of the British rule after the First World War, nursing and midwifery in Tanganyika continued to be dominated by the missionary sisters trained and brought into the colony from Britain. The British colonial rule was responsible for the formulation of regulations that guided nursing and midwifery practice. These regulations were hinged on two British structures namely Her Majesty Queen Elizabeth Overseas Civil Service, and the Unified Colonial Nursing Service and Secretary of State (Moyo & Mhamela, 2011b).

The missionaries-built nursing schools, hospitals, and designed nursing and midwifery curriculum in Tanganyika. Muhimbili was among the hospitals built. It started as a small medical ward called Sewa Haji which later became Muhimbili hospital, and later became the first premises for Dar es Salaam School of Nursing. During this time, nursing curriculum, practice and care was heavily influenced by religion. Up until 1961, several hospitals and nursing schools had been built in various parts of Tanganyika. Shortly after independence from the British rule, the country's name changed to Tanzania in 1964 due to the Union

between Tanganyika and Zanzibar. Nursing and midwifery education, however, continued to be influenced by the colonial and missionary ethos. Today, nursing and midwifery remains a female dominated profession that is lowly regarded and poorly paid, with registered nurses and midwives tending to pursue other more promising career opportunities (Mkony, 2012).

At present, Tanzania, like many other African countries is faced with severe shortage of qualified health care providers; a deficit of about 32% compared to what is recommended by WHO (Kwesigabo et al., 2012). The severe shortage of health care providers is attributed to several factors such as a weak training system, international migration, ageing, and early retirement of health care workers (Sikika & Medical Association of Tanzania, 2013). In line with WHOs recommendations, however, the focus of the Tanzanian health care policy is to increase the training and quality of health care professionals (Juntunen & Nikkonen, 1996). Currently, the MOHSW and private health institutions offer nursing education at various levels of qualification.

Tanzania Nursing and Midwifery Council (TNMC) is the single, semi-autonomous registration and regulatory body, for both nurses and midwives under the MOHSW (Klopper et al., 2012). Besides its regulatory functions, TNMC is responsible for nurses and midwives' education that is aimed at public safety and reliable nursing and midwifery services (Mboineki & Zhang, 2018).

Globally, nurses and midwives have responsibilities as well as opportunities to optimise their participation in effecting change and in shaping health care systems. They come into contact with mothers and children whose conditions require improvement (Amieva & Ferguson, 2012). The WHO report noted that despite the nurses and midwives' central position and contribution in effecting care changes, they were rarely recognised as stakeholders, or as important partners in decision-making related to care policy development (WHO, 2008).

In developing countries, nurses and midwives deliver up to 90% of health care at the same or better quality, and they provide more cost effective services compared to that of a primary care physician (Power of Ten 2011-2013 : Nurse Leaders Address the Profession's Ten Most Pressing Issues, 2011). Despite their contribution, the role of nurses and midwives often remains invisible in the public eye (WHO, 2008). Nurses and midwives' participation at the health care policy formulation is an important step if any health care system is to be successful. The WHO demonstrated its commitment to support nurses and midwives by creating posts within their organisation such as the Chief Scientist for Nursing and

Midwifery, and the Chief Nursing and Midwifery Officer (Ventura, Mendes, Fumincelli, & Trevizan, 2015, p. 438). The creation of these posts was hailed by the global nursing community as an important gesture in reaffirming the importance and role of the nurses and midwives, not only in global health care Organisations such as the WHO, but also within national health care systems (Ventura et al., 2015).

The global shortage of nurses and midwives prompted the WHO to develop a plan of action to scale up the quality of nursing and midwifery education and practice for the African region (WHO, 2013). Scaling up was defined as 'the sustainable expansion and reform of health professionals education and training to increase the quantity, quality and relevance of health professionals, and in so doing strengthen the country's health systems and improve population health outcomes' (WHO, 2013, p. 15).

The vision was to improve competencies needed for providing quality care and, thereby, reducing morbidity and mortality of vulnerable groups such as women and children. It was recognised that apart from a shortage of nurses and midwives there was also insufficient qualified teaching staff (Wheeler, Fisher, & Li, 2014). So far there is paucity of information to ascertain whether this scaling up effort was implemented or not. The need for the health work force to be governed by clear national policies has been emphasised. Again, there is paucity of information in this area mainly attributed to the absence of policies, and governments' inability to make the policies in question publicly available (Murphy et al., 2014).

In an effort to address the issues of scarce human resources, WHO in collaboration with the Global Health Workforce Alliance (GHWA) and other agencies advocated for actions to help resolve the crisis (WHO, 2016). In Western Australia, GHWA supports underprivileged countries such as Tanzania. It provides nursing and midwifery education, training, clinical resources in collaboration with its partners: Muhimbili National Hospital and the Hubert Kairuki Memorial University. GHAWA's educational support aims at enhancing clinical capacity in areas of maternal and child health.

3.11: Chapter three summary

Chapter four has presented the research context for the study covering Tanzanian geographical location and a brief overview of its colonial history, population, and economy. The chapter also discussed important components of the country's health care system, the health care structure including aspects of PHC and secondary care services. The health care policy, health care funding, Tanzania's involvement in the international health care agenda and nursing education have also been presented. In general, this chapter has provided lenses through which Tanzanian health care system may be viewed and analysed. The next chapter presents the research findings

Chapter 4: Methodology

4.0: Introduction

The purpose of this study was to investigate the participation of Tanzanian nurses and midwives in the implementation of Millennium Development Goals 4 and 5. Millennium goals 4 and 5 aimed at the reduction of child mortality and improvement of maternal health, respectively. The background to MDGs and MDGs 4 and 5 were discussed in chapter 1. Chapter two looked at the transition from MDGs to SDGs, and other concepts such as the nursing and midwifery education in Tanzania, the IPC, IPE, empowerment, the Critical Social Theory, Social Identity Theory, as well as nursing and midwifery leadership. This chapter encompasses an overview of the philosophical approaches to the study, the case study design, the research setting, and methods used to collect data. An account of the data analysis process, ethical considerations, and issues of trustworthiness are also presented. The philosophical approach to this study is now presented.

4.1: Philosophical approach to the study

Presenting the philosophical stance in scientific inquiries is essential in identifying and in analysing the problem being studied (Grace & Perry, 2013). Philosophy critically examines the source of knowledge; and when used in research it presents the scrutiny to the knowledge being espoused; it provides the ground for scientific approach in research, the logic and generalizations of the research findings (Leś, 2021). Philosophy is a pedestal on which the contextualization, and the synthesis of what is being studied is placed (Grace & Perry, 2013). Although philosophy is in itself a distinct discipline of study, it is understood to be an umbrella to all other disciplines of study in matters related to knowledge, logic, wisdom and reasons for existence (Grace & Perry, 2013). Since scientific inquiries aim at generating knowledge, it is essential that the justification of the knowledge being claimed is philosophically explained, including the theories of knowledge (epistemology) and existential or contextual conditions (ontology) (Ejnavarzala, 2019). Epistemology and Ontology, which are known to be the branches of Philosophy are associated with knowledge paradigms and are discussed further.

4.2: Epistemological and ontological approach to the study

Epistemology is a philosophical approach that deals with the essence of knowledge, how knowledge is claimed, including the justification and laws that govern the knowledge (Ejnavarzala, 2019). It refers to the theoretical perspective that governs the way knowledge is obtained. Epistemology is further explained as follows:

> Epistemology involves knowledge, therefore, embodies a certain understanding of what is entailed in knowing, that is, how we know what we know. ….it deals with the nature of knowledge, its possibility, scope, and general basis. It involves knowledge, therefore, embodies a certain understanding of what is entailed in knowing, that is, how we know what we know. Epistemology is concerned with providing a philosophical grounding for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate (Crotty, 2020, p. 8).

Ontology is also a branch of philosophy which deals with the knowledge and conditions that govern existence, social, cultural, structural and contextual relationships (Ejnavarzala, 2019). It studies the phenomenon's existence with its structural, cultural, and relational components; it attempts to answer reality questions such as why, what, and how. (Crotty, 2020). Epistemology and ontology are both known to claim knowledge in scholarship (McGregor & Murnane, 2010); and knowledge claims are known as paradigms (L. D. Bloomberg & Volpe, 2012). "A paradigm as a term is used to refer to a world view or to a high-order way of thinking about or categorising the approach or logic that underpins all aspects of a research undertaking from the intent or motivation for the research to the final design, conduct and outcomes of the research" (Ling & Ling, 2016). In the intellectual context, paradigms refer to philosophical assumptions, beliefs, rules, values that govern the way reality is conceived, including how that reality is held and practiced, and these assumptions translate into methodologies and logic related to how knowledge is acquired (Corry, Porter, & McKenna, 2019; McGregor & Murnane, 2010). The two well-known paradigms are positivistic and post-positivistic. Literature associate epistemology with positivistic paradigm, and ontology with post-positivistic paradigm (Corry et al., 2019; McGregor & Murnane, 2010; Young & Ryan, 2019).

Positivism is a scientific model of understanding reality; it uses scientific laws, methods and hypotheses to understand the society and the universe (Corry et al., 2019). In positivist context, knowledge is realised through objectivity, thus, a knowledge a seeker or researcher

discovers the objective truth through value-free methods which involves no judgement or interpretation of findings. This means that positivism advocates for naturalism (the maintenance of the natural environment), and empiricism (natural knowledge or reality based on experience).

Post-positivism, on the other hand, is a paradigm that incorporated reasoning and interpretation of reality and relationships that exist for every phenomenon (McGregor & Murnane, 2010). Scholars also identify interpretivism and pragmatism as parts of post-positivism (Goldkuhl, 2012). Interpretivism incorporates subjective meanings and understanding of reality, hence the need to interpret the information obtained from those involved and the relationships that exist in a given social setting (Goldkuhl, 2012). Pragmatism aims at knowledge that brings about change. In pragmatistic ontology, an important aspect of knowledge creation is to bring about incremental change since society is understood to be in an ongoing processes of change hence the need for action to guide the change (Goldkuhl, 2012). This is to say that post-positivism understands the role that a researcher and participants can have in the process of discovering reality, the need for interpretation, subjectivity, giving voice to the reality, and using the knowledge for bringing about the desired change. It therefore follows that the positivistic paradigm is associated with quantitative research methodologies; and post-positivistic paradigm is associated with qualitative methodologies (McGregor & Murnane, 2010).

The ontological stance of this study is that of post-positivism. This study intends to look at the relationships among the phenomena within the Tanzanian context. The study will use qualitative paradigm in its search of reality, and this will be carried out by using epistemological approaches namely survey, focus group and interviews. Interpretivism will be used to interpret and understand the reality during data analysis, the aim being to understand the enabling and inhibiting factors related to nurses and midwives' participation in MDGs 4 & 5. The part that follows discusses the Case Study design and situates the Case Study in relation to the philosophical, epistemological, and ontological contexts.

4.3: The Case Study design

Available literature recognises quantitative and qualitative methodologies to be the most common methodologies associated with how research is conducted (Ejnavarzala, 2019); and case study is associated with the qualitative methodology (McGregor & Murnane, 2010). Case study is an inquiry into a phenomenon that answers specific questions through a systematic process that investigates a situation, interaction, structure or background by using multiple in-depth data collection methods (Thomas, 2006). It is an approach to qualitative research associated with post-positivism, interpretivism, and pragmatism paradigms (Baxter & Jack, 2008; L. Bloomberg, D., Volpe, M, 2012; Goldkuhl, 2012).

Case study as a method of inquiry, has a distinct advantage of examining events and situations when behaviors cannot be statistically manipulated and when an in-depth analysis of contemporary events are required (Robert K. Yin, 2009; Yin & Campbell, 2018). Qualitative case studies afford the researcher with the opportunity to investigate, understand and appreciate social phenomena in their real naturalistic context by using multiple data sources (Baxter & Jack, 2008). Naturalistic environment is a characteristic of qualitative research in that it does not predict what may happen in the future rather it investigates the relationship between the setting and the participants (Patton, 2015). Using a case study approach allows the researcher to plan and execute scientific collection and reporting of issues by getting close to the target group (Gillham, 2010). Stake (2009) observes that case studies are essential in understanding human affairs given their attentiveness to human needs and are ontologically in harmony with peoples' lived experiences.

Case Study, however, has been subjected to serious scrutiny regarding its ability to claim knowledge through research. The scrutiny and criticisms are based on the view that case study lacks trustworthiness or rigor, generalizability, and reliability whilst natural scientific researchers employ methods to obtain results through quantification, hypothesis testing and manipulation of variables (Thomas & Myers, 2015). For example, positivism; a paradigm in natural science intricately linked to quantitative research, claims to be more rigorous than case study which is linked to qualitative methodology. Quantitative research claims to use objective knowledge through the natural manipulation of variables and other social facts, including the testing of hypotheses and causality as opposed to case study (Khairul, 2008). Positivism claims that a true research knowledge and theory emanates from marshalling evidence from quantification and manipulation of variables in a carefully organised and controlled setting (Thomas & Myers, 2015). Positivism therefore gives importance to criteria

such as internal validity, construct validity, external validity (generalizability) and reliability in knowledge generation through research (Gibbert, Ruigrok, & Wicki, 2008).

Despite the scrutiny from the positivism and quantitative methodologists, the proponents of Case Study and qualitative methodologies hold the view that, the quantitative approach tends to reduce phenomena in constituent pieces, a situation known to scholars as reductionism (Thomas, 2015). Reductionism understands reality from its simplistic form where reality is taken to be parts that may be assembled to obtain the whole (Mazzocchi, 2008). The proponents of the qualitative camp and case study prefer to present reality in its totality including its parts that make the whole reality. This is the reason that interpretivism and pragmatism may be used in qualitative research such as case studies to offer the theoretical and practical approaches to knowledge generation (McGregor & Murnane, 2010). The ontological post-positivism paradigm where case study is understood to draw its roots from, studies a phenomenon in totality, and in relation to the social-cultural, Organisational, or relational contexts. Despite the scrutiny and criticisms, those are some of the factors that make case study credible. This study adopts the case study approach, and therefore aligns with ontological post-positivism, interpretivism and the pragmatic approach. The reason for this choice is to avoid reductionism often associated with positivism paradigm.

Although case study belongs to qualitative methodology, it can have various forms of data collection and analysis (Bloomberg & Patton 2015; Yin, 2014); and case study can also use quantitative data, though it does not study phenomena outside its context (Gibbert et al., 2008). Each approach to knowledge claim, be it quantitative or qualitative, may have limitations. For this reason, some scholars agree to the use of mixed methods in research, in order not to be restricted to one paradigm (Ejnavarzala, 2019). Acknowledging the strengths from each methodology of inquiry allows researchers to go beyond certain boundaries and barriers which define a given paradigm; and to produce integral knowledge. This study has used survey to obtain demographic data related to participants' age, gender, years of service, and aspects of awareness. The study used survey to collect data to complement the qualitative data collected through survey, interviews and focus group discussions. The use of demographic data, a form of quantitative approach, aimed at enriching the study given its context, and all data collected were interpreted to meet the purpose of the study.

The context, purpose, theoretical orientation, envisaged practical application of the study and holistic perspective of the case were essential in deciding the choice of the case study approach. Thus, to fully describe and understand the participation of nurses and midwives' in MDGs 4 and 5, one needs to also understand the social cultural; the structural and professional interactions among Tanzanian health care professionals, since these constitute the context. Participation in the implementation of MDGs 4 & 5 therefore may be understood through interpretation of participants' lived experiences (Interpretivism) that aims at possible practical actions (pragmatism) that are geared towards bringing about positive changes.

The case is also characterised by boundaries. The boundaries are referred to as specifics concerning the time frame of the study and the activity being covered during the research. Whilst the case study approach has boundaries in some instances; it is often difficult to separate the phenomenon' specifics from the context; (Patton, 2015a); and boundaries are not always clear as they constitute a blurring between the case and the context (Yin, 2012). Binding the case, however, ensures that the researcher is clear about the time frame that the research is undertaken; what activities are covered, and what not to cover in the research (Baxter & Jack, 2008). The other advantage of binding the case is to keep the researcher focused on the scope of inquiry; what is included in research, and what it excludes (Ellinger & McWhorter, 2016).

In this study, the participation of nurses and midwives in the implementation of MDGs 4&5 was the case and main unit of analysis; and the steps taken by researcher to satisfy the research questions (Phases) are sub-units of analysis. The boundaries are the time frame for MDGs implementation (2000 – 2015), and the five Tanzanian hospitals involved in the data collection (Three public hospitals, and two private hospitals) as shown in Table 3.1 below. One of the boundaries was the context in which the study was conducted. This was the nurses and midwives who worked in acute care settings in public and private hospitals.

4.4: Determining the case and units of analysis

Baxter and Jack (2008) remind us that it is essential for the researcher to consider the 'case' when considering what the research questions or what the units of analysis will be. The case is defined as "a phenomenon of some sort in a bounded context; in effect your unit of analysis" (p.545). A further characteristic of a case study approach is the sub-units of analysis used and whether or not the case is single, mixed or multiple (Robert K. Yin, 2009). The unit

of analysis can refer to the case itself (Yin & Campbell, 2018, p. 102); this means that "the case is simply identical with the main unit of analysis" (Grünbaum, 2007, p. 83) but can also form sub-units of analysis as understood by looking at the research questions (Grünbaum, 2007), or the steps taken to answer the research questions.

Yin (2003) makes categories of case studies as explanatory, exploratory, or descriptive. Explanatory case studies are those that try to answer or explain a causal-link for real life intervention that may be too complex to be explained through strategies as surveys or experimental means; and exploratory category is used to explore situations or interventions that have no clear concrete outcome (Baxter & Jack, 2008). Descriptive case study is when the intention of the study is to describe the phenomenon in its real-life context (Baxter & Jack, 2008).

This study is descriptive as it seeks to describe in detail the lived experiences (participation) of the nurses and midwives in the context of Tanzania. Case studies are also categorised as holistic (Robert K Yin, 2009). A holistic case study takes into consideration other parts that make the phenomenon including the context, the cultural and structural components (Yazan, 2015). This study is holistic; it looks at 'participation of nurses and midwives in MDGs in relation to the whole context of the health care setting in Tanzania, the nurses' education, the culture, and all other factors that affect nursing and midwifery in Tanzania. Case study can be instrumental and interpretive. Instrumental case study intends to accomplish a certain goal, and not simply to describe and understand a given phenomenon (Baxter & Jack, 2008); and interpretive case study is where there is subjectivity and meaning given by participants and, or the researcher. In interpretive case study, the reality and meaning is drawn from the participants' experiences, the researcher's intuition, and the context (Yazan, 2015) This study is instrumental and interpretive since it seeks not only to offer a detailed description of the issue under study, but also to propose practical strategies to improve participation of the nurses and midwives in future health goal implementation.

Figure 3.1, therefore summarises the study as follows: This case study fell under the rubric of embedded single, descriptive, holistic, and interpretive case. The findings from the analysis sufficiently describe what the enabling and inhibiting factors were, and the influence they had on nurses and midwives' participation in the implementation of MDGs 4&5. The participation of nurses and midwives in the implementation of MDGs 4&5 was the case and

main unit of analysis; and the steps taken by researcher to satisfy the research questions (Phases) are sub-units of analysis. The boundaries are the time frame for MDGs implementation (2000 – 2015). The study context was Tanzania, and information used in the study was supplied by nurses and midwives who worked in maternity and general wards.

Figure 4.1: Embedded single case design (Adapted from Yin 2014, p 50)
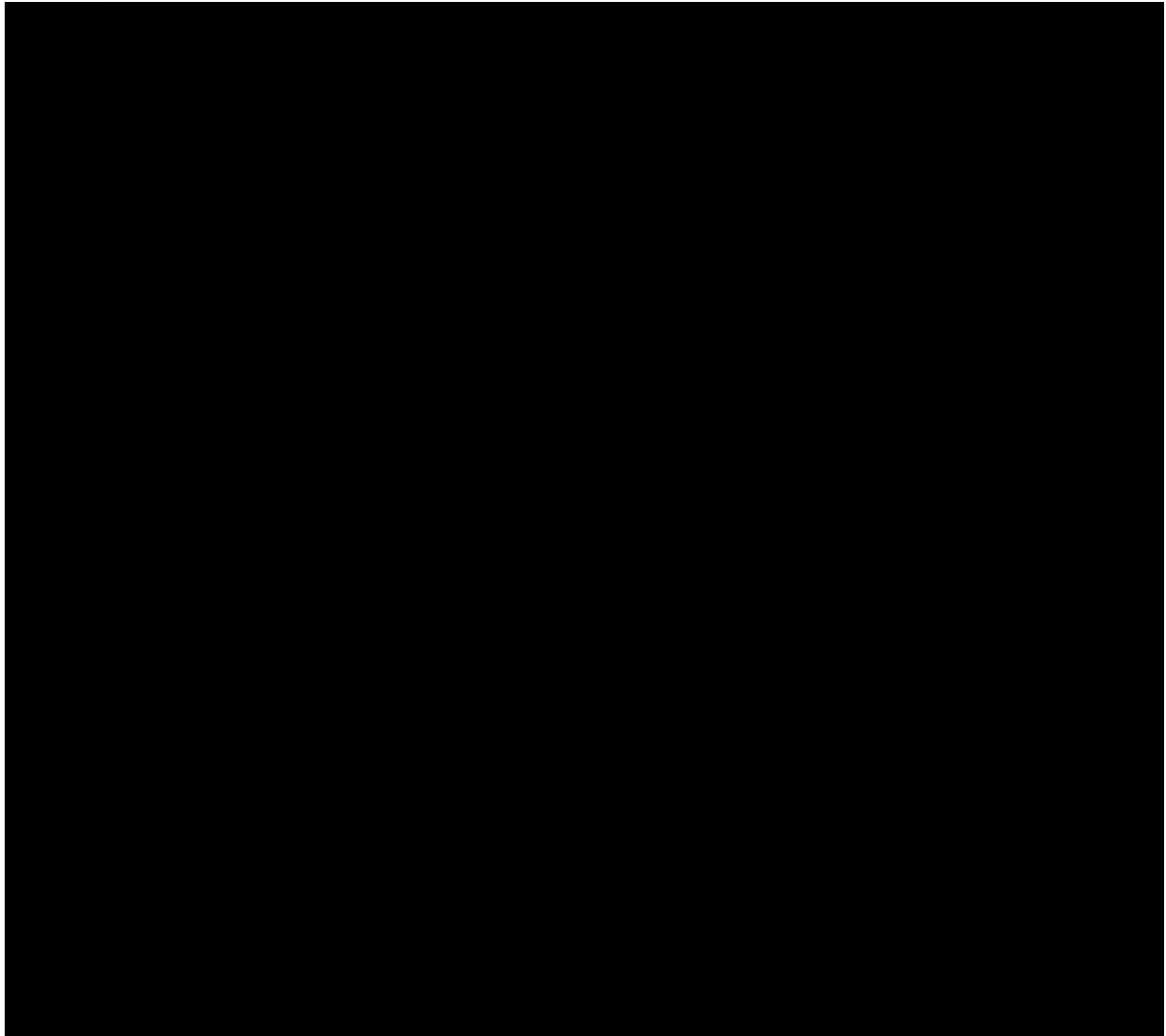
The phases of the study as per Figure 3.2 are presented and each phase is now summarised below.

Figure 4.2: Phases of the study: Embedded sub-units of analysis

Phase 1   **Phase 2**   **Phase 3**   **Phase 4**
Phase 5

Investigating awareness of MDGs among N&M **Data collection:** Staff survey & Interview	**Investigating N&M participation in implementation of MDGs** **Data collection:** Staff Survey, Focus Groups and interviews	**Developing Framework from Phase 1 and 2** **Action:** Creation of domains - Data from Phase 1 & 2	**Substantiating Interviews** **Data collection:** Additional Interviews with selected N & M's Administrators	**Formulating Practical Strategies for Future Participation** **Action:** Collaboration with N & M's Administrators

4.5: Phase 1: Investigating MDGs' awareness among nurses and midwives in Tanzania

The first phase consisted of the development of the survey tool and the administration of the questionnaire to participants. The survey tool was developed from the research questions, and the questions in the survey consisted of what, how and why questions as was reflected in the research questions (Appendix 1). This phase captured information on whether nurses and midwives in Tanzania knew about MDGs (awareness). Data about MDGs awareness was particularly covered in the second part of the survey tool, and it included open-ended and closed-ended questions.

Awareness in this context meant nurses and midwives being informed and knowing about MDGs through official communication channels (as professionals), or through other information sources. The survey questionnaire was distributed to nurses and midwives who volunteered to participate in the survey across the five hospitals. Each participant in the survey self-reported about their awareness of MDGs.

Awareness was also investigated through interviews with administrators. The administrators (also known as non-clinical staff) were included in the data collection process because they are experienced nurses and or midwives, had various administrative responsibilities in the Tanzanian nursing and midwifery services, and they were assumed to have knowledge of

how health related MDGs were implemented in Tanzania. Further information about administrators is given in chapter five.

4.6: Phase 2: Investigating nurses and midwives' participation in implementation of MDGs.

The second phase aimed at collecting information about nurses and midwives' participation in the implementation of MDGs. Participation refers to the extent to which nurses and midwives were involved in activities that aimed at reducing child mortality and improvement of maternal health between 2000 and 2015. Participation also entailed deliberate and conscious input by nurses and midwives; active involvement in the planning, implementation, and evaluation of activities to reach Goal 4 and 5 of MDGs. Conscious and active input refers to what nurses and midwives did with their awareness about the goals and targets of the MDGs 4 and 5, and not what they did as part of their everyday professional or clinical work.

The questionnaire described in phase one also collected data about participation by using the questions in parts 3, 4, and 5 of the survey tools. Part 3 gathered information about participation in general, part 4 collected data about enablers and inhibitors to participation, and part 5 gathered data about future participation. Clinical staff also took part in focus group sessions (Appendix 2), and individual interviews were held with administrators of the nurses and midwives (Appendix 3), and the researcher again collected data about nurses and midwives' participation in MDGs.

4.7: Phase 3: Developing the framework from the first two phases

The framework evolved from the data collected in phases one and two of the study with the intention of developing core elements of the framework which would then contribute to how nurses and midwives prioritised recommendations into the future. Frameworks are an essential part of research as they show important features and factors that are to be presented in research (Horowitz et al., 2019). Frameworks provide a researcher with clear structure and step by step pathway on which data may be summarised (Gale, Heath, Cameron, Rashid, & Redwood, 2013). The framework was developed by analysing the collected data in the first two phases, followed by a construction of a visual diagram.

4.8: Phase 4: Testing the framework

This phase involved conducting additional interviews via phone call with purposefully selected Tanzanian nurses and midwives' leaders and academics, some of whom were interviewed in phase one. It is those administrators who participated in interviews that were intended for participation in phase 4, and the reason being that these administrators were already aware of the study and had participated in data collection for phase 1. These administrators were first asked to check the relevance of the framework developed in phase 3 to the current study. Additionally, administrators were emailed four questions developed from the four domains (each domain had one question), and the four questions were intended to test the framework and to cover any possible gaps. An appointment was made for a follow-up interview to discuss answers to the emailed questions. The interviews also aimed to gather administrators' views that would help the researcher to formulate the practical strategies for future participation by nurses and midwives in health care goals such as SDGs.

4.9: Phase 5: Formulating practical strategies for future participation

This phase was a follow-up to phase four, and it was done by using input from those administrators and academics interviewed in phase 4. This information was summarised and assisted to form practical strategies to improve nurses and midwives' future participation in the health care agenda including in SDGs.

4.10: Integration of the phases

The use of phases as shown in figure 2 is essential in understanding how the approach for data collection, analyses of the case and sub-units were carried out. Phase 1 and 2 necessitated the development of framework (phase 3), the testing of framework from substantive interviews (phase 4) and formulation of strategies for future participation (phase 5). The framework describes the need for essential changes to effect participation and attainment of Sustainable Development Goals (SDGs). The framework developed in phase 3 assisted to bridge and demonstrate commonalities and relationships between phases thus seeking to draw description and triangulation of the rich data that contributed to the study. Triangulation as a concept is discussed next.

4.11: Triangulation

In qualitative research, triangulation refers to the application of different data sources with intention to attaining convergence of information needed to understand a given phenomenon (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014). The importance of triangulation goes beyond convergence of information. Triangulation addresses the issue of researcher's biases, personal judgement, ideologies and values to enhance transferability and trustworthiness (Fusch, Fusch, & Ness, 2018). Carter et al. (2014) outlined four types of triangulations as data triangulation (convergence of data from different groups of participants); method triangulation (using different methods as sources of data); investigator triangulation (where more than one researcher is used in the study); and theory triangulation (Where more than one theory is used for understanding a phenomenon). This study used data triangulation and method triangulation. These methods of data triangulation used in this study are described below.

4.12: Data triangulation

As stated above, data triangulation refers to the use of data obtained from different types of sources to attain convergence of views required to understand a phenomenon being studied. The best way to think about data triangulation is to think in terms of three data points as people, time and space (Fusch et al., 2018). The aspect "people" refers to groups of people involved in data collection as sources of data; "space" refers to where data was collected from; and "time" means period through which data was collected.

In this study, data was collected from different groups of people collectively referred to as clinical staff (nurses and midwives who worked in hospitals), and administrators (nurses and midwives who had administrative functions within the nursing and midwifery services in Tanzania). Data was collected from different points and settings, specifically from five hospitals: two in the city of Dar es salaam, and three hospitals from Kigoma region, and were collected around the same time (between February and March 2017 for phase 1 and 2). The data obtained from different groups of people and from different locations were converged and analysed to obtain commonalities which then aided to obtain results to understand the phenomenon being studied.

4.13: Methodological triangulation

Methodological triangulation is the use of different methods of data collection as a multi-strategy approach to attain data convergence and completeness (Fusch et al., 2018). It is the application of different methods of obtaining data like the use of interviews or documentary review in a study. Method triangulation may be divided into "across or between method, and within method triangulation" (Fusch et al., 2018). Across method triangulation means triangulation of data from different designs for a given study, whereas within method design means data triangulation from different methods of data collection such as focus group or interviews. In this study, method triangulation was used for data collected by using interviews, focus group sessions and survey. These three methods used during data collection were triangulated to attain complementarity of findings and to enrich the knowledge generated by the study. The next section describes how data was collected in the first two phases.

4.14: Phases 1 and 2

4.14.1: Introduction:

The aim of these phases was to investigate nurses and midwives' awareness and participation during the MDGs implementation period between the year 2000 and 2015. Phase one and two investigated the nurses and midwives' awareness and participation by using survey, interviews, and focus group discussions. This section will detail the research setting for data collection, participants, data collection methods as well as approach for data analysis. Figure 4 offers a summary of phase one and two.

Table 4.1: Data Collection Summary - phase 1 and 2

COUNTRY SETTING: TANZANIA				
Region	**Hospital setting**	**Participants**	**Data collection**	**Data analysis**
Dar es salaam	1.Muhimbili	Clinical staff (nurses and midwives)	Survey & FG	Content analysis and Descriptive Statistics (DS)
	2.Kairuki	Clinical staff	Survey & FG	Content analysis and DS
Kigoma	3. Maweni	Clinical staff	Survey & FG	Content analysis and DS
	4. Kasulu	Clinical staff	Survey & FG	Content analysis and DS
	5.Kabanga	Clinical staff	Survey & FG	Content analysis and DS
		Administrators	Interviews	Content analysis

4.14.2: Research setting

This research was conducted in Tanzania, with data collected from purposefully selected participants in targeted hospitals both in the city and in the regional/rural environment. The aim was to capture the views from participants who were in different geographical social contexts and who were managed by both public and private systems.

The hospitals were also purposefully selected from the city of Dar es Salaam on the East coast, and from Kigoma region West of Tanzania. Out of the five selected hospitals, three were government funded and managed: one of which was a city hospital (Muhimbili National Hospital) and the other two were in the Kigoma region of Western Tanzania. The other group of selected hospitals was privately managed. One was a teaching hospital in the city of Dar es Salaam (Hubert Kairuki Hospital) and the other was in Kigoma (Kabanga hospital). The purposeful sampling of the hospitals took into consideration the hospital ownership (public and private ownership), and the size of the hospital. The selection also considered the difference in the hospital setting. For example, Muhimbili hospital was selected as the largest

teaching and publicly owned hospital found in the city of Dar es salaam. Kairuki hospital was selected as one of the largest privately-owned teaching hospitals also situated in the city. Maweni hospital represented a medium sized government-owned hospital situated in the regional area, and Kasulu hospital was included as a small publicly owned hospital in remote area of Kigoma. Kabanga hospital was selected as a small privately-owned hospital found in remote area of Kigoma region. A brief description of each hospital is provided next.

4.14.3: Muhimbili national hospital

Muhimbili hospital evolved from Sewa Haji Hospital. This was a small hospital started by an Indian businessman in 1897. With the advent of the British colonial rule after WWII, Sewa Haji Hospital became Princess Margaret Hospital. The hospital obtained the current name (Muhimbili) following the independence of Tanganyika in 1961. Despite the change of names, one of the wards at Muhimbili retained the name Sewa Haji until today.

In 1963, Dar es Salaam School of Medicine commenced within the hospital premises and became part of the faculty in the University College of Dar es Salaam. In 1991, the University became Muhimbili University College of Health Sciences (MUCHS). This meant that Muhimbili hospital and MUCHS remained the same institution. In 2000 Muhimbili hospital and MUCHS were separated for efficiency in administrative and accountability purposes. Because of its new status related to clinical functions, modernisation, and other government reforms; Muhimbili hospital became Muhimbili National Hospital (MNH) owing to its capacity to manage more complicated medical cases. Currently, the hospital offers such services as internal medicine, surgery, obstetrics and gynecology, pediatric, psychiatric, geriatric, dentistry, and other medical, clinical, and allied health services. Despite the separation of the hospital and the University functions, the two institutions are in the same physical space, collaborating in many areas such as research, and clinical training (Mwangu et al., 2008). The number of employees at Muhimbili Hospital could not be ascertained.

Photo 4.1. Muhimbili National Hospital
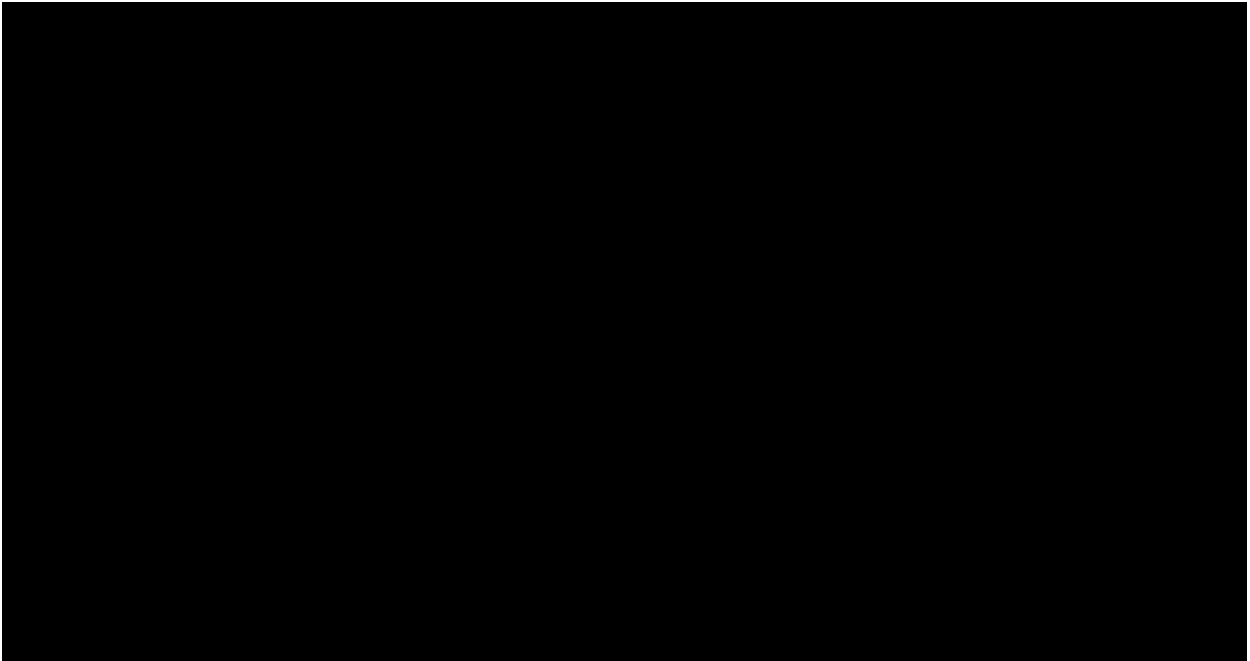
Emergency Medicine Association of Tanzania (2021).

4.14.4: Kairuki hospital

Kairuki Hospital (KH) is one of the two privately owned hospitals purposefully selected for this study since it is a tertiary private hospital that offers both academic and clinical services. The hospital is in the city of Dar es Salaam and is one of the four accredited teaching hospitals for medical students in Tanzania. The hospital, formerly known as Mission Mikocheni Hospital, was inaugurated in 1987 and took its current name from the co-founder; the late Professor Hubert Kairuki and his wife. At its inception, the hospital had a 30-bed capacity offering mainly maternity services. The number of staff at KH could not be ascertained.

Over the years, the KH has expanded its services to Tanzanian society increasing its bed capacity to 150. It offers services in women health, pediatric, internal medicine, and surgery. As a teaching hospital, KH manages Hubert Kairuki Memorial University (HKMU) and Kairuki School of Nursing (KSN). Both HKMU and KSN offer tertiary education to medicine, nursing, and allied health professionals such as pharmacists, dentists, ophthalmologists, and others.

Photo 4.2. Kairuki hospital
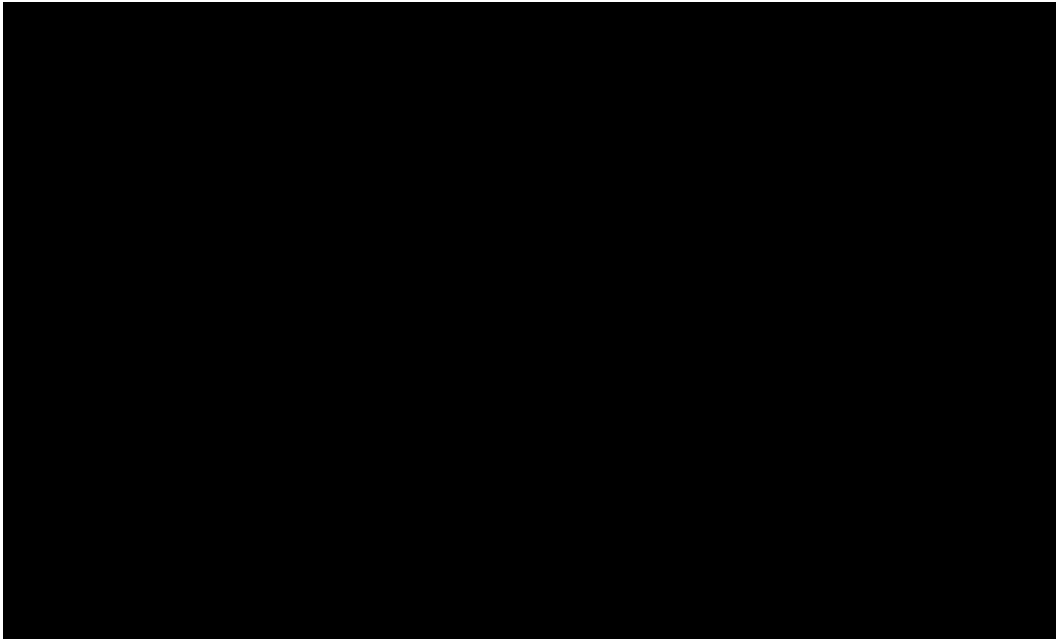
Afya Directory (2022).

4.14.5: Maweni hospital

Maweni Hospital is a medium-sized government managed regional hospital that serves as a referral health facility for other health centers, district, and private hospitals in Kigoma region western of Tanzania. Maweni Hospital commenced its services in 1972 and was built to serve a catchment area of about 45,087 square kilometers. This area includes six districts and eight councils namely Kakonko, Kibondo, Kasulu, Buhigwe, Uvinza, and Kigoma/Ujiji. The region is also administratively divided into 21 divisions, 139 wards and 482 villages, and has a total population of about 2,361,883 people.

Of the six districts that make Kigoma region, only three districts have hospitals: Kibondo district hospital, Kasulu district hospital and Baptist council designated hospital. The three districts without hospitals can receive medical services from nearby district hospital, or from Maweni regional hospital. Besides the district hospitals, Kigoma Region has two hospitals that are owned and managed by faith-based organisations, these are Kabanga hospital and Heri mission hospital. Kigoma region has a total of 278 health facilities comprising five hospitals, and 32 health centers, and 240 dispensaries (Regional Commissioner's Office, 2017/18, p. 1).

Maweni Hospital has a capacity of 300 beds. Only 159 beds are in use, and the rest were undergoing repairs at the time of this study. Maweni hospital employs about 230 staff and offers services such as outpatient, surgery, internal medicine, pediatric, obstetrics and gynecology, orthopedic, psychiatric, radiology, laboratory, and pharmacy. Currently, Maweni hospital is managed by a team comprised of eleven members. There are also two sub teams/committees namely hospital therapeutic committee and quality improvement team (Regional Commissioner's Office, 2017/18 p. 2).

Photo 4.3. Maweni hospital
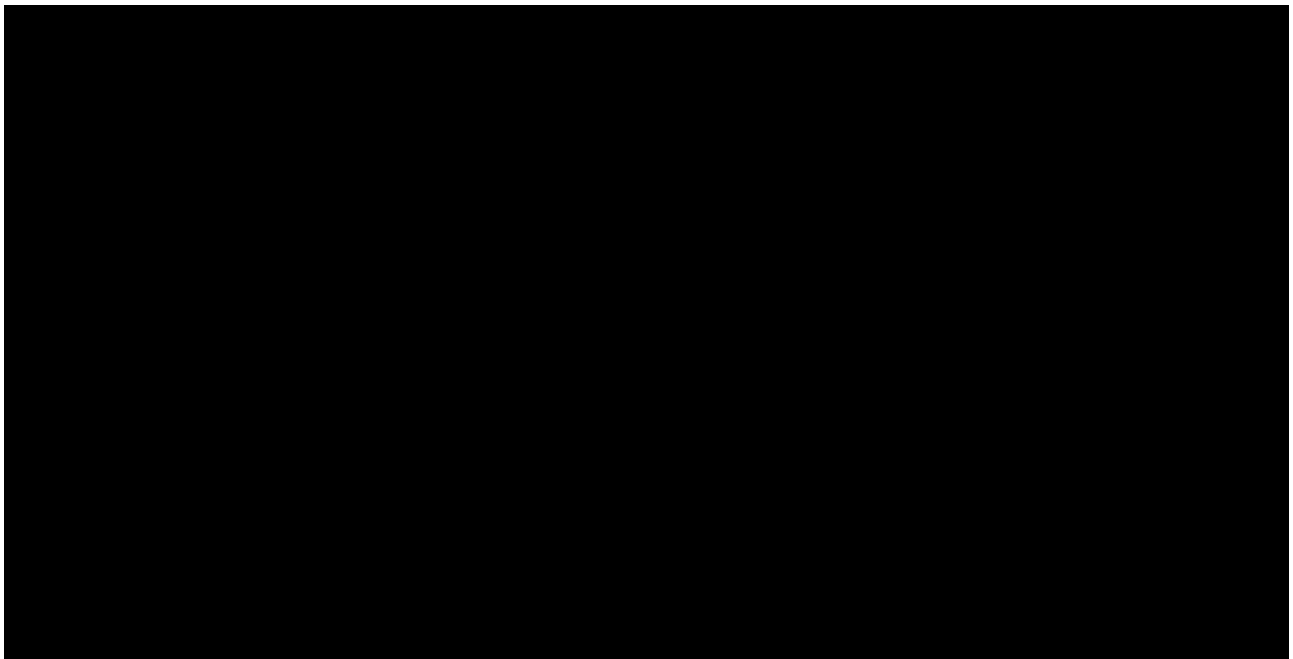
LATAWAMA (2020).

4.14.6: Kasulu hospital

This hospital is in Kasulu administrative district in Kigoma Region – Western Tanzania. The hospital is situated about 75km to the North-East of Kigoma municipal town. Kasulu hospital serves a population of about 208,244 of Kasulu township as per 2012 population census (Wikipedia, 2020). Most people who use the facility come from its catchment areas. The hospital started in 1963 as a government managed facility with 180 beds. Kasulu hospital is made of 8 wards including the male and female medical wards, antenatal, pediatric, postnatal wards, female and male surgical wards, and medical private ward. Kasulu hospital also has a parasitology, hematology, and biochemistry units. The hospital has curative, preventative,

and administrative services; with 140 staff of which 42 are medical staff. The hospital employs 22 registered nurses and midwives, also 56 enrolled nurses. Other staff include pharmacists, general staff, and laboratory technicians.

4.14.7: Kabanga hospital

Kabanga Hospital is one of the two private hospitals that were part of this study. The hospital was founded in 1950 by the Bishop of the Catholic Diocese of Kigoma; Jan van Sambeek of the White Father's Congregation. He founded this hospital in response to the urgent need for medical and health care services within Kigoma region. From 1951 until 2004, the hospital was under the management of the Medical Missionaries of Mary (MMM) and the International Congregation of Religious Sisters based in Ireland. In 2004, the hospital was taken over by Reverend Paul Ruzoka, the then Bishop of the Catholic Diocese of Kigoma. The hospital is currently managed by Bene-Maria Sisters; a religious congregation based in Burundi.

Kabanga Hospital has a total of six wards and bed capacity of 165. The hospital has male and female wards, pediatric, maternity, leprosy wards, nutritional unit, and long-term cases. Other ancillary services include administration and laboratory. Besides providing health and medical services to about 800,000 people within Kasulu District, the hospital provides care to refugees from Burundi and the Democratic Republic of Congo (DRC) with a total number of about 200,000 people (Kabanga Referral Hospital, 2014). Next to the hospital, there is a nursing school which provides Certificate and Diploma education to about 150 students. Both the hospital and school of nursing and midwifery are under the management of the Catholic Diocese of Kigoma. The next section looks at the sampling of participants.

Photo 4.4. Kabanga hospital
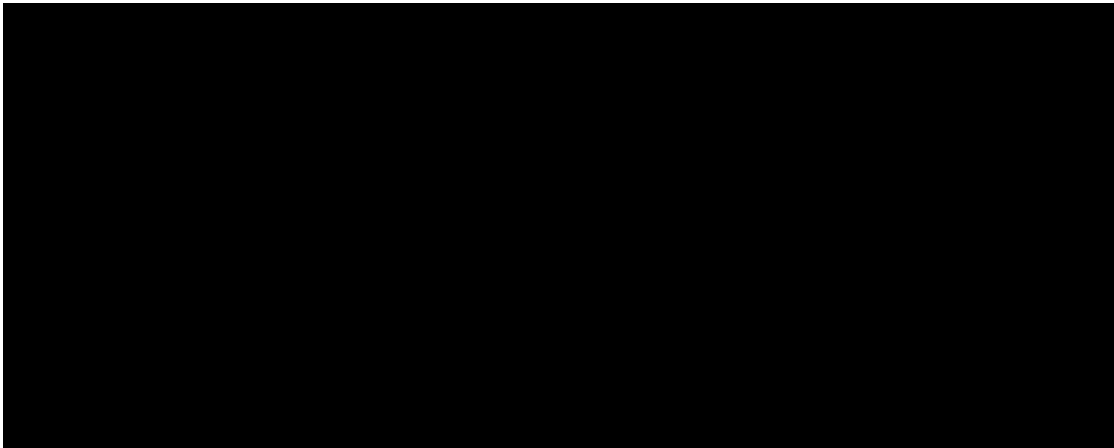
Kabanga hospital foundation (2020): https://images.app.goo.gl/F6hjGri4GEfKJRnJ7

4.15: Sampling

Sampling is an essential part of research, and it is one of the endeavors that the researcher must accomplish. Sampling involves the selection of representatives from a given population from whom information is collected, and inferences about the research results are made (Turner, 2020). There are two major categories of sampling, and these are probability and non-probability sampling. In probability sampling, each member of the population has equal chance of being selected through random selection of the participants (Turner, 2020). Probability sampling includes simple random sampling, systematic sampling, cluster sampling, and stratified sampling. On the other hand, non-probability sampling is a method used in qualitative research where the selection of representatives is made on pre-determined criteria by the researcher (Walter, 2019). Non-probability techniques include convenience sampling, purposive sampling, snowball sampling, quota sampling, and self-selected sampling.

Purposeful sampling, sometimes referred to as purposive or judgement sampling (L. D. Bloomberg & Volpe, 2012) was used in this study. It is sampling method in which the researcher selects appropriate settings, events and participants to provide sufficient information to answer the research questions (Teddlie & Yu, 2007). Purposeful sampling makes choice of rich-cases to enrich the study and participants who can sufficiently shed light on the inquiry being studied (Patton, 2015b). This method of data collection carries the technical and theoretical connotations. Technically, the sample is selected to suit the purpose,

hence the need to obtain an eloquent sample; and theoretically it is sampling that fulfils the theoretical perspectives and reasoning for the study (Cardano, 2020).

Purposive sampling was deemed suited to this study because the researcher had a desire to obtain specific information, therefore the selection of the sample aimed at those (nurses and midwives) that the researcher knew had the required information, and the sampling method was in line with the purpose of the study. Purposeful sampling was therefore used to select the participants for all phases as shown in figure 2, and for the hospitals involved in this study. In purposeful sampling, the availability and willingness by informants to participate in the study and their ability to provided clearly articulated and reflected information is also taken into consideration (Palinkas et al., 2015).

In qualitative research, the researcher aims at offering in-depth description of the case and context. This aim can be achieved if participants that are involved in the study are knowledgeable enough to provide information to suit the purpose of the study (L. D. Bloomberg & Volpe, 2012). The usefulness of purposeful sampling is its ability to use cases and to gather information in its completeness, to describe the phenomenon' connectedness to the context and to avoid generalization. What is usually deemed a weakness in probability sampling becomes strength in purposeful sampling (Patton, 2015b). Purposeful sampling requires the researcher to have access to participants in the field who can help identify information-rich cases (Suri, 2011).

The researcher used purposeful sampling being aware that there are other research sampling methods. For example, random sampling could not be used as this method is suited to quantitative studies, and convenient sampling used in qualitative research has a disadvantage that it relies mainly on availability of participants, and not necessarily on the richness of information from participants (L. D. Bloomberg & Volpe, 2008). Purposeful sampling therefore goes with the purpose of the study (L. D. Bloomberg & Volpe, 2008), and the purpose of this study was to obtain information-rich and in-depth description of the case, hence the reason for choosing purposeful sampling.

4.16: Recruitment of participants

Prior to commencing data collection from the nurses and midwives, written permission was obtained from Notre Dame University, The National Institute for Medical Research, and Muhimbili hospital to authorise recruitment of nurses and midwives as participants for the study. The Ethics approval from Notre Dame University was referenced: 016127F (Appendix 4). The approval reference from Tanzania National Institute for Medical Research was NIMR/HQ/R.8a/Vol. IX/2334 (Appendix 5); and approval from Muhimbili University was 2016-10-18/AEC/Vol.XI/296 (Appendix 6). These approvals were presented to hospital administrators prior to commencing data collection.

Several letters were sent to nurses and midwives' administrators, and this was facilitated by the co-supervisor in Tanzania (Appendix 7 & 8). Eight administrators accepted, and they volunteered their time for interviews. Clinical staff (nurses and midwives) also volunteered to take part in the study following the advertisement to participate in the research which was sent to the hospital block managers and displayed on block notice boards (Appendix 9). Clinical staff indicated their willingness to participate in both survey and focus groups, and a total of 66 clinical staff participated in the study.

Once permission was granted by all the hospitals, posters written in Kiswahili advertising the study was placed on the nursing staff notice boards, and the posters stayed there for about a week. The co-supervisor coordinated the placement of the posters on the notice boards. The hospital management supported the study by arranging a meeting between the researcher and potential participants. The co-supervisor also forwarded letters requesting the possibility of an interview with the nominated administrators. The administrators were not known to the researcher; they were chosen based on the positions they occupied within the nursing and midwifery administration.

4.17: Inclusion and exclusion criteria

The participants who participated in phases one and two were nurses and midwives who worked in hospitals including maternity and pediatric wards in five selected hospitals. Given their nursing and midwifery role, it was assumed that these participants had an awareness and that they were involved in the implementation of health-related goals (MDGs 4 and 5). As some regional hospitals may not have had maternity or pediatric wards, enrolled nurses (ENs), assistant nursing officers (ANO) and nursing officers (NO) were also included as they

had general nursing skills; and they often cared for mothers and children on medical wards. At times, these participants undertook nursing or midwifery duties in the community. The researcher was therefore of the view that this group could also be included in the study.

Whilst the focus of the study was on nurses and midwives in hospitals it was also deemed necessary to interview eight administrators who had key roles within the nursing and midwifery services of Tanzania. As already stated, administrators were nurses and midwives who had administrative and executive functions in the nursing and midwifery hierarchy as shown on the list of key informants (Table 3.2 below). Administrators were from both regions involved in the study (Dar es salaam and Kigoma). Some administrators worked in public or private hospitals, and others had administrative responsibilities within the nursing and midwifery hierarch. The assumption was made that administrators had insights into nurses and midwives' participation in MDGs 4 and 5.

Nurses and midwives working in community health posts, dispensaries, health centers, theaters; medical doctors; and allied health employed in Primary Health Care (PHC) were not included. The reason for the exclusion of staff in PHC was that PHC was outside the scope of this study. Nurses and midwives working in hospitals were appropriate as it was assumed that this group of health care professionals would have more awareness and involvement in delivering the outcomes of MDGs 4 and 5. The following section details the data collection process.

4.18: Data collection methods

As previously mentioned in the design of this study and in accordance with the requirements of a case study approach to research, multiple data collection techniques namely survey, focus group discussion and interviews were used as shown in data collection plan below (Figure 4) to provide a comprehensive picture of the data collection process and participants involved. Initially, a documentary review related to MDGs implementation was included among the data collection methods. The documents targeted included any correspondences such as letters, emails, memos, notes, calendars, reports, evaluations, and others that showed how nurses and midwives were invited, supported and participated in MDGs' activities. Data from documentary reviews was not obtained because there were no data available in the form of memos, calendars, reports, policies, guidelines or any form of documentation about nurses and midwives' participation at the time of data collection. Thus, data from documentary

review was not collected as this type of data was not available. In order, therefore to achieve a wider perspective of the case, the other methods (survey, focus group, interviews) were used to collect data necessary to answer the research questions. A reflective journal was also kept.

A total of 74 people provided information during phase 1 and 2, of which 66 clinical staff (nurses and midwives) participated in the survey and focus groups; and eight administrators participated in open-ended interviews. Four administrators took part in interviews in phase 4, and four administrators contributed to the formulation of practical strategies for future participation (Phase 5). The research protocol details are shown in the data collection plan (Table 3.2 below).

Table 4.2: Data collection plan - Phase 1 and 2

DATA COLLECTION ACTIVITIES	ATTENDED BY	ACTIVITY/LOCATION
DATA COLLECTION PREPARATION	The Researcher with guidance from the Supervisor(s)	Application to UNDA and NIMR to obtain Ethics clearance
RESEARCH TOOLS (Survey/FG/Interviews, Consent Form).	The Researcher	Perth - WA
SESSION 1	The Administrator	Interview at the administrator's office
SESSION 2	The Administrator	Interview at the administrator's office
SESSION 3	Clinical staff (nurses and midwives)	Administration of survey at Muhimbili hospital
SESSION 4	Clinical staff (nurses and midwives)	Focus group discussion at Muhimbili hospital
SESSION 5	The Administrator	Interview at the administrator's office
SESSION 6	The Administrator	Interview at the administrators' office
SESSION 7	The Administrator	Interview at the administrator's office
SESSION 8	Clinical staff (nurses and midwives)	Administration of survey at Kairuki hospital
SESSION 9	Clinical staff (nurses and midwives)	Focus group session at Kairuki hospital.
SESSION 10	The Administrator	Interview at administrator's office
SESSION 11	Clinical staff (nurses and midwives)	Administration of survey at Maweni hospital
SESSION 12	Clinical staff (nurses and midwives)	Focus group session at Maweni hospital
SESSION 13	The Administrator	Interview at the administrator's office
SESSION 14	Clinical staff (nurses and midwives)	Administration of survey at Kasulu hospital
SESSION 15	Clinical staff (nurses and midwives)	Focus group session at Kasulu hospital
SESSION 16	Clinical staff (nurses and midwives)	Administration of survey at Kabanga hospital
SESSION 17	Clinical staff (nurses and midwives)	Focus group session at Kabanga hospital
SESSION 18	The Administrator	Interview at the administrator's office

4.19: Survey

Surveys are techniques of gathering research data in applied research to gain knowledge, attitude, belief, opinion and personal or professional experiences within a given population sample (Armour, MacDonald, & ebrary, 2012). Surveys are considered flexible and are widely used as research instruments in both qualitative and quantitative research to collect and evaluate data necessary for generating robust research findings (Hammer, 2017).

The advantage of using a survey is that it can gather data for both large, medium, and small population samples. Self-administered surveys have high response rate and are used on a wide range of research topics (Armour et al., 2012). In this study, the survey was used given its advantages of reaching more people within a short time and, also that it enabled the researcher to interact directly with those who participated in the study.

The survey was administered to participants (nurses and midwives) who worked in clinical areas of the participating hospitals. The survey tool had six parts (Appendix 6), and it intended to gather information as follows: Part 1 was for participants' details; Part 2 was for MDGs awareness; Part 3 was for participation in MDGs; Part 4 was for inhibitors and enablers for participation; Part 5 was for future participation; and Part 6 was for responses to the UN and WHO's support for nurses and midwives. The survey had both closed and open-ended questions, and the presentation of findings in Chapter 5 will follow this pattern. Some closed-ended questions asked respondents to choose from the options give, and these options were taken from the local Tanzanian context as shown in the survey tool. The survey therefore allowed participants to respond to the questionnaire related to awareness and participation in their own words about their own work contexts and experiences.

4.20: Survey pre-testing

Prior to administering the survey, the pre-testing of the survey questionnaire was carried out, and this took place in Tanzania a week prior to data collection. Three experienced nurses volunteered in the pre-testing exercise which aimed at reviewing the survey questions. The pre-testing exercise was administered by the co-supervisor with the intention to ensure that the questions were clear (no ambiguities), were grammatically correct with no typographical errors; the language used was appropriate to participants' level and was congruent to culture. Also, pre-testing intended to gauge whether the meaning conveyed by the survey questions matched the aim of the study and the potential participants' comprehension.

The three staff that volunteered in the pre-testing (a psychiatric nurse, a critical care nurse, and a midwife) understood the target group and the potential ability for participants to answer survey questions. The three staff who were involved in pre-testing did not participate in the study; they had qualifications beyond graduate level and were familiar with survey as a data collection technique.

Although Kiswahili was the first language of the three reviewers, they also had excellent English competency. The feedback for pre-testing was that the language was at the level of the participants' understanding, with no ambiguities. One nurse, however, observed that more space between the open-ended questions was required for participants' responses. This suggestion was implemented prior to final printing of the survey questionnaire.

Once the survey was deemed ready for distribution, participants who had voluntarily accepted to take part in the study gathered in a hospital meeting room provided by the hospital administration. The researcher was the only person present in the room with participants during the administration of the survey. The rooms were commonly used for hospital meetings; they were well ventilated, well-lit, and clinical staff sat apart from each other.

Prior to completing the survey, the researcher gave explanation about the purpose of the research and was able to clarify any information required. The information sheet written in Kiswahili was distributed (Appendix 7). The information sheet included the right to withdraw at any time from the study without incurring any punitive actions. The participants were asked to sign a consent form once they had read and understood the content in the information sheet (Appendix 9) to indicate their willingness to participate in the study. Participants were also asked to indicate their willingness to take part in focus group sessions that were scheduled following completion of the survey.

All participants who attended and received information about the study voluntarily gave their consent to participate in the survey and focus group discussions. This process was repeated for each hospital; and between 30 and 40 minutes were set aside to complete the survey. Once the survey was completed by the participant, it was returned to the researcher. All returned responses were collected and locked in the researcher's supervisor's office.

The presence in the field of the researcher is said to increase the survey response rate to nearly 100% (Fowler, 2009), and the same percentage of 100% was observed in this study. At

Muhimbili Hospital, the surveys were conducted during the day shift (10am), but some nurses and midwives who were rostered to work that afternoon attended the survey. At Kairuki Hospital, the survey was conducted at 2pm, and both day and afternoon shift nurses attended. At Maweni, Kasulu hospitals, the survey was conducted at 8am. Both night day duty nurses were involved in completing the survey. At Kabanga hospital, the survey was conducted at 2pm to capture the attendance of both day and afternoon shift nurses. Following the completion of the surveys, focus group sessions followed.

4.21: Focus group discussions

Focus group (FG) discussions were among the techniques used during data collection. It has been suggested that a focus group is a method that relies on group interaction on a topic determined to meet the study objectives; is a friendly method of data collection that is respectful, non-condescending and gives voice to members of the group (Gubrium, 2001). Despite its suitability, it has been argued that focus groups can be time consuming, and often the researcher has to work around making sure that attendance in sessions is enhanced (Breen, 2006). Focus Group was preferred in this study as it allowed the researcher and participants to interact directly, it allowed the free sharing of information as well as an opportunity to clarify information from either side during the session.

During this study, focus group discussions took place immediately after the completion of the survey to save time and to ensure participants' attendance. The researcher facilitated the focus groups to elicit in-depth discussion and the free sharing of experiences and information around participation in MDGs 4&5 by the nurses and midwives in Tanzania. The free sharing strategy not only offered the opportunity for participants to express their thoughts, feelings, and perspectives, but also their understanding on the topic (Stalmeijer, McNaughton, & Van Mook, 2014).

Prior to the field trip to Tanzania, the researcher read extensively about focus group sessions, covering information such as group size, recruitment of participants, how to moderate the discussion based on the case being studied, and how to ascertain exhaustion of information from participants. The researcher also had a couple of discussion sessions with the Supervisor on how to manage FGs. During the discussion with the supervisor, areas such as group sizes, the management of FGs, and other logistical requirements were covered. By the time the field

work started, the researcher was familiar focus group's management techniques, and was confident about conducting and moderating the group discussions.

During FGs, participants were organised in groups ranging from eight to twelve people. They included registered nurses, midwives, and enrolled nurses (ANOs and NOs) who worked in various acute wards and midwifery settings. FG sessions were conducted in quiet empty (not in use) classrooms (for four hospitals), and in a meeting room (at Kairuki hospital). Group participants were verbally asked to give permission for the discussion to be recorded. A total of six FGs were undertaken across the five participating hospitals. Prior to FG session, the researcher welcomed participants and thanked them for their willingness to volunteer in the study. The overview of the topic and aim of the focus group was provided, followed by a brief discussion of the interaction rules such as free sharing of information, respect for everyone's opinion, and confidentiality of information. The researcher's personal background was declared, and he assured the participants that professionalism and confidentiality throughout the data collection process, data treatment, and during the publication of the findings. Following this introduction, participants were sufficiently relaxed to start the sharing of information on the topics.

The focus group discussions used open-ended questions that intended to sufficiently answer the research questions. (Appendix 9). As participants engaged in the discussion their responses sparked ideas, perspectives, comments, and meanings that became mental cues for further discussion. During this moment, it was important for the FG moderator and also for the note taker to pay attention to participants' responses and the meaning in those responses. The sharing of ideas and mental cues is useful in refreshing memories and thoughts of other participants together with generated meaningful ideas (Patton, 2015).

At each participating hospital, the researcher conducted the group discussion, and a second person was hired to take notes of the key points and responses to the questions. The second person was a master's student who assisted the researcher with taking notes during all the discussions, and he signed a confidentiality statement. A tape recorder placed closer to participants was also used and participants' responses were recorded and later checked for accuracy at the end of each session. Data transcription commenced with converting participants' responses from Kiswahili to English. This was necessary as Kiswahili was the language used throughout data collection. This conversion was achieved by writing participants' responses in English.

A notes board was also used to summarise key points from participants' responses after each session. These responses were then summarised on A3 papers prior to erasing responses on note boards (Figure 3.3). The average time allocated to each discussion group was between 30 and 45 minutes. This time was deemed enough for questions to be posed, and sufficient time for the participants to respond and give their opinion. The focus group discussion session ended once the researcher noticed that there was no new information being generated by participants for the questions posed.

Figure 4.3: Example of Focus Group Summary for Muhimbili Hospital

14/2/2017

FOCUS GROUP
- MUHIMBILI

Fully Participated?
- Not sure if we fully participated. It's a
sector MoH.
- Only few of US participated
- Not obvious participation
- Not sure to what extent we participated
- Participation was very little, less considered
- Even when our points given
- We were only told what to do.
- Few received training of some sort,
  but not obvious
- We heard some of the things to be
  done Via media to consult
- They don't seem to be
- Some of the people in ministry are not
  nurses or midwives

Participated as Stake holders/Wadau?

- Participated as implementers.
- Most decisions like these are for doctors.
- We had low voice or none.
- Nurses have to learn to speak out
- May be next time, not now
- We did our job as per usual.

4.22: Interviews

Open-ended interviewing is a data gathering method frequently used in qualitative studies, where person-centeredness is placed at the forefront (Wilson, 2012). An interview is suitable for collecting data that is not to be manipulated in the form of numbers, but rather where the researcher envisages investigating trends or themes patterns pertaining to a phenomenon under study (Wilson, 2012).

Within the context of this study, key administrators were interviewed individually as it was assumed, they would have insight into the awareness and implementation of the MDGs 4 & 5 in Tanzania. Preparations for the interviews involved mailing information to administrators and requesting a personal face-to-face interview. The letters were followed by telephone calls to organise an agreed time and place at the interviewee's preferred location, mainly the participant's offices. The interviews involved asking guiding questions with the intention to use same questions for each interviewee (Appendix 1). The questions were designed to elicit in-depth responses to "why" and "how" questions relating to nurses and midwives' involvement in MDGs implementation in Tanzania. A total of eight administrators were interviewed; and the average time for each interview was between 40 and 60 minutes. Flexibility of the question schedule provided the interviewee enough time to give responses to issues beyond the guiding questions. This type of interview has been termed semi structured (Wilson, 2012). Consent was given for the interview to be audio recorded. In addition to the audio recording, the researcher took some notes, including verbal and non-verbal cues. The cues were then entered in the researcher's reflective journal to capture aspects of the interview that could not be recorded.

4.23: Journaling

Journaling is often referred to as 'expressive writing' to denote the art of storytelling, reflection, and contemplation (Dwyer, Piquette, Buckle, & McCaslin, 2013). In qualitative research, journaling is used as a reflective and analytical tool that may be used to demonstrate the trustworthiness of a given research (Dwyer et al., 2013). Reflection has been considered an intellectual and affective component in learning and qualitative research (Chirema, 2007).

During data collection, the researcher kept account of unique events, observations and behaviours displayed by participants. Journaling was used with the intention to understand and appreciate situations that arose during the field work. Every day after returning from the

field work the researcher used this moment for writing some observations in the journal and reflected on the FG process and interactions with the participants.

Initially, the journal did not have a lot of entries. This activity was consistent with the notion that the art of reflection as a skill takes time to develop. For example, on the first day of conducting the survey and focus group discussions at Muhimbili hospital, the researcher reflected on the observations about the extent of enthusiasm shown by nurse participants and entered them into the journal (Figure 6). The researcher described how nurses who were off duty on data collection day at Muhimbili and had made effort to participate in the research. Some stated they had commuted from "Kimara" and "Mbezi" about 15 to 20 km away from Muhimbili. These nurses were eager to participate in the research and did not mind waiting to be in the second focus group. Three nurses had been rostered to work in the afternoon, but they did not mind coming to participate in the research in the morning, knowing that they would start work in the afternoon.

At Maweni hospital the researcher documented in the journal about the eagerness shown by the nurses who had finished their night duty on the morning of data collection. Usually, night duty nurses sign off duty at 7.30am, but they waited and actively took part in survey and then focus group discussion at 10am. At Kasulu hospital, it rained heavily on the morning of data collection, but the rain did not deter nurses who were off duty on that day from coming to hospital to participate in the study.

Another example of the journal entry was that during one of the interviews with the administrators, the researcher noted the disappointment expressed by one of the interviewees. This person stated that in their view, issues and questions related to nurses and midwives' implementation of the MDGs had previously been answered by other professional groups instead of the nurses and midwives. She was therefore happy that this study was being conducted with expectation that its recommendations may give voice to nurses and midwives. Following the administration and collection of the survey and following each focus group discussion and interview, the field notes were documented including observations and reflections relating to the research questions.

Figure 4.4: Journal Entries

4.24: Data analysis

Analysing data is a process that involves bringing some form of order, structure and meaning to data mass gathered by the researcher on a given phenomenon (Bloomberg, 2012). According to Yin (2002), data analysis involves examining, categorising, and bringing together all collected data for making sense out of them. The interpretation of the data is aligned with the research question and aims of the study. Data in form of text or statements

may be reduced to phrases or words or theme. Most common words or themes reported by participants in each text or sentence are noted, and the meaning attached to the theme is described in relation to the research question (Lear, 2010). In this study, closed-ended and open-ended responses as well as participants' demographic details were analysed.

Closed-ended responses in the survey – part of participants' personal details was analysed by using descriptive statistics for all participants across all five hospitals as shown in the survey analysis. The total responses were then quantified and displayed as results in form of tables (chapter 5) for further description. Closed-ended questions were converted into numerical values for general observation of participants' characteristics such as age, gender, role, and years of service. The numerical values such as frequency of occurrences for certain responses by participants were presented in tables as percentages also for general observation and description.

For open-ended responses, the researcher used Inductive Content Analysis (ICA) for analysing data collected during phase 1 and phase 2. In choosing the Inductive Content approach, the researcher was aware that " there is no one best method or approach of analysing qualitative data, but rather particular methods must be selected based on the type(s) of data and questions involved in the study" (Simula, 2018, p. 173). It is suggested that the chosen approach to qualitative analysis should ensure the researcher maintains a focus on the meaning and key aspects of the research question (Schreier, 2014). Inductive Content Analysis was found to be the most ideal approach for analysing the open-ended interview questions as this approach helped the researcher to maintain the focus on key aspects of the study.

Inductive content approach is flexible and appropriate for studies whose purpose is to describe phenomenon where there is limited literature or no existing theory on the study being undertaken (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). The main aim of the ICA approach is to create concepts and categories from which an in-depth description of the phenomenon being studied is made for knowledge generation (Elo & Kyngäs, 2008).

Inductive content analysis requires that analysed data keeps focus on the meaning which is in line with the research question; and not necessarily on what was said (Schreier, 2013). Content analysis also requires that the researcher makes the process simple through analytical creation of categories and themes which are reflective of the phenomenon being studied;

keeping in mind that creation of categories must be both empirically and conceptually grounded (Elo & Kyngäs, 2008). Important categories, and sentences emerging from the data were displayed in tables followed by descriptions and explanations necessary for making sense of the information. During the process of creating concepts and phrases, attention was paid to the research questions.

In analysing the data through qualitative content, the researcher adapted the steps followed by Elo & Kyngas, (2008) as follows: Data transcription; immersing in data to obtain insight by reading and re-reading of participants' responses to obtain the sense and meaning from the phenomenon being studied; creating categories and subcategories in relation to research questions; creating statements/themes from participants' responses; and reporting the findings. The steps are shown in figure 3.5 below.

Figure 4.5: Steps followed during data analysis.
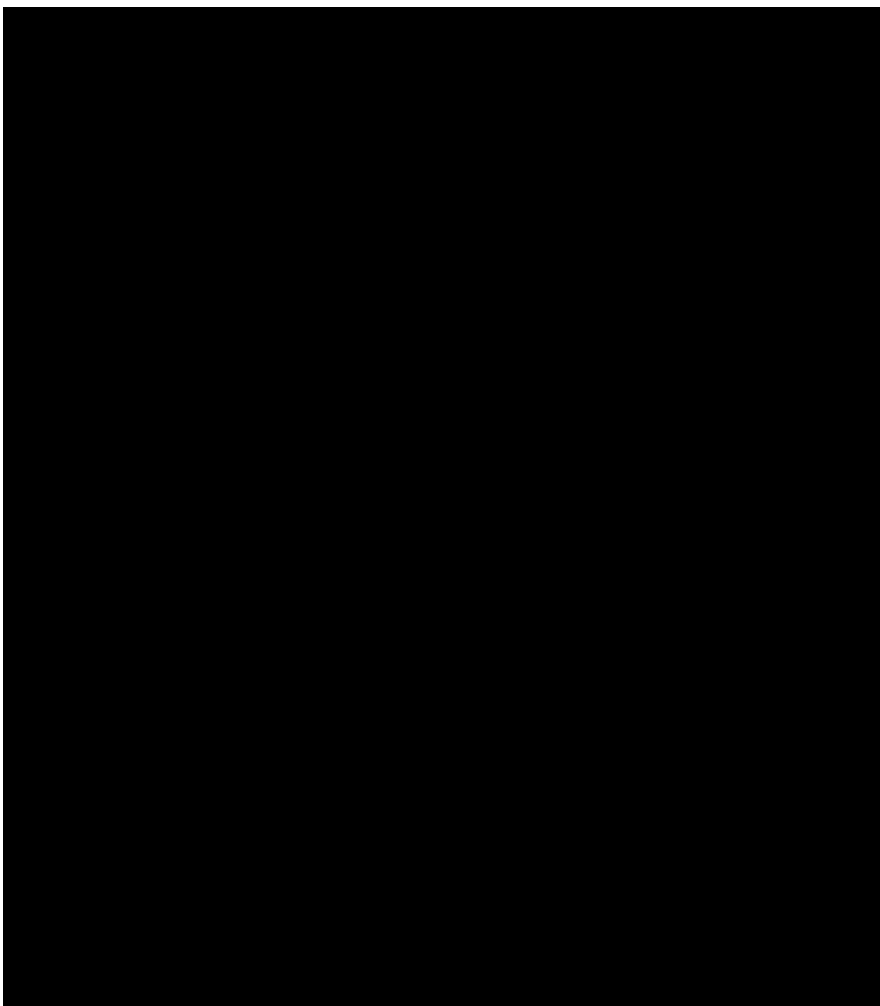
Adapted from Elo & Kyngas, (2008 p. 110)

4.24.1: Phases 1 and 2.

The first step to qualitative data analysis in phase 1 and 2 was to transcribe the tape-recorded data from interviews and focus group discussion into English text. Transcription is an artificial conversion of recorded participants' oral expression to written text (McLellan, MacQueen, & Neidig, 2003). During transcription, the researcher converted participants' audio recorded responses from Kiswahili to English as shown in an example below (Figure 3.6).

Figure 4.6: Transcribed Text
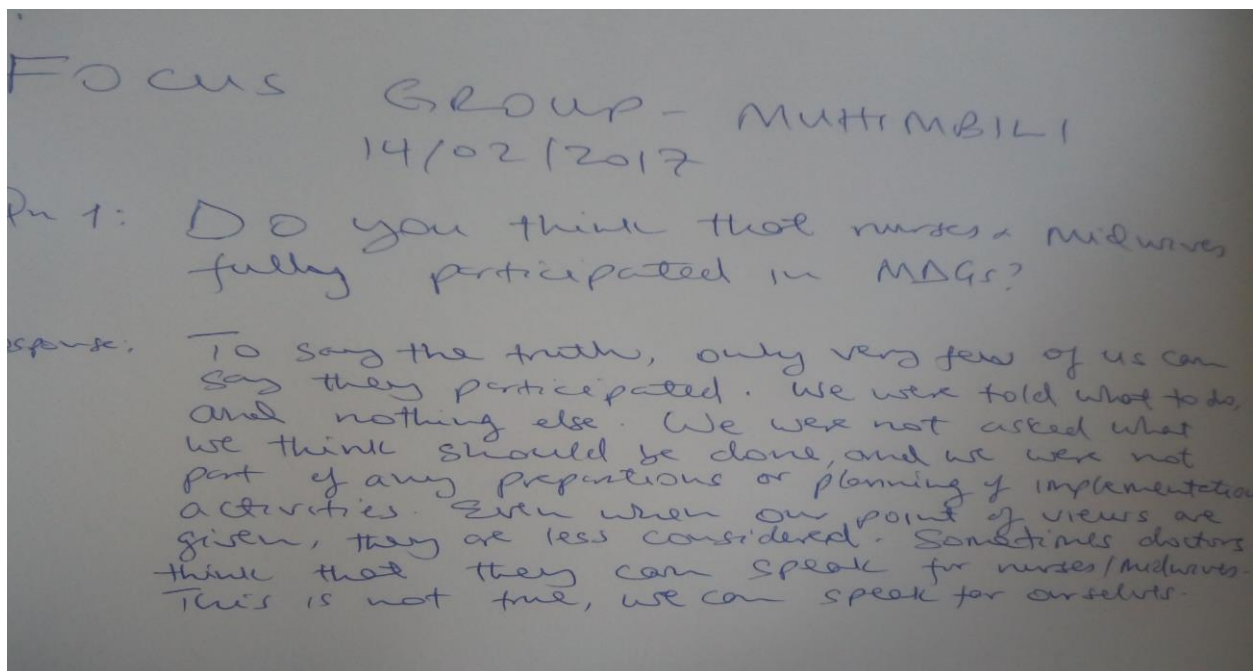
Converting recorded information into English was necessary as Kiswahili was the language used throughout data collection; and it is the national language of Tanzania. Both the researcher and the second person (a master's student) are proficient in both English and Kiswahili. The two are natural Kiswahili speakers and they used English as the medium of instruction from high school. The transcribed texts were checked for correctness against audio taped data by the second person who assisted the researcher during data collection (survey and FG discussions). The researcher added to the transcribed text, the field notes that were recorded during data collection as reflections of what was going on during field work. The field notes were used to give more understanding and sense to the study context.

There is divided opinion regarding how data transcription should be carried out. While some scholars take verbatim transcripts to be essential in data transcription, most researchers in social sciences have shifted the transcription focus from verbatim form to interpretive processes (Skukauskaite, 2012). Verbatim transcripts refer to the use of naturalised transcripts which involve the transcription of the actual utterances and participants' speech or verbal interaction in as much detail as could possibly be (McLellan et al., 2003; Oliver, Serovich, & Mason, 2005). McLellan et al.argue that data transcription is never the production of what happened or said during data collection, it is rather an interpretive and analytical exercise where the researcher decides what is included in the transcript and what is not included. In other words, qualitative research has features related to contextually situated meaning which allow acknowledgement of subjective influence without compromising quality in the research process (Birks, Chapman, & Francis, 2008). Transcripts therefore are not always meant to read like conversation, they are instead to look like written text (McLellan et al., 2003).

During data transcription, the researcher understood that the production of verbatim text or emphasis on naturalised transcripts was not the intention of data transcription. The reason for avoiding naturalised transcripts was that data transcription was to have analytical and interpretive decisions that characterised this stage of data treatment. The researcher chose to transcribe parts of the data that contained the story that would lead him to information related to the research questions and the framework as presented in the literature review.

It therefore follows that; care was taken not necessarily to present the expressions; instead, it was the meaning that drew the researcher's attention. In other words, sighs, laughter, body language, voice tone and non-verbal expressions were omitted. This is what is referred to as latent content analysis (Elo & Kyngäs, 2008); which means being attracted to underlying meaning, ideas, and conceptualization from participants.

For the first part of the survey (participants' details), the researcher read participants' personal details for each hospital and wrote down their responses in tabular form as shown in the Appendix (Data analysis for Kairuki Hospital). For closed-ended responses such as "Yes" and "No", the responses were counted for each participant per hospital, and this gave a "Yes" and "No count". The survey responses related to participants' demographics and MDGs awareness were converted into quantitative information and displayed in form of tables or percentages and were presented and described in findings (Chapter 5).

For open-ended questions, each participant's responses per hospital were tabulated. The responses for all parts of the questionnaire (MDGs awareness; MDGs participation; MDGs implementation; decision making; role for nurses and midwives) per participant were summarised. The researcher then looked at similar responses for all hospitals and came up with a list of statements/phrases as common responses per each survey question as shown in Table 3.3. Statements enabled the researcher to see similar responses per question for all participants. The common responses from participants were then used as guide in describing the findings to answer the research questions.

Table 4.3: Main areas for analysis

MDGs AWARENESS	PARTICIPATION IN MDGs	MDGs IMPLEMENTATION	DECISION MAKING	FUTURE STRATEGIES
• How made aware? • Why made aware. • When made aware	• Who participates? • Enablers • Impeding factors • Importance for participation • Encouragement to participate. • Why participating • Why not participating. • Future Participation • Participation as stake holders • Past participation • Mobilisation to participate. • Support for participation. • Future participation	• Enabling factors • Inhibiting factors • Importance • Who participates? • Why implement.	• Who decides? • Forums for decision • Enabling factors • Inhibiting factors • Future decisions	• Context • Level of Participation • Influencers • Essential Changes

The second step of data analysis was to read all transcribed text to make sense of the participants' responses. This step is called immersion in data to get sense of the whole (Hsieh

& Shannon, 2005). Immersion in data means reading and re-reading the data actively while at the same time searching for meaning (Braun & Clarke, 2006); (Kiger & Varpio, 2020). During this stage, the researcher read the whole text word by word (several times) to get a flow of ideas, and in doing so, looked for connections in the story. Attention was paid to unexpected ideas that deviated and contradicted the research aim. This is essential as contradictory issues may provide sources of information worth perusing for future research.

The third step was to look for information from data that would lead to the creation of categories and sub-categories from each of the main areas of data analysis as shown in the table above. This process involved the identification of key words as codes and categories for each open-ended research question of study aim. Codes are words or identifiers associated with parts of the data which are essential to the study being pursued Bloomberg & Volpe, 2012). It is emphasised that the creation of codes is essentially an interpretive exercise done in many different ways by researchers (Wicks, 2017).

The categories were used as pointers or descriptors for obtaining detailed information about the category from the transcribed text. For example, in Table 3.3, MDG awareness constituted the main area for analysis from which other sub-category words such as "how made aware", "why made aware", and "when made aware" were developed. These sub-category words were used to look for common participants' responses (statements) from the interview, focus group and survey questions.

Step four was the creation of statements from participants 'responses to open ended questions from interviews, survey and focus group discussion. The creation of statements/phrases was preceded by the reading of transcribed text to create common word responses for each research question from categories and sub-categories. For example, from the sub-category "how made aware" (Interview), common response statements were "direct communication", "Workshops", "Media", and "Professional Associations". These statements were presented as words or as short statements, and they are reported as research findings in chapter 5.

4.24.2: Phase 3

This phase involved developing the framework. As stated earlier, the framework was developed from phases 1 and 2. The main components of the framework were its domains (context, level of participation, shifting culture, shifting capacity), and what each domain meant. The Framework necessitated the development of a visual representation of the participants' responses and the mapping of the way forward as recommendations for future participation. The created visual structure had four domains namely the context, level of participation, the shifting culture, and the shifting capacity. The data analysed from awareness and participation (phase 1 and 2) showed some gaps in the four domains, hence the need to obtain more data to cover those gaps. The data collection process is described in phase 4, and more description of the framework is provided in chapter 5.

4.24.3: Phase 4

This phase was a follow-up to phase 3, and it involved the testing and the strengthening of the framework. The framework developed in phase 3 was assessed for its relevance to this study. The testing of the framework was done first, by emailing nurses and midwifery leaders a visual construction of the framework. The framework was emailed together with detailed information for each of the domains that constituted the framework as stated in phase 3 above. In general, the details emailed to administrators were the analysis of the data collected in phase one and two which led to the summary about the Tanzanian context, the level of participation by nurses and midwives during MDGs, the presentation of need for essential changes by identifying possible change influencers as well as the way forward for future participation.

The testing of the framework was followed by the need to collect more data to formulate the practical strategies for future participation. Data in phase four was therefore collected through open-ended interviewees with selected nurses and midwifery leaders, some of whom were interviewed in phase one and phase two.

The leaders were emailed questions from the domains that constituted the framework, and these questions were emailed with the framework itself. The questions were intended to cover any possible gaps in the data collected during the first two phases, the aim being to strengthen the framework created in phase three. Administrators were asked to review the questions and the framework. A telephone interview appointment was made with each

administrator on a day convenient with them. The aim of the interview was first to ascertain the relevance of the framework, and also to collect additional data to fill any possible gaps for information collected for the first two phases. Interviews also helped to obtain input from interviewees for use as recommendations for participation in future health care goals such as the SDGs phase and beyond. The results for data collected in phase four are presented in chapter five. The next part describes the formulation of strategies for future participation.

4.24.4: Phase 5

Phase 5 was a follow-up to phase 4. This phase involved analyzing input obtained from nurses and midwives' leaders about strategies for future participation. Data obtained from phase four interviews were categorise in themes corresponding to the key parts of the framework namely the context, level of participation, need for essential changes (shifting culture and shifting capacity). The results for data collected in this phase are presented in phase five of chapter five in form of statements. The statements are presented as strategies to enhance future participation by nurses and midwives in health care goals namely SDGs and beyond. Ethical issues related to the study are discussed next.

4.25: Ethical considerations

Ethical considerations in this study involved seeking the ethical and governance approval from both the University of Notre Dame Australia (UNDA) and the Tanzania National Institute for Medical Research (NIMR). The approval from NIMR gave permission to collect data from other hospitals, except Muhimbili which has its own ethics approval process. The study utilised low risk ethical principles affecting aspects of beneficence, non-maleficence, justice, and confidentiality. The reference number from the University of Notre Dame Australia (UNDA) was 015163F; that from the National Institute for Medical Research in Tanzania (NIMR) was NIMR/HQ/R.8a/Vol. IX/2334; that from Muhimbili University (MUHAS) was 2016-10-18/AEC/Vol.XI/296. Appendices for these ethics' approvals are attached.

Prior to data collection in phases 1 and 2, the researcher articulated the purpose of the research and included an explanation of the data collection processes. The responsibilities and the rights of the participants were outlined. A rapport was developed with the participants

through professional and honest communication in Kiswahili, which encouraged participants to openly share their thoughts and feelings.

The participants were informed that they were under no obligation to participate in the study, and that they could withdraw from the study at any time without impunity. It was essential to assure participants their participation was voluntary. The potential power differential between the researcher and the participants was acknowledged, and participants assured that information gathered would not be used for purposes other than the research. Administrators were not involved in the survey or focus groups, instead they only participated during interviews as interviewees. Assurances were given to the clinical staff who took part in data collection that all information collected would be kept confidential. This process assisted in achieving a balanced relationship with the participants and increased the trustworthiness of the study.

Once clinical staff understood their expected roles during the study, forms including permission to tape record the interview or focus group sessions were signed. Gaining this consent in Kiswahili helped to build trust and demonstrated lack of coercion. The researcher acknowledged and observed the principle of confidentiality throughout the study.

4.26: Data storage

To ensure confidentiality, all consent forms, survey, and focus group responses were locked in the co-supervisors' safe in her office for all the time of data collection in Tanzania. Data was then taken on return to Australia and immediately scanned and stored on the researcher's home computer and on Dropbox. The computer and Dropbox were password protected, and could only be accessed by the researcher and supervisors. Hard copies were also kept in the supervisor's office. The uploaded data would be used solely for research purposes.

4.27: Demonstrating trustworthiness

In the 1980, qualitative researchers replaced the concepts reliability and validity with the term 'Trustworthiness' (Cypress, 2017), and scholars use the term "trustworthiness" as synonymous to "rigor" (Elo et al., 2014a). In qualitative studies the term trustworthiness is preferred in place of "reliability and validity" to ascertaining rigor and relevance of the study (Finlay, 2006). Rigor refers to measures taken by the researcher to address issues of openness in the research process and issues of merit (Bloomberg & Volpe, 2012). The debate

concerning rigor in qualitative research also moved from the positivist convention of reliability and validity to the researchers' attention to confirmability of information discovery (Streubert & Carpenter, 1999). Whilst it has been argued that qualitative research has come of age in convincing the positivists of the credibility of qualitative research, there is argument that there remains a place for specific trustworthiness of findings (Finlay, 2006). Rigor includes the processes of ensuring credibility, dependability, confirmability and transferability (Houghton, Casey, Shaw, & Murphy, 2013).

In this study, trustworthiness was assured through designing the research questions and research tools focused on seeking answers to the problem being studied (nurses and midwives' participation in MDGs 4 & 5).

The methods of data collection (interviews, FG, survey) were appropriate to the study purpose, and participants who were knowledgeable about the problem being studied were involved in the study. Triangulation of information was carried out, and this process checked for similarities of results from all three methods used in data collection namely interviews, FG, and survey.

4.28: Credibility

Credibility entails how well data collected during the research are able to provide some tentative answers to the research questions (Elo et al., 2014a). Credibility looks at whether the research findings remain accurate from the perspectives of both the researcher, the reader, and the participants (Bloomberg & Volpe, 2012). Data collection took place in Tanzania where interaction with participants continued at various stages of data collection and management.

Credibility was observed by choosing data collection strategies (survey, focus group discussions and interviews) that matched the study purpose. A journal was also kept recording memos regarding conceptual meaning from the raw data. Journal entries also enabled me to reflect on my subjective influence and included my personal observations and impressions during data collection. This reflexive stance enables the researcher to become immersed in the data (Birks et al., 2008).

To elicit credible information regarding the case study topic, I purposely selected the recruitment of nurses and midwives together with administrators who were assumed to be well informed about the nurses and midwives' participation in MDGs. Purposeful selection of participants supports the view that there is no single reality that people construct (Elo et al., 2014b). During data transcription, participants' views were kept intact by retaining meaning conveyed within their responses. Also concepts relevant to the unit of analysis were identified. During focus group discussions, the researcher summarised the main responses given by participants on the noticeboard for participants to see and correct if needed. A tape recorder was used during focus group sessions, and another person other than the researcher (who had signed the consent form) wrote participants' responses. The responses were reviewed by the researcher and notes taker at the end of each focus group session. After the data collection day for Muhimbili and Kairuki, the collected data (forms and tape recorders) were kept in the co-supervisor's office until the whole data collection exercise was completed.

4.29: Dependability

In qualitative lexicon, dependability is used in place of reliability (Finlay, 2006); and it refers to the fit between the descriptions and interpretations of the data (Morse, 2015). To demonstrate these elements, I followed a structured pattern in the data collection, analysis, and triangulation. For example? It has been argued that dependability is essential in maintaining trail of evidence to enable other researchers to follow the processes inherent within a given study from data collection, analysis and report (Prion & Adamson, 2014).

4.30: Confirmability

Confirmability is comparable to objectivity and neutrality in quantitative research (Bloomberg & Volpe, 2012). It also refers to absence of biases, the use of audit trail for data collection, treatment and triangulation (Morse, 2015). Triangulation refers to the use of different methods to understand a phenomenon; also it means looking at data obtained from different sources and assess the extent to which the data verify the research findings (Houghton et al., 2013). This viewpoint implies that the research findings are free from biases, and accurately represent participants' views, rather than the views of the researcher (Elo et al., 2014a). As the researcher in qualitative research is the instrument, it was necessary for me to explain to the participants my role and perspectives on the research topic.

The researcher kept a journal of memos documenting thoughts and beliefs about the research. These activities assisted in the transparency of biases and how the data shaped the findings.

Confirmability is also about presenting sufficient details about the data being reported, the openness of the research process from research design, data collection, transcription, structure categorisation, data analysis and data reporting in such a way that processes involved provide an audit trail (Sharts-Hopko, 2002).

The case study research design used in this study matched well with the data collection techniques, which were a survey, focus groups and interviews. The data from these sources were triangulated to grasp a better understanding of the findings. As explained above, data triangulation aims at confirming that data collected from different sources converge on same conclusions or findings. In this study, different data sources: survey, interview and focus group discussions were used; and participants' responses from these three data sources were analysed as per steps outlined above in order to obtain desired description of the case and to answer the research questions. This is to say that data collected from survey, interview and focus groups were analysed and reported separately. The analysis was preceded by data transcription into written texts; data were read and re-read to grasp the meaning conveyed by the participants; they were converted into phrases and statements that matched the main parts of the case and research questions before finally being reported. Confirmability therefore was ensured through openness and by giving sufficient details about the case being studied, the study context, details about data collection methods including evidence of data analysis (steps followed in data analysis, data analysis plan for individual hospitals, key words and themes for data analysis, samples of focus group summaries and journal entries). Although data analysis and reporting were done separately for each data collection technique (survey, interview, focus group), the findings obtained from each technique were cross-checked and then reported together in accordance with the research aims, and research questions.

4.31: Transferability

The term transferability stands for the extent to which the researcher is able to situate the research findings to the context under study (Sharts-Hopko, 2002). It is argued that the purpose of qualitative research is not to generalise findings, as could be expected for quantitative findings, rather to offer a means to transfer findings to interested researchers. Case study research can provide a reasonable method of researching similar topics within

similar contexts. The findings from this study may apply to other parts of Tanzania and countries with a similar context.

4.32: Researcher's reflection

My nursing career started in Western Australia after I migrated there from Africa. Prior to migrating to Australia, I was a high school teacher. As an immigrant, I practiced high school teaching only for a short moment in Perth. Before changing my career to nursing. Available research supports the view that peoples' career choices and change are influenced by a number of factors, which relate to life changes, work conditions, personal motivations and life expectations (Lazarescu & Kouzas, 2017). I was personally influenced into the nursing career by a personal feeling of wanting to explore "the other sides of myself", or my other abilities and taking opportunities that my new country could offer. After completing my undergraduate nursing and master's degrees with some years of clinical experience, I developed the need to explore how nurses and midwives in Africa were becoming involved in responsibilities and activities other than bedside nursing. I chose to do my research in Tanzania because the research topic and context resonated with my personal experience, and I was familiar with Tanzanian social setting despite having not practiced nursing there. I had observed and read about different roles, responsibilities and professionalism among Australian nurses and midwives, and I wondered whether the same roles and responsibilities were being practiced among Tanzanian nurses and midwives.

My field work in Tanzania was a positive one. I was comfortable with the Tanzanian social norms, I was culturally competent, and I had an excellent command of Kiswahili as a national language. I was comfortable talking to both participants in managerial and administrative nursing roles as well as those nurses and midwives in clinical settings. When I was preparing my first data collection trip to Tanzania, I was not sure how participants would relate to me. I was aware that my connection with Tanzania and my nursing background would enable me to identify with participants as an insider. I was also aware that I could be considered an outsider owing to presumed Western nursing experiences and views.

In Tanzania, I made a habit of introducing myself before every interview or FG. I shared my background with participants, and more importantly I stated that I was a registered nurse in Australia. Having the same nursing background with participants helped in creating trust with them, hence I situated myself as an insider among participants. An insider is a researcher who

identifies well or comes from the same place with where the research takes place (Hill & Dao, 2020). Being an insider helped me to build rapport with participants and to increase participants' confidence to respond to research questions.

The researcher's role during data collection is to become an interface for interaction with participants (Creswell, 2013). It is also essential for researchers to be reflexive of their identity particularly when they occupy an insider role (Hill & Dao, 2020). I was aware that as an insider I was open to some degree of bias and prejudice, and this was addressed by remaining neutral with participants' responses, being an active listener, recording or writing down participants' responses and opinions only, and summarizing those responses for participants to look at prior to ending the sessions.

4.33: Chapter four summary

This chapter has presented the methodology for qualitative case study. The chapter started by discussing the philosophical approach, including ta discussion of epistemological and ontological orientation to the case study design and data analysis. An account of participating hospitals in Dar es salaam and Kigoma have also been presented including the detailed discussion about the selection of participants, the methods of data collection across the five hospitals namely the survey, focus group discussion, and interviews.

Inductive qualitative content was chosen as an approach for data treatment and analysis, and it aimed at presenting a thick description of information to satisfy the research questions and the study aim. Through content analysis key categories were developed, and these provided insights that emerged from data for developing the framework. The next chapter (Chapter 4) covers the details about Tanzania as the study context.

Chapter 5: Presentation of Findings

5.0: Introduction

This study aimed at investigating and describing the participation of nurses and midwives in the implementation of Millennium Development Goals (MDGs) 4 and 5. The study took place in Tanzania, a country situated in the East African Region and categorised as Low- and Middle-Income Countries (LMIC) since 2020. The purpose of the study was to uncover and describe the inhibiting and enabling factors for nurses and midwives' participation and to make recommendations for improved participation by this important group of health care professionals in achieving Sustainable Development Goals (SDGs) for the period 2021 to 2030. The research questions for this study were:

1. How were the nurses and midwives in Tanzania made aware of the MDGs 4 and 5?
2. How did the nurses and midwives in Tanzania participate in implementing the MDGs 4 and 5?
3. What are the factors that enabled or impeded Tanzanian nurses and midwives from participating in the implementation of MDGs 4 and 5?
4. How did the Ministry of Health and Social Welfare (MOHSW), hospital administrators in Muhimbili Referral Hospital, Hubet Kairuki, Maweni, Kasulu and Kabanga hospitals respond to UN and WHO call to support nurses and midwives in implementing MDGs 4 and 5?
5. What lessons can be learnt from nurses and midwives' participation in MDGs that will assist in formulating strategies for participation in future health care goals such as the SDG?

This chapter presents the findings of the data according to the five phases that constituted the sub-units of analysis as described in chapter three. Diagram 1 shows how findings will be presented according to the phases. Each phase built on the previous phase commencing with Phase one which provided the demographic data (DD) and assessment of nurses and midwives' awareness of the MDGs. Phase two gathered data about how nurses and midwives (from their perspective) participated in the MDGs. Phase three analysed data collected during the first two phases identifying key categories for the creation of the conceptual framework. This framework was then tested in phase four including confirmation of relevance of the framework to the study. Additional data was collected in phase four in order to obtain

practical strategies for future participation, and these practical strategies were consolidated in phase five. A summary of findings is given at the end of each phase. Phase 1 which included demographic data and awareness on MDGs is presented first.

Figure 5.1: Phases for presenting findings
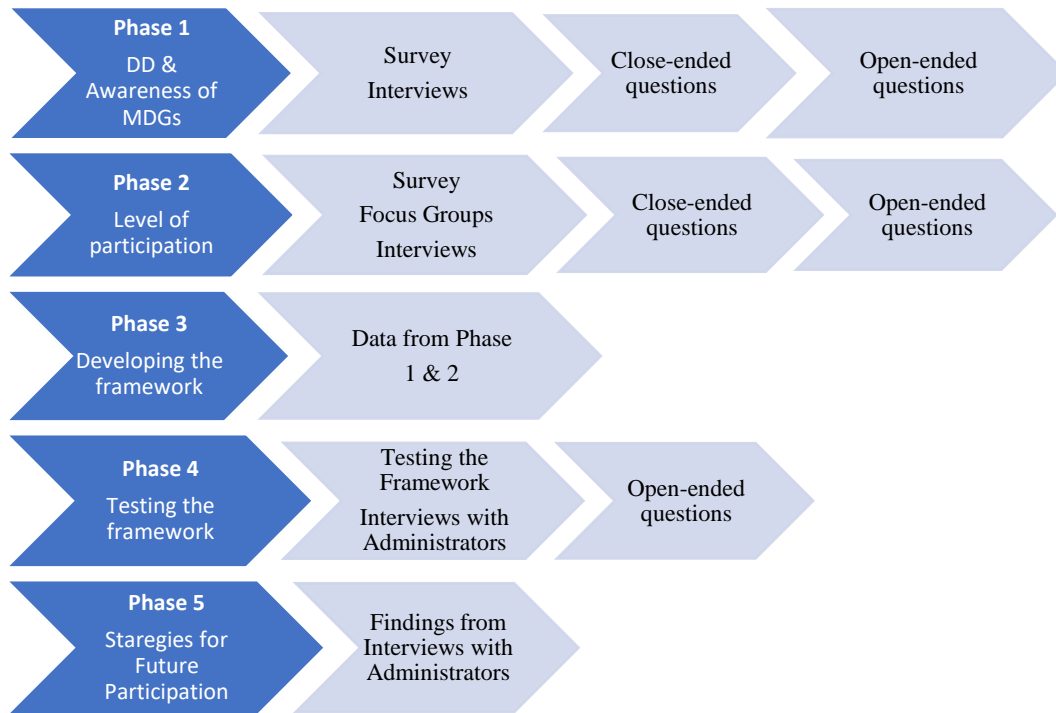
5.1: Phase 1: Demographic data and awareness of MDGs

The presentation of findings for phase one is summarised in diagram 2 bellow.

Figure 5.2: Phase 1 Findings

5.1.1: Demographic data

The aim of collecting demographic data was to offer essential information about participants' characteristics such as age, role, gender, working experience, and this demographic data is presented for all clinical participants in phases one and two across the five participating hospitals. The number of participants for each hospital is identified in the left column and the hospital type in the far-right column of Table 1. As can be seen in the Table, the hospital type was either public or private. The total number of clinical participants in survey and FG for all hospitals (n = 66) may not be repeated in the subsequent tables. The participants' demographic data is displayed in Table 1 below.

Table 5.1: Participants' age, role, gender

HOSPITAL	PARTICIPANTS' AGE						ROLE RN/EN		GENDER		HOSPITAL TYPE
	19 - 28	29 - 38	39 - 48	49 - 58	59 - 68	69+	RN	EN	F	M	PUBLIC(PC)/ PRIVATE (PV)
MUHIMBILI (23 Participants)	3	10	8	1	1	0	12	11	22	1	PC
KAIRUKI (11 Participants)	1	2	3	5	0	0	5	6	10	1	PV
MAWENI (8 Participants)	1	3	3	1	0	0	2	6	7	1	PC
KASULU (12 Participants)	0	4	6	2	0	0	4	8	8	4	PC
KABANGA (12 participants)	8	2	1	1	0	0	6	6	9	3	PV
TOTAL	13	21	21	10	1	0	**29**	**37**	56	10	**Total 66**

Table 5.1 above, shows the demographic characteristics of the participants in the study including gender, role, age, in 10 years age brackets from 19 to 69 years and over. Participants' role included registered nurses (Nursing Officers and Assistant Nursing Officers) and enrolled nurses (EN). Also included was the type of hospital, either private (PV) or public (PC). Public hospitals were Muhimbili (in Dar Es Salaam Region); Maweni and Kasulu hospitals (in Kigoma Region). The private hospitals were Kairuki (in Dar es Salaam region) and Kabanga (in Kigoma Region). The details for these hospitals are provided in chapter 3.

The total number of participants from Muhimbili was 23, out of which 22 were females (96%) and one male (4%). Kairuki hospital had a total of 11 participants composed of 10 females (91%) and one (9%) male; Maweni hospital had eight participants: seven females (88%) and one male (12%); Kasulu hospital had 12 participants: eight females (67%) and

four males (33%); and Kabanga had 12 participants: nine females (75%) and three males (25%).

The total number of participants who took part in the survey was 66. Females were 56 (85%) and 10 males (15%). The majority (37) of participants, were enrolled nurses (56%) and 29

registered nurses (44%). This finding was most likely due to the RN program (Bachelor's degree) being introduced in Tanzania around early 1990s. Male nurses were fewer in the sample (15%) compared to females (85%). This finding was not surprising as the nursing and midwifery profession has traditionally been dominated by females. There was equal number of participants (21) of the age 29 to 38; and 39 to 48. The two age groups made 63.6% of the survey sample. One participant identified as being between the ages of 59 and 68.

Table 5.2: Participants' years of service

HOSPITAL	YEARS OF SERVICE						
	0 - 5	6 - 10	11 - 15	16 - 20	21 - 25	25+	TOTAL
MUHIMBILI	5	7	4	3	3	1	**23**
KAIRUKI	1	5	0	0	0	5	**11**
MAWENI	2	4	0	2	0	0	**8**
KASULU	0	5	4	1	2	0	**12**
KABANGA	9	1	1	1	0	0	**12**
TOTAL	17	22	9	7	5	6	**66**

Table 5.2 shows the participants' years of experience for the five participating hospitals. Twenty-two nurses represented 33% of all participants had between 6 -10 years of working experience followed by 17 nurses (26%) with less than 5 years of experience. Most experienced nurses were found in Dar Es Salaam region (Muhimbili and Kairuki) with six staff members having more than 25 years or more of experience.

Eight percent of all participants who had 25 years of experience and more worked at Kairuki hospital. Kabanga had the majority of the least experienced participants (n9) representing 14% of all participants with less than five years of experience. This finding may be associated with its remoteness. It is possible that after graduating, nurses stay for a short time, prior to moving to bigger town centers where there are more opportunities for professional growth, better amenities, and entertainment.

5.2: Awareness of MDGs

This first phase presents findings from data collected about MDGs awareness. Awareness data was collected through a self-reporting survey tool administered to nurses and midwives (n66) who worked in clinical areas in five hospitals, and interviews administered to non-clinical staff or administrators (n8) who had various administrative, managerial, and academic roles within the nursing and midwifery services and in the academic institutions. The questionnaire had specific questions that sought information about how nurses and midwives became aware of MDGs 4 and 5.

5.2.1: Findings about MDGs awareness

The second part of the survey had closed-ended questions (question 1, 3, and 5) that sought participants' responses about MDGs awareness. These three questions are listed below:

1. Have you heard about Millennium Development Goals?
3. Have you heard about the target to reduce the under five years mortality rate set by the government of Tanzania?
5. Have you heard about the target to improve maternal health set by the government of Tanzania?

The above questions required closed ended (Yes/No) responses from the participants. If participants chose a 'Yes' response to question 1, they were then asked to select from the six listed options (information source on the far-right side of Table 3): work meetings; my supervisor; colleagues; workshops; media; and other sources. "Other sources" included information received through the nursing college syllabus or journal articles that a participant might have read individually. Participants could list more than one option as source of information on MDGs. Only two items were named, and these were 'college syllabus' and 'journal article'. The responses to the above questions are presented in table 3 below.

Table 5.3: MDGs awareness

HOSPITAL	QNS	1	3	5	Sources
MUHIMBILI (Total responses 23)	YES	22	23	23	Work meetings ……....27 Colleagues…….……...33 Media…….………...45 Supervisor……….…...18 Workshops…….……...12 Other………….………36
	NO	1	0	0	
	%YES Response Rate	96	100	100	
KAIRUKI (Total Respondents 11)	YES	9	11	11	Work meetings……....21 Colleagues...................48 Media…….………...24 Supervisor……….……12 Workshops……….…...12 Other……….………....18
	NO	2	0	0	
	% YES Response	82	100	100	
MAWENI (Total Respondents 8)	YES	7	8	8	Work meetings…. …....33 Colleagues……….…...24 Media…….……...…..45 Supervisor………. …..12 Workshops……... …..27 Other…….……... ….18
	NO	1	0	0	
	% YES Response Rate	88	100	100	
KASULU (Total Respondents 12)	YES	7	12	12	Work meetings……. ...42 Colleagues…….. … ....33 Media…….…. ….. ..…24 Supervisor…….. …...24 Workshops…..……...18 Other…….…..……....12
	NO	5	0	0	
	% YES Response Rate	58	100	100	
KABANGA (Total Respondents 12)	YES	11	12	12	Work meetings 42 Colleagues……….…...24 Media…….………...36 Supervisor…….…....…22 Workshops……..…....18 Other…….……….....…24
	NO	1	0	0	
	% YES Response Rate	92	100	100	
	RESPONSES	Media			174
		Work meetings			165
		Colleagues			162
		Supervisor			88
		Workshops			87
		Other			108
	TOTAL				**784**

Participants from Muhimbili, Kairuki, Maweni and Kabanga had an overwhelming "Yes" response rate to confirm that they heard about MDGs (96%; 82%; 88%; and 92% respectively). Participants from Muhimbili hospital returned between 96-100% response rate to questions 1, 3, and 5. Participants from Kairuki Hospital also returned a response rate between 82-100% for all three questions. Maweni Hospital registered 88% -100%; and Kasulu and Kabanga Hospitals registered 58% and 92% 'Yes' response rate to question one respectively, and 100% to the remaining two questions (question 3 and 5). The lowest "Yes" response from Kasulu meant that a significant number of participants (42%) confirmed having not heard about MDGs. The reason for the lowest "Yes" response from Kasulu is not clear. One would have attributed this low response rate to remoteness, as Kabanga Hospital is the most remotely placed. All participants from the five hospitals returned a "Yes" response (100%) to confirm that they heard about the government's target to reduce child mortality and to improve maternal health (Questions 3 and 5).

The responses in table 3 also indicate that out of the six listed options available for participants to choose from regarding information source on reduction of child mortality and improvement of maternal health, the three most popular choices were media, work meetings and colleagues. Media sources were the most popular among participants with a total of 174 responses from all five hospitals followed by 165 responses for work meetings, and 162 responses for colleagues.

Looking at these sources of information for the three questions on awareness in the survey, it was clear that the media (TV, internet, magazines, and newspapers) were widely used to communicate information about MDGs four and five to nurses and midwives in Tanzania (total 174). The second most popular was work meetings (total 165) and third information source was from colleagues (total 162). The fourth important source was from other sources such as school syllabus and journals which were read individually. The least source of information on MDGs was through workshops. While the use of media could be considered an important strategy for creating awareness of health care goals, this strategy may not be effective as messages given through media may be intended to the general public, and not to intended to reach the nurses and midwives who would be considered important implementors of the planned MDGs activities.

5.3: Findings from interviews

Data collection through interviews involved an individual recorded conversation between the researcher and several key personalities collectively referred to as administrators. The administrators were people with nursing and midwifery background assumed to have knowledge about MDGs implementation, and they had important administrative and managerial responsibilities within Tanzanian nursing and midwifery hierarchy.

The interviews with administrators had five open-ended questions. Out of the five questions, only one question intended to collect data about MDGs awareness, and it read as follows: "How did nurses and midwives first hear about Millennium Development Goals"? The themes that emerged from the interview responses related to the above question were "Direct Communication"; "Workshops"; and "Media" and "Professional Associations". The code next to the quotes refer to interviewee's responses. For example, INT1 means a response from the first administrator interviewed.

The responses given were varied depending on the respondents' role within Tanzanian nursing and midwifery system, and interviewees verbalised how they first heard about MDGs, and how they thought nurses and midwives in clinical areas got to hear about the two health-related goals. The first interviewee stated how Tanzania was positioned, and how the Ministry of Health communicated the health goals to key people in the health care system. The three areas of responses are explained below.

Direct Communication

One of the administrators stated:

> "Tanzania is part of the Global health agenda; therefore, we got to know immediately once the MDGs were passed by the United Nations (UN) General Assembly. The Ministry of Health and Social Welfare (MOHSW) informed key stakeholders throughout the country". (INT1).

The above respondent communicated the role of Tanzanian government in passing information passed by the UN General Assembly, and which needed action from stake holders in the MOHSW. In her response, the administrator noted that immediately as MDGs were passed, the government of Tanzania shared the information to various government

departments including MOHSW, which in turn communicated the same information to other departments within the health care system.

Another interviewee noted that nurses and midwives in clinical areas as well as administrators received information from the Ministry of Health and Social Welfare through official communication and training. She stated:

> "We were informed about MDGs through direct communication from the MOHSW, we received training on what it meant for us" (INT2). She continued: "Some information came from above, and we were informed what needed to be done as part of the implementation strategies" (INT2).

Workshops

Another interviewee referred to workshops as a means of how they first heard about the MDGs 4 and 5.

> "We attended some workshops organised by staff from the MOHSW, and during the workshop sessions we got to know about MDGs; …but also, the Nurses and Midwives Association within the hospitals informed their members about MDGs and what needed to be done in the area of child and maternal health; ….and various educators were invited to give information and education about implementation strategies" (INT 4).

Information through training and workshops was also echoed by the third interviewee who confirmed that information about MDGs reached them through organised training and workshops. She stated that the MOHSW organised some training sessions following the adoption of MDGs by the UN General Assembly in 2000. Here is what she had to say.

> "The MOHSW organised awareness workshop and training campaigns by mobilising different professionals who were then directed to achieving MDGs targets" (INT3).

Media

Another respondent referred to the role of media and TAMA as means through which MDGs became known to them.

"A lot of information reached us through media, …. but of course, there were letters, memos; and managers attended some workshops organised by Tanzania Midwives Association (TAMA); …I believe some nurses and midwives at the bottom of the hierarchy did not hear much about MDGs" (INT5).

As stated above by one of the participants in the interview, media which included radio, television, and newspapers was used to spread information about MDGs. The issue here remained that the information given through media did not specifically target nurses and midwives in clinical areas, rather it was intended for the general public. Information given to the general public does not necessarily affect participation of nurses and midwives in MDGs implementation. Also, information given through media did not reach those in rural areas who do not have televisions, and who do not read newspapers.

Professional associations

Besides direct communication, workshops, and media, the MOHSW also used nurses and midwives' professional associations and other health implementing agencies to get across, the message about MDGs. One interview confirmed this as she stated:

"Communication about MDGs came across through professional associations such as TAMA and other agencies including Non-Governmental Organisations (NGOs), that's how information was disseminated" (INT7).

According to respondents, TAMA and other professional associations communicated information down the health services hierarchy. It however seems that information received was not put in action to the extent of making a difference to nurses and midwives' participation in the implementation of the envisaged goals.

In general, the findings about MDGs 4 & 5 awareness have been reported based on data gathered in phase one through self-reporting survey administered to clinical staff and interviews with the administrators. The findings from the survey confirmed that all participants from the five hospitals showed they were aware of the goals and the target by the Tanzanian government to reduce the child mortality and the need for improvement of maternal health. The survey findings demonstrated that the most popular source of information about MDGs especially to clinical staff was media, followed by work meetings and information from colleagues.

The findings from interviews with administrators again highlighted that nurses and midwife became aware of MDGs 4 & 5 immediately after the millennium goals agenda was declared by the UN General Assembly. The MOHSW communicated information to various departments through the Ministry officials; workshops; information sessions and meetings. On the other hand, media, nurses and midwives' associations, workshops, and memos were used to reach the administrators and clinical staff in hospitals. The next phase (Phase 2) presents findings about nurses and midwives' participation in the MDGs.

5.4: Phase 2: Participation in MDGs

Phase two builds on phase one, and while phase one presented findings on MDGs awareness; phase two presented findings from nurses and midwives' participation in MDGs. Data for phase two was obtained through self-reported survey, focus groups (FG) sessions with clinical staff across the five hospitals and also from interviews with the administrators. For phase two, the findings from the survey will be presented first, and this will be according to the sections in the questionnaire that focused on participation: The closed and open-ended questions identified enablers and inhibitors to participation; response to the UN and WHO's appeal to support the nurses and midwives; and finally, potential future participation for nurses and midwives. The presentation of findings from FG sessions will be presented after those from the survey, followed by findings from interviews.

Figure 5.3: Phase 2 Findings

Phase 1 — Demo Data & Awareness of MDGs	Survey Interviews	Close-ended questions	Open-ended questions
Phase 2 — Level of participation	Survey Groups Interviews	Close-ended questions	Open-ended questions
Phase 3 — Developing the framework	Data from Phase 1 & 2		
Phase 4 — Testing the framework	Testing the Framework Interviews with Administrators	Open-ended questions	
Phase 5 — Staregies for Future Participation	Findings from Interviews with Administrators		

Figure 5.4: Phase 2 – Participation in MDGs

Phase 2. Participation in MDGs	*Survey *Focus Group *Interviews	**Questions:** Close-ended Open-ended
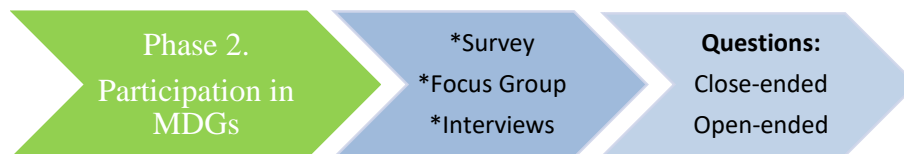
5.4.1: Findings from Survey

Participation in MDGs

Part three of the survey tool sought to gather information about participation in the implementation of MDGs 4 & 5, and it consisted of both open and closed ended questions.

Figure 5.5: Findings from Survey

Phase 2. Participation in MDGs → Survey → Questions: Close-ended Open-ended

Closed-ended questions.

The relevant closed-ended questions in the survey were 1, 5, 7, 9, 10, and are listed below.

1.   Did you participate in implementing the MDGs?

5.   Did you get involved in work meetings to discuss how to improve child health and keeping records for immunization, births, and deaths?

7.   Did you get involved in work meetings on how to improve antenatal and postnatal care as well as record keeping?

9.   Did you participate in seminars/workshops/forums outside your work area to discuss how to improve maternal or child health and record keeping?

10. Who participates in the seminars/workshops/forums outside your workplace to discuss how to improve maternal or child health and record keeping?

The findings from the closed-ended questions (shown above) are displayed in table 4 below.

Figure 5.6: Closed-ended questions

Phase 2. Participation in MDGs → Survey → Questions: Close-ended

Table 5.4: Responses from Closed-Ended Questions

HOSPITAL	QN➡ Response ⬇	1	5	7	9	10 Participants in workshops/ seminars/forums. Only 3 options with higher responses are listed
MUHIMBILI	YES	19	9	10	7	Doctors……………….……. ….21
	NO	4	14	13	16	Policy makers…………..……...19
	YES %	83	39	43	30	Politicians………...…….…….....11
KAIRUKI	YES	9	8	7	2	Doctors…………………...…….14
	NO	2	3	4	9	Policy makers……………..…......7
	YES %	82	73	64	18	Politicians……………………….6
MAWENI	YES	6	7	6	3	Doctors…………………………...7
	NO	2	1	2	5	Policy makers…….…… …...…….4
	YES %	75	88	75	38	Nurses Officers & Midwives. …...3 Politicians…………….…...…….…3
KASULU	YES	10	6	5	4	Doctors…………….….…...11
	NO	2	6	7	8	Nurses Officers & Midwives…….9
	YES %	83	50	42	33	Politicians…….………………….7
KABANGA	YES	10	4	5	3	Doctors……………………......11
	NO	2	8	7	9	Policy makers………………...…9
	YES %	83	33	42	25	Nurses Officers & Midwives…......6
						Doctors Total …………………64 (85.1%)
						Policy makers Total……………29 (38.6%)
						Politicians Total………..….……22 (29.3%)
						Nurses and Midwives Total…...18 (23.9%)
						Total Responses ……………133

Table 5.4 depicts participants' responses from above mentioned closed-ended survey questions (QN 1; 5; 7; 9 and 10). The responses are presented as "YES" and "NO", and as percentages for each hospital. The final column presents options from participants for groups of people that they thought participated more in seminars and workshops organised outside the workplaces (QN 10). Only three of those with high responses are listed, except for Maweni hospital where four options are listed due to nurses and midwives as well as politicians having equal score of three each.

Table 4 shows that 83% of the participants from Muhimbili hospital confirmed their participation in MDGs implementation. However, only 39% and 43% confirmed having participated in improving child health and post-natal care respectively including the keeping of records. Also, only 30% of participants at Muhimbili indicated that they took part in workshops organised outside of their workplaces (QN 9); and they mentioned doctors as being the group that participated more in those workshops and seminars (21 responses) followed by policy makers and politicians. Nurses and midwives were not mentioned among the three participants in seminars, workshops, and forums organised outside of their workplaces.

Respondents from Kairuki returned 82%; 73%; 64% 'yes' responses to questions 1, 5, and 7, respectively. Their participation in workshops and forums outside the work area (Qn 9) was 18%; and like it was the case for Muhimbili, nurses and midwives were not listed among the three groups of people that participated in workshops and seminars outside their workplaces (Qn 10).

Participants at Maweni Hospital also returned a high positive response for questions 1, 5 and 7 at the rate of 75%; 88%; and 75% respectively. Their participation rate outside their workplace (Qn 9) was low (38%). Unlike Muhimbili and Kairuki hospitals, nurses and midwives were mentioned in third position (same for politicians) to have participated in workshops and seminars outside their workplaces.

Kasulu and Kabanga hospitals followed a similar pattern of positive responses at 83% to question 1. Kasulu returned a 'Yes' response of 50% to question 5, and only 42% and 33% to question 7 and 9, respectively. Nurses and midwives were mentioned in second position to have participated in workshops and seminars organised outside their workplaces (Qn 10).

Kabanga, returned lower 'Yes' responses to questions 5, 7 and 9 at a rate of 33%; 42% and 25% respectively. Nurses and midwives were not listed among the three groups of people that participated more in workshops and seminars organised outside the workplaces (Qn10). In general, it was evident that most nurses and midwives across all participating hospitals confirmed having participated in the implementation process of MDGs (Qn 1).

A low response rate was returned by participants (nurses and midwives) across all five participating hospitals regarding their participation in workshops and forums organised outside their workplaces (Question nine). In other words, the participation of nurses and midwives was low for forums, workshops and seminars organised outside the workplaces.

The responses from question 10 (Right column) show that nurses and midwives were the least participants among the three listed groups of people that participated in meetings organised outside their workplaces (23.9%) compared to doctors (85.1%), policy makers (38.6%) and politicians (29.3%). It was therefore the respondents' perception that the doctors, policy makers and politicians participated more in forums, workshops, and seminars to discuss about MDGs implementation strategies than nurses and midwives.

Open-ended questions

Part three of the survey also had open-ended questions (QN 2 + 3) that were complementary to the closed-ended questions, and which sought to collect more information on MDGs participation. The questions were:

2. "If you answered 'YES' to the above question, how did you participate"?

3. "If you participated in implementing the MDGs, why did you participate"?

Figure 5.7: Open-ended questions
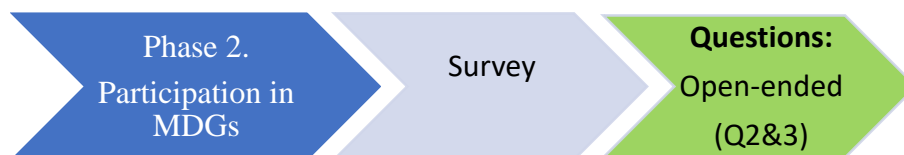
The responses on how nurses and midwives participated in MDGs 4 and 5 were varied. In general, respondents associated participation to doing normal duties in the wards and in the clinics well knowing that this clinical group is closer to the mothers and children they cared

for every day. Below are the themes with participants' responses to question 2 and 3 above. The code next to the quote refers to the response identification given by the respondent during survey.

Figure 5.8: Themes for participation
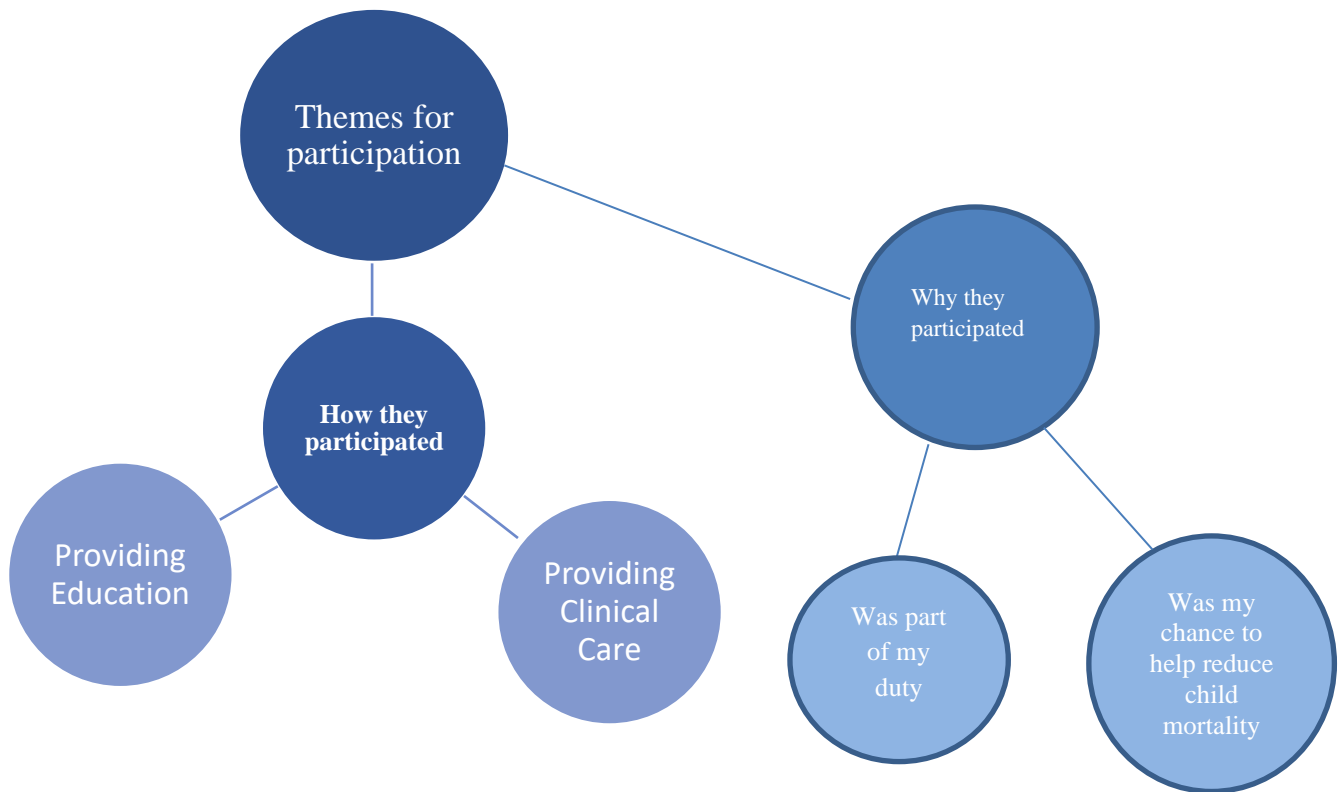
The second open-ended question: "How did you participate"? emerged with two themes which were: Providing Education; and Providing Clinical care. These themes are discussed below

Providing Education

One respondent related participation with her responsibility of providing education to patients that attended clinics as she noted:

"I participated by attending normal duties; I gave education to patients in the clinic about different family planning methods" (SURV4).

It was also noted:

"We provided education on family planning and nutrition to expecting mothers in the clinics, we taught them about the importance of taking vaccines, and this was our usual duties which I believe was part of participation in MDGs" (SURV7).

The education element was also echoed by another respondent who mentioned other areas that she thought were part of participation in the implementation of MDGs.

"I was involved in providing education to mothers about malaria, nutrition, personal hygiene and the importance of attending clinics regularly for health check-up; I kept immunization records; I attended meetings at work where we discussed patient care and at times, we received new work instructions; and I attended the training about family planning and how to manage postpartum hemorrhage" (SURV9).

In addition to providing education, participants stated that they were also involved in providing clinical care.

Providing clinical care

Participation by way of providing clinical care in areas such as vaccinations, antenatal and postnatal care, and the keeping of care records also featured among the participants' responses as the following statements show:

"I vaccinated mothers and children; I educated them on the importance of maintaining children and adult vaccination schedule; and I provided antenatal and postnatal care both in the clinic and in the ward" (SURV12).

"I feel I have the obligation to do my best to improve maternal and child health just like other professionals; … It is important to improve community health outcomes" (SURV3).

The importance of keeping records and research also featured among views presented by nurses and midwives. One respondent stated:

"It was necessary for me to get involved in keeping the records on clinical care since it is part of the best practice and is essential for comparison of health outcome, evaluation and research" (SURV14).

Question three of the open-ended questions: "Why did you participate"? also identified two common themes which were: "Was part of my duty" and "It was my chance to help reduce child mortality". These themes are discussed further.

Was part of my duty

Most participants were of the view that their participation was only part of doing their usual nursing or midwifery duties including attending to patients' needs, day to day clinical care, and any other. When giving the reason for her participation, one participant has the following to say:

> "We did what we normally do every day…we were told there are Millennium goals, but we continued doing what we do at work every day" (SURV17)

Another participant reiterated observed:

> "As nurses, we were willing to do anything that our managers wanted us to do, but we were not asked to do anything different. When I come to work, I'm willing to do anything that I'm asked to do" (SURV2).

The second theme for question three is presented next.

Chance to help reduce child mortality

The second theme from the participants' responses as reasons for participating in MDGs was in line with what they considered an opportunity for them to improve mothers and children heath. Here is what some participants said:

> "I have the knowledge and I know what I can do to help. I thought it was a chance for us to work harder to reduce the children mortality. During work meetings the discussions came up, but not much happened" (SURV10).

The other participant related her response to nurses being key implementers of MDGs.

> "As nurses, we are stake holders, we are the ones who run mothers and children's clinics, it was an opportunity for us to show our commitment to reducing child mortality". (SURV15).

Part four of the survey tool is presented next to cover those aspects that enhanced and those that inhibited the nurses and midwives' participation.

5.4.2: Enablers and inhibitors to participation

Part four had closed-ended and open-ended questions that aimed to investigate the enablers and inhibitors to participation in the implementation of MDG four & five. The closed-ended questions were 1 & 6; and open-ended questions were 2, 4 & 5. The first question asked participants to confirm whether or not they fully participated in MDGs. The second question asked for reasons to their participation (enablers), if a "YES" response was chosen in question one. The third question sought reasons for not participating (inhibitors/impediments) if a "NO" response was chosen. The fourth and fifth questions asked participants to confirm if they were decision makers on maternal and child health in their workplaces and district, regional, and national levels respectively, and they were asked to give reasons if they chose a "YES" response. Question six asked participants to choose three from among the six factors (options) provided that they thought would be important in improving their participation. The six options were: better education; experience in health care policy; experience in health care planning; support to nurses and midwives; better nurses and midwives' image; more opportunities for nurses and midwives. Part four questions were:

1. Do you think nurses and midwives fully participated in the implementation related to MDGs 4 & 5 (maternal and child health?)

2. If "YES" to question one, why do you think nurses and midwives fully participated?

3. If you answered "NO" to question1, what were the reasons for nurses and midwives not to have fully participated in MDGs 4 and 5?

4. Do you think nurses and midwives were among decision makers on matters related to MDGs 4 and 5 (maternal and child health) in their workplaces? Please give reasons for your answer

5. Do you think nurses and midwives were among decision makers on matters related to MDG 4 & 5 (maternal and child health) at district or regional or national levels? Please give reasons for your answer.

6. Which of the factors listed below would have been important in improving

nurses and midwives' participation in MDGs 4 & 5 (Improved child and maternal health)?

A summary of the responses to questions one, four, five and six are provided in Table seven below. In the far-right column, three factors or options were listed by respondents for each hospital as being important in improving their participation. A factor with the highest response for each hospital is listed first. The responses to question two are shown after Table seven.

Table 5.5: Enablers and inhibitors to participation

HOSPITAL	QN ➡ Response ⬇	1	4	5	6 Factors important in improving participation (3 factors with the highest score) are listed for each hospital
MUHIMBILI	YES	16	8	2	Support for N & M ………………......................…… 16 Better education ………… …..…14 Experience in health care policy….……………………….. 12
	NO	7	15	21	
	% NO	30%	65%	91%	
KAIRUKI	YES	8	2	0	Support for N & M ……………………………..……….17 Better education ……………………………...………15 Better image for N & M ……......………………………13
	NO	3	9	11	
	% NO	27%	82%	100%	
MAWENI	YES	8	3	1	Support for N & M ……………….………………….17 Better image for N & M ……….………………………… 15 Better education ……………………………..…12
	NO	1	6	8	
	% NO	11%	67%	89%	
KASULU	YES	9	3	0	Better education …………………...……………16 Experience in health care policy……………………..… 14 Support for N & M ………………......................…13
	NO	3	9	12	
	% NO	25%	75%	100%	
	YES	12	5	0	

KABANGA	NO	1	8	13	Support for N & M ……………………………….…15
	% NO	8%	61%	100%	Better education ……………………………..…14
					Better image for N & M ……………………………..13
					Total responses ……….…………………... 216
					Support to N & M (Total)……….78 (36.1%)
					Better Education (Total) ………...71 (32.9%)
					Better Image to N & M…………………………41 (19%)

Table 5.5 above shows that 30% of the participants at Muhimbili Hospital returned a 'NO' response to the question on full participation (Qn 1). This means that 70% of participants from Muhimbili confirmed having fully participated in the implementation of MDGs 4 and 5. The high 'Yes' response rate to full participation at Muhimbili hospital may be associated with the open-ended responses above where the majority of respondents confirmed that their participation was through performing their normal duties in the wards and clinics.

65% and 91% of the participants from Muhimbili respectively returned a "NO" response to questions 4 and 5 to indicating that they were not among decision makers at their workplaces and at district and regional or national levels.

Participants from Kairuki returned 27% 'NO' response to question one; and 82% and 100% a 'NO' response to question four and five, respectively. At Maweni hospital, 11% of survey participants returned a 'NO' response to question one; 67% and 89% of the participants registered a 'NO' response to questions four and five, respectively. From Kasulu hospital

25% of the participants registered a 'NO' response to question one; 75% and 100% a "NO" response to questions four and five respectively. Respondents from Kabanga hospital indicated 8% a 'NO' response; but their return rate to questions four and five were 61% and 100% respectively.

It was evident from the responses to the questions in this part of the survey that the majority of participants from all five hospitals confirmed having fully participated in MDGs four and five. Participants, however, were clear that they were not among decision makers both in their workplaces and at district, regional and national levels. This therefore means that although nurses and midwives confirmed having fully participated in the implementation processes of MDGs 4 and 5 through doing their usual clinical and educational roles, they also confirmed that they were not among the decision makers for MDGs implementation decisions.

Results for question six show that three most important factors for improving participation were support for nurses and midwives (78 scores), better education (71 scores), and better image of nurses and midwives (41 scores).

Question two and three shown above (Part four of the survey) asked participants to state the reasons why they thought they participated fully (enablers) or why they thought they did not participate fully (inhibitors) in MDGs implementation of MDGs. The emerging themes for the two questions were: Closeness to patients; Heavy workloads, Inadequate Representation and Lack of Empowerment.

Figure 5.9: Enablers & Inhibitors to Participation
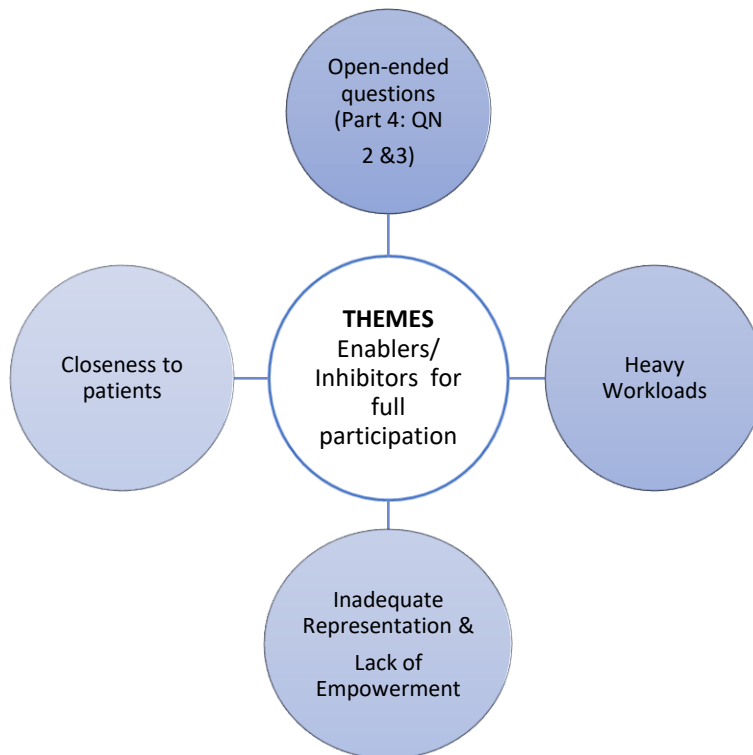
Closeness to patients

Closeness to patients was reported as an enabling factor. Participants who thought they participated fully in MDGs 4 and 5 gave reasons related to being the majority among the health care workers, and they were aware of being closer to patients than anyone else among employees of the health care as one respondent observed:

> "Nurses and midwives are the majority in the health care system and are closer to patients than anyone else; the care given to expecting mothers and the young children is very much in the hands of nurses and midwives" (SURV5).

Another respondent also observed:

> "We are closer to patients, …we participated fully by doing our normal duties; we educated patients in clinics, and attended to all planned training to improve our skills" (SURV8)

Participants who thought they did not participate fully in MDGs gave reasons that varied from heavy workloads to having no representation, and empowerment for them to speak for their own profession. They mentioned inhibiting factors to their participation as being

overworked during their normal shifts (on the wards and in clinics) such that they did not get time to attend meetings leaving patients unattended, as there could be no one to cover the shifts for them.

Heavy workloads

This was reported as an inhibiting factor to participation. Some responses from participants who returned a "NO" response to question one stated that they did not participate fully due to being overworked in clinical areas such that they had no time to get off their duties to take part in training or to be part of decision-making forums.

> "We do not get time to be off our normal duties to attend workshops; …we are always
>
> overworked, …. we hardly get time to take a break" (SURV3).

Another participant reported:

> "We hardly get time to take a break, and we keep working without stopping; at times
> we hardly have a moment to write what we did for the day; we cannot get
>
> time to attend anything else leaving our patients on their own" (SURV15).

The issue of being overworked was also echoed by another respondent as follows:

> "We are too busy from the time we start work to the end; imagine two
> nurses/midwives on looking after 30 patients, some of whom may be in labor. It is
> hard to imagine that one will leave the patients and go to attend a meeting or
> workshop leaving patients unattended on the ward" (SURV 22).

Participants also reported lack of empowerment, and not being sufficiently represented.

Inadequate representation and lack of empowerment

Inadequate representation and lack of empowerment of nurses and midwives was reported as an inhibitor to participation. Respondents cited lack of representation in MDGs implementation decisions, and they were aware that most decisions were made by medical doctors as well as other groups of people. On the other hand, respondents understood the need to speak up for themselves, represented by the following statements:

"We were not sufficiently represented in implementation decisions especially if you

  think about the numbers of nurses and midwives in health care" (SURV6).

"The doctors make most decisions, also staff must learn to voice up their point of

views and be able to stand for the interests of our profession" (SURV1).

"Until we, nurses and midwives start speaking out, other people will continue to

decide for use" (SURV23).

The results about support for nurses and midwives are noted next.

5.4.3: Support for nurses and midwives

Part six of the survey had closed-ended questions (question 1 and 2), and open-ended questions (question 3 and 4) that gathered information on the UN and WHO's support for nurses and midwives to participate in MDGs. The closed and open-ended questions were:

1. In recent years, did you observe nurses and midwives being encouraged to participate in decisions related to MDGs 4 and 5?
2. In recent years, have you observed nurses and midwives being encouraged to participate more in decisions that are important to their work and to nursing?
3. If you answered "YES" to the above questions 1 and 2, who encouraged nurses to participate?
4. If you answered "NO" to questions 1 and 2 above, why do you think nurses and midwives were not being encouraged to participate?

The participants' responses to closed-ended questions above (question 1 and 2) are summarised in table 6 below.

Table 5.6: Response to UN and WHO's call

Hospital	QN ➡ Response ⬇	1	2
MUHIMBILI	YES	6	5
	NO	17	18
	% YES	26%	22%
KAIRUKI	YES	1	0
	NO	10	11
	% YES	9%	0%
MAWENI	YES	1	1
	NO	8	8
	% YES	11%	11%
KASULU	YES	2	0
	NO	10	12
	% YES	16%	0%
KABANGA	YES	3	3
	NO	10	10
	% YES	23%	23%

Table 5.6 shows that the majority of participants returned a "NO" response to the first and second closed-ended questions regarding the response to UN and WHO's call to support nurses and midwives in the implementation of MDGs. The low response rate to questions one and two of the survey tool confirm that majority of nurses and midwives across the five hospitals had not been encouraged to participate in MDGs 4 and 5. It also means that most participants reported having not observed encouragement for them to participate in decisions that are important to their work and to their professional practice.

The open-ended question of the survey tool (question 4) again asked participants to give reasons as to why they thought they were not encouraged to participate in MDGs 4 and 5, and in the decisions that are important to their work and their profession.

The question read as follows:

"If you answered "NO" to questions 1 and 2 above; why do you think nurses and midwives were not being encouraged to participate"?

The presenting themes for the reasons given to question 4 above are that nurses and midwives were 'not being acknowledged', and 'Insufficiency of material support'.

Figure 5.10: Reasons for No Encouragement to Participate
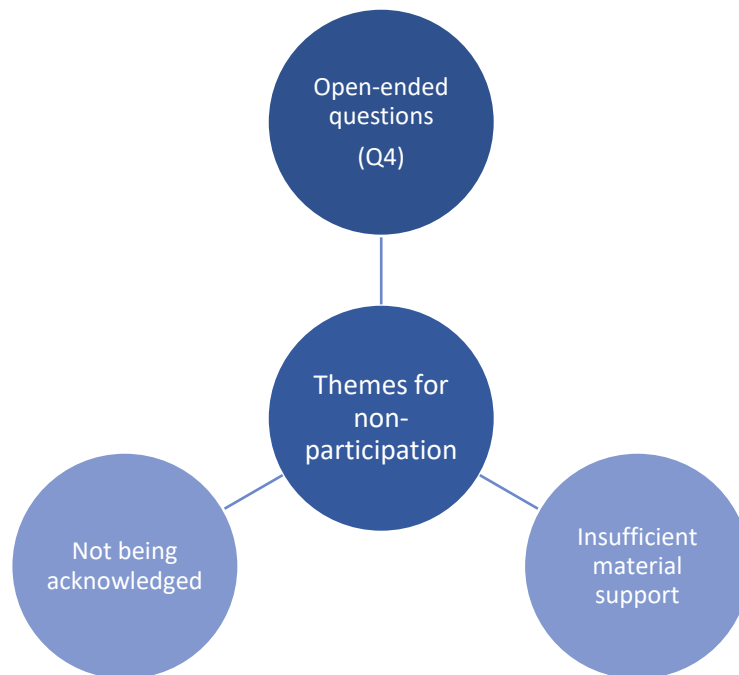
Not being acknowledged

Respondents reported that since a significant number of employees in the Ministry of Health were not experts in MDGs 4 and 5, they did not see the need to include nurses and midwives in MDGs decisions. In other words, respondents felt being left out of decisions about MDGs as the majority of those who were involved in those decisions did not have the nursing or midwifery background.

"….it is hard to know, but some people who were responsible for decisions of MDGs

Implementation did not know much about maternal and child health as we do,

nurses and midwives are yet to be given a place they deserve in health care" (SURV3).

"If there were plans for us to participate, the people who make decisions would have created a room for us to attend those meetings where decisions are made; and we would have a chance to speak about our concerns; including having enough nurses on the shift" (SURV 24).

The responses from participants who responded to survey were clear about lack of support from MOHSW. They voiced not being given a place in decisions about maternal and child health and not enough staff to do clinical duties. This was contrary to the expectation of the document that was released by WHO where a call was made for nurses and midwives to be given due support in the implementation of MDGs 4 & 5. In this document, governments and health care services were urged to work collaboratively with nurses and midwives in recognising the key role and stake that nurses and midwives have in attaining health care goals (Amieva & Ferguson, 2012).

Insufficient material support

Other respondents indicated the lack of equipment and financial support as being possible reasons for not being mobilised to participate in implementation decisions. Some respondents acknowledged the fact that the government had limited financial resources to cater for such expenses as holding more workshops or training, and for providing enough equipment and materials for use in clinical areas. Besides equipment, respondents also mentioned lack of self confidence among nurses and midwives.

"Possibly there was not enough funding to get all nurses and midwives mobilised, and

I think that the policy makers' priorities did not target nurses and midwives. Despite

all that, we need to demonstrate being confident in ourselves, demonstrate self-drive

and support to each other" (SURV 31).

Even though many factors could contribute to the challenges related to material support not being provided to nurses and midwives, the issue of insufficiency of funds was discussed as part of the literature review, and it was mentioned as one of the constraints that undermined the attainment of MDGs 4 & 5 for most LMIC, Tanzania included. Participants also reported lack of support from policy makes, which may mean that there was no policy to show how nurses and midwives may be supported or their role in MDGs 4 & 5.

The level of participation by nurses and midwives is presented in the next section.

5.4.4: Future participation

Part five of the survey had two closed-ended questions (question one and two) that asked participants to indicate the level of participation they wanted to see in future health care activities in their workplaces, at a district, regional and/or national level. For both questions, participants were asked to choose between the three options as listed below: Part five questions were:

1. In future, how would you like to see nurses and midwives participate in important health related decisions in workplaces?
    - Less participation
    - Same participation as today
    - More participation

Please give reasons for your answer.

2. In future, how would you like to see nurses and midwives participate in important health related decisions at district, or regional or national levels?
    - Less participation
    - Same participation as today
    - More participation

Please give reasons for your answer.

The responses to these questions are provided in table seven below.

Table 5.7: Future nurses and midwives' participation in MDGs

Hospital	Participation level	Responses QN 1	% Response	Responses QN 2	% Response
MUHIMBILI	Less participation	0	0	0	0
	Same participation as today	2	9%	0	0
	More participation	21	91%	23	100%
KAIRUKI	Less participation	0	0	0	0
	Same participation as today	1	9%	0	0
	More participation	10	91%	11	100%
MAWENI	Less participation	0	0	0	0
	Same participation as today	0	0	0	0
	More participation	9	100%	9	100%
KASULU	Less participation	0	0	0	0
	Same participation as today	2	17%	1	9%
	More participation	10	83%	11	91%
KABANGA	Less participation	0	0	0	0
	Same participation as today	0	0	1	8%
	More participation	13	100%	12	92%

Table 5.7 above shows that most participants from all five hospitals were in favour of more nurses and midwives' participation in decision making of the health care activities at their workplaces and at other higher levels in the health care sector. The response rate for 'more participation' ranged from 83% - 100%.

In addition to the two closed-ended questions above, participants were asked to give reasons for each choice they made on questions one and two of part five stated above (Future participation).

The key themes that arose from respondents' responses to the open-ended question on future participation were: 'Effectiveness and better outcome'; Connectedness and effective implementation; and Cooperation.

Figure 5.11: Reasons for future participation
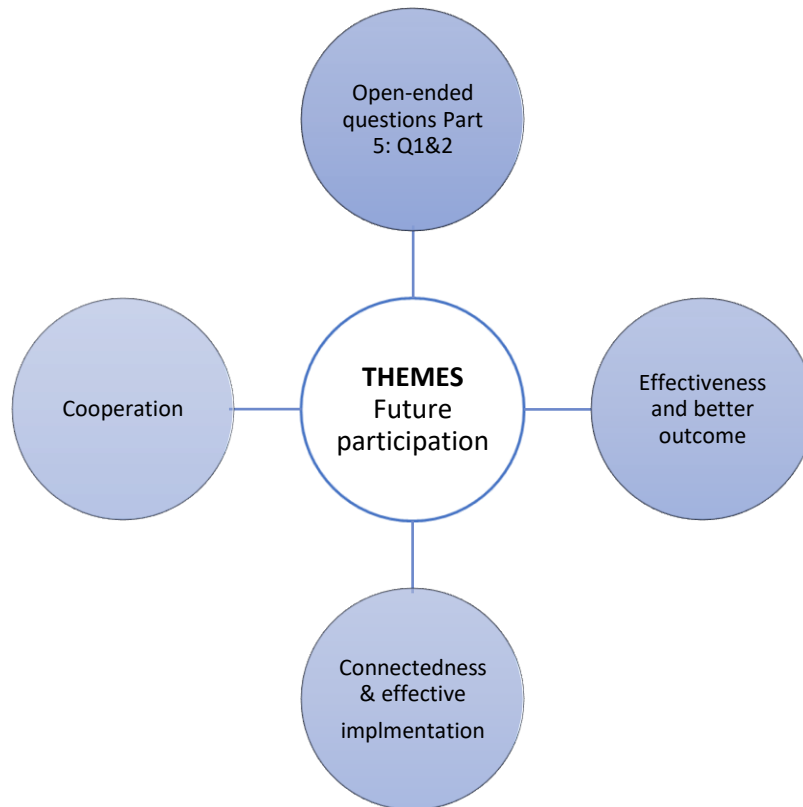
Effectiveness and better outcomes

Respondents indicated that more participation for nurses and midwives in their workplaces and at other higher levels meant that implementation would bring positive results on attainment of goals. Also, implementation strategies would be much more effective to achieving a positive effect reaching all levels of the health care system. Some respondents observed:

> "The more participation by nurses and midwives, the more the effect will trickle down the health care system and implementation strategies will reach every worker very quickly. More future participation means better outcomes in attaining goals" (SURV 14).

> "Nurses and midwives are the backbone of the health care; if they are well organised and are provided with the tools they require, there is no doubt that most plans will be implemented effectively, and with desired outcome" (SURV20).

Participants also reported their connectedness and linkage role in the health care system

Connectedness and effective implementation

Respondents confirmed that nurses and midwives undertake a key linkage role in the health care system, and that they possess knowledge and skills that are necessary to improve maternal and child health outcomes. In future, effective participation would mean that there is better coordination during implementation and decision-making which in turn would improve health outcome for patients. This view was emphasised by respondents:

> "Nurses and midwives have the required knowledge, they do more to care for mothers and children; with more participation, there will be better coordinated implementation plans" (SURV8).

> "We are the main contact between doctors and the patients; we are the main work force in health care, our effective participation is crucial to the wellbeing of the patients" (SURV21).

The absence of cooperation among health care professionals was reported as one of the inhibiting factors to participation.

Cooperation

Respondents expressed difficulties with implementing decisions and strategies of which they were not aware. They showed readiness to cooperate with other health care professionals in the implementation of health care decisions.

> "It is hard to implement strategies you do not understand fully; we would be among the main implementers of most health care related programs and decisions; cooperation among different professions in health care is important; and our staff must learn to speak up" (SURV13).

"The information about MDGs was not well communicated, some of us heard about the goal on maternal health from colleagues, it was kind of continuing with the usual work since you don't know what else to do. If we were told exactly what to focus on, and who to work with, we could do it" (SURV15).

The next section presents findings of data gathered during focus group sessions.

5.5: Findings from focus groups

Question one and two of the FG targeted information about nurses and midwives' participation in general; question three sought information about nurses and midwives' mobilisation and support for participation; and question four collected information about future participation.

Figure 5.12: Findings from Focus Groups

Phase 2. Participation in MDGs → Focus Groups → **Questions:** Open-ended

5.5.1 Findings about participation

The questions which gathered information about nurses and midwives' participation were:

1. Do you think nurses and midwives in Tanzania fully participated in MDGs 4 & 5 implementation?
2. Did nurses and midwives participate in MDGs 4 & 5 as stake holders?

Participant responses to the above two questions were varied, but not different from previous responses obtained through the survey. The FG participants felt that their participation in MDGs 4 & 5 was about doing their normal clinical duties in the wards and clinics. They further observed that they were instructed on what to do, and they were aware that at times their point of view was not given due consideration. The emerging themes therefore were Participation through clinical work; Participation as implementers of the MDGs; Participation through Nurses and Midwives' Associations.

Figure 5.13: General Participation
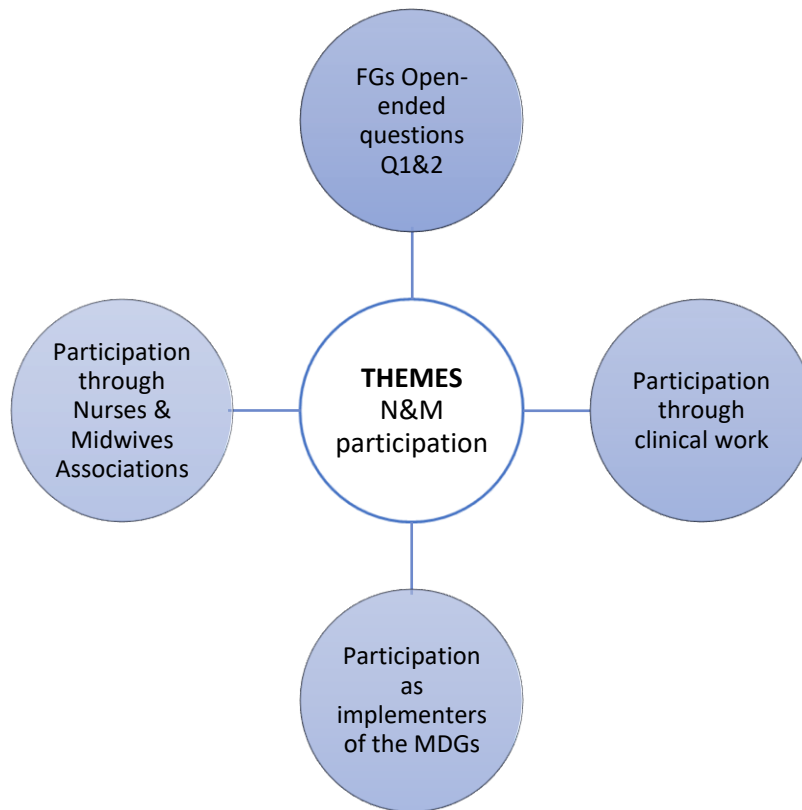
Participation through clinical work

As it was reported from data collected from survey, respondents during the FG sessions were able to associate participation with doing their usual clinical work. They reported participation in MDGs as being nothing new other than doing what they knew they would do while at work. One clinical staff observed:

> **"**Our participation was not obvious, …. we were told what to do, we did what we had to do, and that was to do our daily duties" (FG1P1).

It was also observed:

> "It is not easy to know if we participated fully, it is up to the Ministry of health to determine. What I can say is that we did our best to take care of the patients under the circumstances, I believe each one of us did what they had to do as a nurse or a midwife" (FG3P5).

The above survey responses from clinical staff show that their participation in MDGs were through performing what they were being instructed to do. Nurses and midwives were otherwise considered to be actively involved in the planning, implementation, record keeping for various interventions, and the reporting of progress. The expectations from WHO on strengthening the nursing and midwifery services were that nurses and midwives would work collaboratively with other health care professionals. They would be supported, empowered and share the ownership of implementation activities.

Participation as implementers of MDGs

Participants reported less obvious participation, and like in previous findings reported from the survey, they confirmed having not been among the main decision makers, and that they acted as implementers of the activities already decided for them. It was observed:

> "Our participation in activities of this nature is truly little; even when our point of views is given, they are less considered. …nurses and midwives are often not part of the main decision-making forums on matters related to health. By the way, most top officials in the ministry of health are not nurses or midwives; they may not see the need to consult us or our leaders before making decisions, we were given directions of what to do during Millennium Goals". FG4P1.

This view was reiterated by yet another participant:

> **"**We participated as implementers of the MDGs activities; and this was a Challenge. Nurses were asked to implement what had already been decided, …. our representation in decision making forums or meetings was low especially considering our numbers in the health care system" (FG2P6).

Participation through nurses and midwives' associations

Participants also clearly denied having participated as stake holders. They stated that their participation was through their associations only, and as implementers of what had already been decided. On the other hand, participants were aware of their inability to challenge the status quo, and the need to put forward their point of views. These findings do not differ from those already reported through survey. It was emphasised:

"Through our leaders and associations in workplaces we can say that in a way we had a voice, but in most cases, decisions related to nursing care are done by medical doctors, …and doctors who are the main decision-making group still think that they represent us. Nurses and midwives must feel confident and comfortable to raise the issues that concern their professional practice, and if they don't, someone else will do it for them" (FG4P7).

"Nurses and midwives do about 90% of the work related to maternal and child health; they must therefore feel comfortable and confident to put their point of views across during the meetings or in any forum" (FG2P2).

The response from participants here acknowledged some degree of participation, but only through the leaders of their professional association. Again, it is clear that nurses and midwives in clinical areas are aware of their immense contribution to maternal and child health. The UN and WHO understood this indispensable contribution of nurses and midwives in achieving MDGs 4 & 5. The two UN agencies are clear about the need to partner with all health care workers, nurses and midwives included through the two documents already mentioned in chapter 1, namely Global strategy for women's and child health; and Strategic directions for strengthening nursing and midwifery services respectively.

The support received by the nurses and midwives is discussed below

Support for participation

Question three of the four questions discussed during FG sessions intended to gather responses on the support that participants received in relation to the UN and WHO's call to support them during implementation of MDGs. Question three stated as follows:

"Do you believe that nurses and midwives were sufficiently mobilised and given enough support during the implementation of MDGs"?

In response to the question on mobilisation and support during implementation of MDGs, two themes emerged, and these were "business as usual", and "programs not related to MDGs".

Figure 5.14: Support during implementation of MDGs
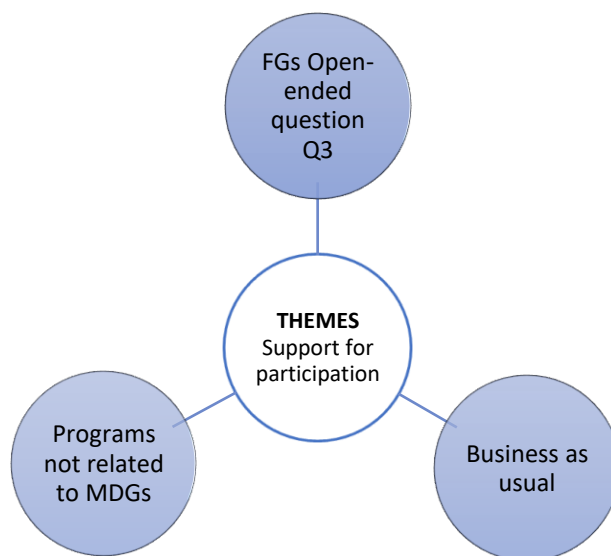
Business as usual

Participants reported that initially they had some positive expectations given the publicity that MDGs received through various information and media outlets. They confirmed not receiving the support they thought they would receive, especially if you consider that MDGs 4 and 5 were related to the nursing and midwifery roles. The general feeling during FG sessions therefore was that nurses and midwives went on to perform their usual clinical duties and implement programs that were not necessarily those aiming at achieving the goals. A participant stated:

> "Nothing was done different to our normal duties, MDGs received high level publicity and we expected that things were going to be done differently, but there wasn't much on the ground" (FG3P4).

Again, participants confirmed having not received obvious support on the ground especially for those that were in rural localities who might have thought that their urban based counterparts had a different experience. One of them said.

"Not easy to know, …we are in a rural area, for us we saw nothing new, we went to work, and we performed same duties as before, and we still do the same today" (FG5P2).

Programs not related to MDGs were also reported by the participant and is explained below.

Programs not related to MDGs

 It was also reported by participants that the launch of MDGs were followed by various clinical training in several areas, but they were not sure if these skills training were purposely conducted to support the nurses and midwives in the implementation of MDGs. It was also reported that at times there were no equipment and supplies for nurses and midwives to effectively complete the planned maternal care programs. A member of the FG emphasised:

"Yes, we were trained in skills such as emergency care obstetrics, family planning etcetera; …. these were among the programs we saw, but we were not sure if they were related to MDGs" (FG1P6).

Yet another FG participant reiterated lack of support due to insufficiency of clinical equipment, and material supplies to enable nurses and midwives do their job affectively.

"Instead of receiving support, at times we are being blamed by the community for not doing our job properly, but it is because we don't have enough equipment; we are told there is no money" FG4P4.

The responses above are like those already reported under section 5.4.3 (support from UN and WHO), where it was noted that there was no obvious support specifically directed to nurses and midwives from the MOHSW. The issue of lack of material and human support caused by staff shortage was also reported. One aspect of the participants' response which appears new is about the blames that nurses and midwives received from the community. This explains the role of the nurses and midwives as frontline staff who are the first contact with the community. When things go wrong, they are the first to face the public even on matters that are beyond their reach such, for example lack of essential supplies and clinical equipment essential for patients care.

Nurses and midwives' participation in future goals as identified by participants are explained below.

Future participation by nurses and midwives

The last question (question four) discussed during the FG, collected information about the lessons to be learnt from nurses and midwives' participation and strategies for the future. The question read as below:

"What would you recommend being done in order to improve the nurses and midwives' participation for future implementation of similar goals"?

The recommendations on what ought to be done for better future participation highlighted two themes namely "increasing self-confidence" and "improved work resources", and each of these two themes are further discussed.

Figure 5.15: Recommendation for future participation
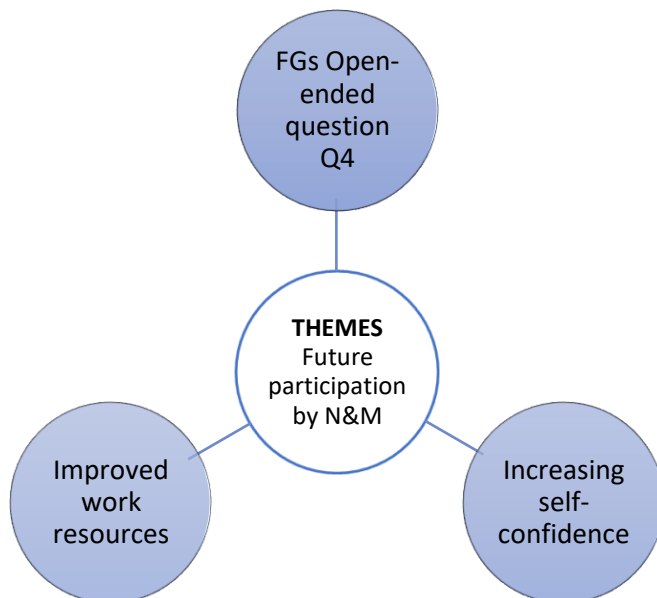
Increasing self confidence

On self-confidence, participants recommended that it was important for nurses and midwives to show case their abilities in order to win the trust of other professional groups and to demonstrate that they merit being part of the decision-making group on MDG implementation activities. Participants also felt that by demonstrating their abilities and self-confidence, nurses and midwives would improve their public image. One member of the FG stated:

> "It would be better for nurses and midwives to be consulted from the initial phases of SDGs implementation, we must demonstrate self-confidence and 'I can do attitude' to improve our image" (FG3P7).

Self-confidence was further reiterated:

> "Nurses and midwives must trust themselves, feel more confident and prove that they can be part of the main group to make the difference during SDGs" (FG3P1).

> "It is up to us to improve our image to Tanzanian society by showing what we can do, thus earning the community trust" (FG4P5).

> "We must demonstrate 'the can-do attitude' and self-confidence" (FG1P3).

The next part presents the findings on improving work resources.

Improved work resources

This second theme involved the availability of human and material resources to cater for daily clinical care. Participants verbalised the difficulties of attending meetings including being involved in other related implementation activities. They knew it would be difficult for those on duty to attend MDG activities without being relieved from clinical duties. They also emphasised the need to have improved budget, necessary equipment, and other clinical supplies to enable them to do their work as required. Here is what was said.

> "At times we are too overworked to have some moment to have input in other activities, and improved budget is required to enable us have enough equipment for doing our work" (FG2P5).

> "We are too overworked, if this continues, we can't achieve much during

SDGs" (FG4P7).

"There is a need to improve our health care budget, implementation activities depend on available budget" (FG3P2).

The following part presents themes as findings conducted with administrators.

5.6: Findings from interviews

Three questions gathered data on participation from interviews by administrators. Question 2 and 3 focused on general participation by nurses and midwives, and question 5 collected information about future participation. Question 1 and 4 on the other hand gathered data on awareness and mobilisation, respectively. The findings on general participation are presented first, and findings on future participation are presented next.

Figure 5.16: Findings from interviews
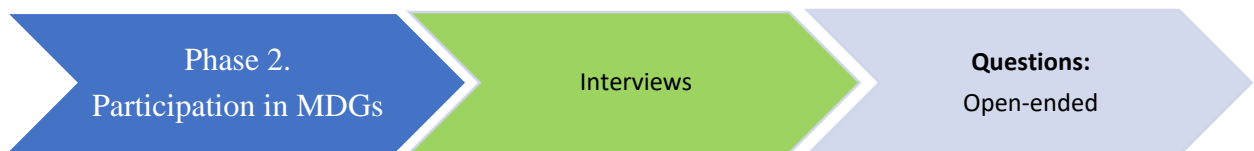
5.6.1 General participation

The interviews with administrators had two questions (question 2 and 3) that sought information about the participation by nurses and midwives in the implementation of MDGs 4 & 5. The two questions were:

2. Do you think nurses and midwives fully participated in MDGs 4 & 5?

3. Did nurses and midwives in Tanzania participate in decisions related to MDGs implementation activities as stake holders?

In response to these two questions, three themes were identified as follows: "Role congruence"; "Participation as implementers of decisions"; and "Recognition of skills".

Figure 5.17: General participation
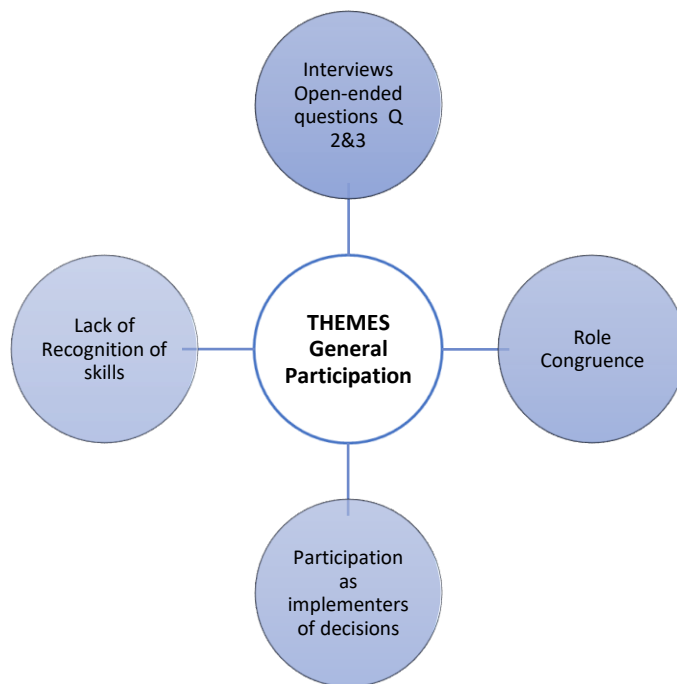
Role congruence

On the question of whether nurses and midwives fully participated in MDGs 4 & 5, the administrators affirmed the participation of nurses and midwives' given their numbers, and closeness to patients. Administrators also mentioned the central role nurses and midwives play by providing care to mothers and babies across the whole stretch of the health care system. The administrators observed:

"Yes, they participate fully; …. nurses and midwives are the majority in the health care system and are closer to patients than anyone else. The care given to expecting mothers and the young children is very much in the hands of nurses and midwives". INT2). It was further observed:

"The doctors have an important medical role to play, but for most of the time, expecting mothers are cared for by nurses and midwives; nurses and midwives are at every level of the health care system starting from village health centers to national administrative structures; they carry out the largest share of all maternal and child related work" (INT4).

The findings from the interview with administrators on nurses and midwives' participation are like those that were reported from survey. The issue of nurses and midwives not being acknowledged, hence being left out of key decisions in MDGs was reported under the section "Support for nurses and midwives". Similarly, nurses and midwives' closeness to patients was reported as an enabling factor for participation.

Participation as implementers of decisions

It was the perception of the administrators that despite nurses and midwives having fully participated, they were not at the center of the decisions of the activities for implementation. It was instead made clear that nurses and midwives were implementers of what had been decided by others. The following are quotes to substantiate these views.

"Nurses and midwives were part of the MDGs implementation process, they were implementers of the decisions already made but they were not part of the decision making if you consider their number in the health work force. …. only few top officials among us were possibly involved in decision-making forums, we hope this situation will change in future" (INT2).

"Theoretically, you could say that nurses and midwives participated as stakeholders, but it's not. Full participation starts with being there among decision makers. Most program leaders in the Ministry of health are medical doctors, therefore nurses and midwives are not given a priority in decisions" (INT5).

"In most cases, health decisions in the Ministry of Health are made by doctors who are not nurses or midwives; but Tanzania is moving in the right direction, it is a good achievement for nurses and midwives to have a Directorate to manage their services" (INT 1).

As can be seen above, nurses and midwives participated in MDGs 4 and 5 not as stakeholders, instead they participated as implementers of the decisions already made by other health professionals and personnel. These findings are again close to those already

reported by participants in FGs where clinical staff confirmed their participation, but not as stakeholders.

Another important theme that was evident from participants' views was the lack of recognition of skills which are presented next.

Lack of recognition of skills

Administrators further reported the limitation for participation as stakeholders as being lack of recognition of the skills that nurses and midwives possess. According to administrators, the recognition for nurses and midwives' skills would have translated into them being part of the stakeholders in decisions related to MDGs implementation. Here is what was said:

> "The skills and expertise of the nurses and midwives are yet to be valued and there is a need for these skills to be recognised; nurses participated fully so were the midwives; the only issue was that their representation in decision making wasn't as it should have been, in most cases, medical doctors are still decision makers, and the society seems to be familiar with this situation" (INT8).

> "It's until nurses and midwives are given their due place in decisions and their skills and experiences are recognised that we will then say 'Yes', they participated as stakeholders" (INT6)

The findings about lack of recognition of nursing skills are similar to those findings already reported about participation by doing normal duties and participation as implementers of decisions already made by other professional groups reported through survey and FG. The next section presents findings on future participation.

5.6.2 Future participation

The interviews with administrators also had one question (question 5) which sought answers about strategies for future participation. The question stated as follows:

> "What would you recommend being done in order to improve the nurses and midwives' participation in future implementation of similar goals"? Two themes were

identified from the responses, and these were: "Improving capacity"; and "Improving leadership".

Figure 5.18: Strategies for future participation
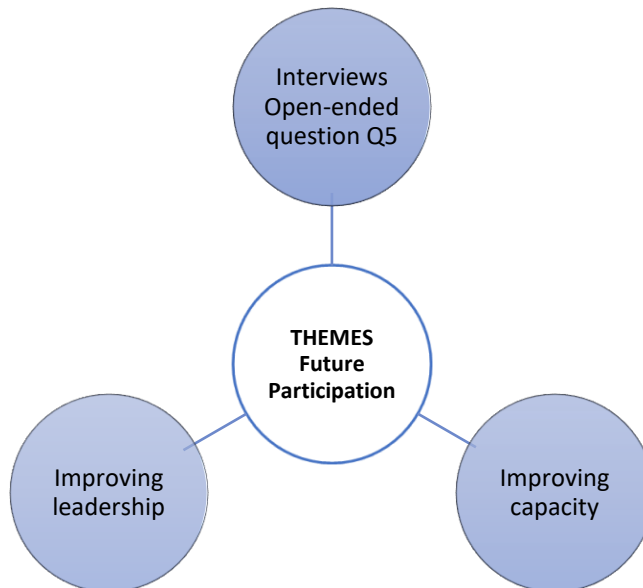
Improving capacity

The recommendations of what needed to be done for future participation were mainly directed towards such areas as ameliorating nurses and midwives' confidence and capacity building through skills training, improving current staff workloads, as well as providing the necessary equipment required for clinical interventions which would increase the nurses and midwives' capacity overall. Here is what was recommended:

"A focus will have to be directed towards staff training to improve nurses' skills and competencies, increased budget for more staff enrolment and training, record keeping. Nurses and midwives' leadership need to promote self-confidence and quality by ensuring that required tools and equipment are available". (INT1).

"There is a need to increase the budget, more staff and work equipment; the budget will have to favour the periphery areas as towns are better equipped with equipment compared to rural areas" (INT 6).

The findings about this theme of improving capacity are also comparable with those already reported from other means of data collection namely FG and surveys in phase 1 and 2.

Improving leadership

Besides improved nurses and midwives' capacity, it was also noted that in future, clinical staff will require empowered and knowledgeable leaders who are available to mentor and support nurses and midwives both in clinical, administrative, and managerial areas. Here are some of what administrators thought could be done to improve participation and realization of SDGs in future:

> "Better knowledge and confidence especially to nurse leaders is essential to influence wider representation by nurses and midwives in major decisions at all levels... don't forget that improving nurses' image and support from peers and better collaboration among various groups who work in health care will give us better outcomes". (INT6).

> "There is a need to improve nurses and midwives' training model and leadership skills; the quality of education must focus on skills, competencies, confidence building and ethics" (INT1).

> "Nurses and midwives' leaders to be empowered and to have a voice for making the profession more visible, men to be encouraged to enroll in nursing and midwifery courses, it will help to improve the stance of the profession" (INT4).

The recommendations given above on future participation will require empowerment and self-confidence to be driven and supported by nursing and midwifery leadership. It also requires commitment and advocacy which includes lobbying for support from other government structures such as the Ministry of Education and various Non-Government Organisations. The issue of self-confidence was also reported among the findings from Focus Groups. The next part looks at findings about support for participation.

5.6.3: Support for participation

Interviews with administrators had one question which sought to collect data about how nurses and midwives were mobilised and supported by the MOHSW during MDGs implementation. The question stated as follows:

"How were the nurses and midwives encouraged, mobilised and supported by MOHSW as part of the implementation of MDGs"?

The responses given by administrators during interviews were classified into the following themes: "Improving professionalism" and "Improving mobilisation".

Figure 5.19: Support from MOHSW
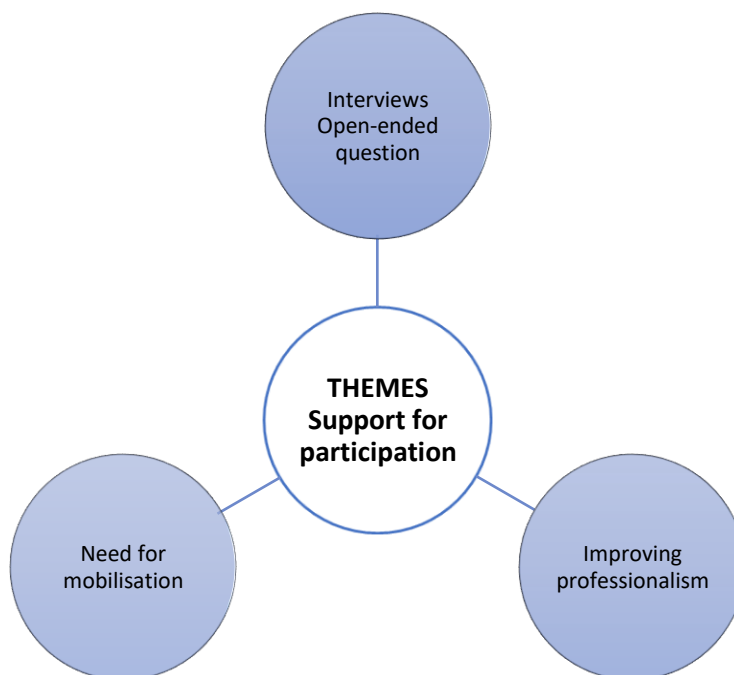
Improving professionalism

Administrators reported insufficient support to nurses and midwives during MDGs implementation phase. However, they also reported positive steps in the strengthening of the nursing and midwifery services whereby the recently created Directorate in the Ministry of Health would support this important health care group. The Directorate also intended to

improve nursing and midwifery education by advocating for increased enrolments in colleges and universities. Here is some of what administrators had to say:

> "The MOHSW has stepped up the nurses and midwives' services including the creation of the Directorate for nurses and midwives, …. MOHSW is scaling up nursing education in colleges and universities, there are increased enrolments, and is committed to supporting post graduate education and research" (INT1).

> "There are plans to increase enrolment for nurses and midwives, but I did not see anything done as part of support for implementation of MDGs, …. It would have been a good move to achieving the goals if nurses and midwives were mobilised and be at the center of the implementation activities, the nurses and midwives' place in health care cannot be underestimated" (INT2).

> "Nurses and midwives are responsible for more than 75% of the work related to child and maternal health; this is a professional group which need to be supported at all levels if future goals are to be realised" (INT5).

The issue of being overworked in clinical areas has been reported through results from survey and from FG as one of the inhibiting factors. Previous findings showed that nurses and midwives in wards and clinics were at times unable to attend work meetings or workshops due to the shortage of relieving staff. Once the enrollment in nursing colleges and universities are improved as part of the scaling up initiative, the problem of being overworked will most likely be manageable and staff on the wards would be able to attend work meetings or workshops. Again, lack of support by MOHSW came up. Lack of support was also reported by participants in survey, and administrators revisited the indispensable role of nurses and midwives in maternal and child health programs, citing their contribution as being more that 75%. The administrators' views are in line with those expressed in the WHO's SDSNMS.

Need for mobilisation

Administrators also acknowledged the positive steps that nursing and midwifery in Tanzania have made so far, and they wished for those steps to be supported through better mobilisation of the nursing and midwifery workforce. Mobilisation refers to how nurses and midwives are

organised and made ready to act in the implementation of the goals through training, professional orientation, and support. One administrator observed:

> "I'm not sure that anything extra was done to encourage and support nurses and midwives, …. if that had been done, it would have had a positive impact in achieving the MDG goals. Our nursing has evolved, and this positive progression must be maintained if positive outcome in health care is to be realised" (INT5).

Another administrator reported:

> "There was no mobilisation on the side of our staff, nurses and midwives went on to doing what they usually do at work. Yes, there were training especially for midwives, but we can't say it was about mobilisation for implementation of MDGs" (INT6).

> "Perhaps in big cities nurses and midwives were encouraged, but for us who are away from the capital city, there was nothing encourage nurses' participation and we saw nothing about mobilisation" (INT8).

The findings about support for participation are comparable to those reported through FG and survey. The findings reported through the themes 'improved workload', and better mobilisation have also been reported as what needs to be done to improve participation by nurses and midwives in the future. The next part presents the triangulation of data collected from survey, FG, and interviews.

5.7: Triangulation of findings

Phase two presented findings collected from survey, FG, and Interviews. While the survey had both closed and open-ended responses from the survey tool, FG sessions and interviews only had open-ended responses from participants. As it was noted in the findings presented in this phase, there is a similarity of the responses given under each method used in data collection namely survey, FGs, and interviews. Figure 5 shows the common themes for the findings presented in phase 2.

5.20: Triangulation of findings
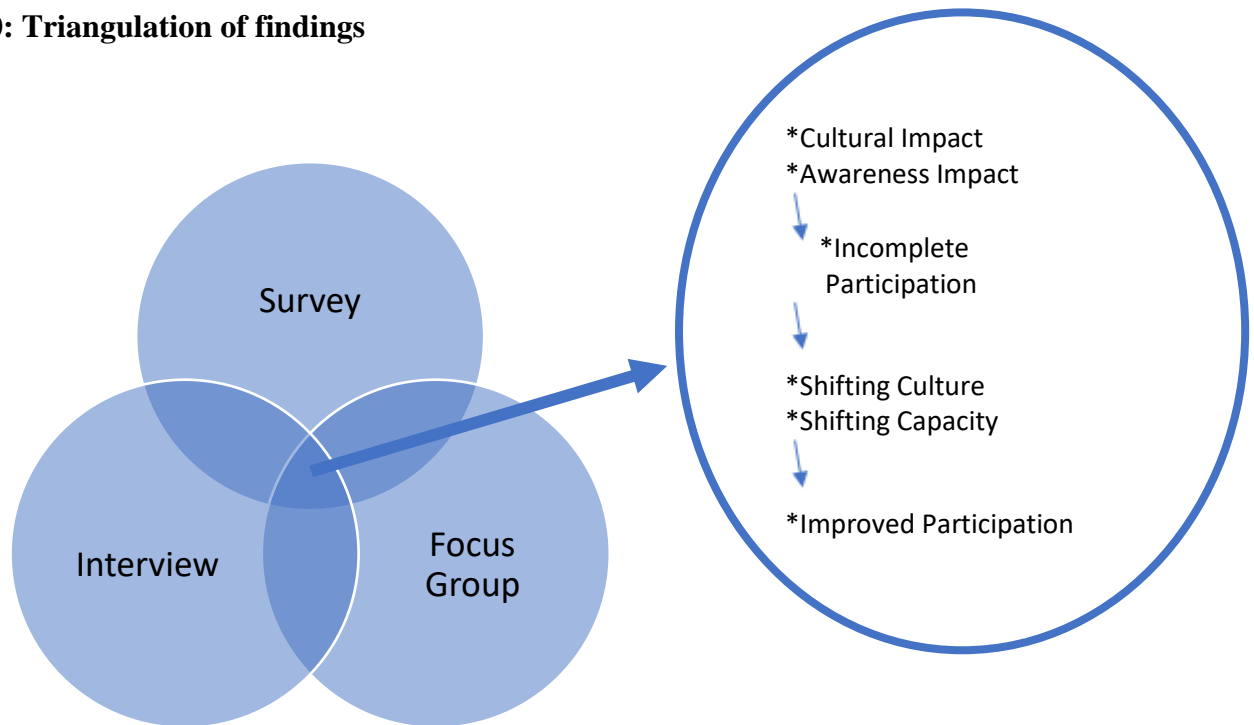
As shown in figure 5 above, the findings about general participation and future participation are dependent on the institutional culture where the nurses and midwives' practice. The institutional culture also plays an important role in supporting participation and eventual attainment of the goals. For example, participation through doing normal duties was a result of lack of information and awareness of the goals and targets to be attained; and lack of awareness led to incomplete participation by nurses and midwives. It is therefore envisaged that deliberate efforts are needed to change the institutional culture, and to enhance nurses and midwives' knowledge and capacity to attain future health goals.

The findings about enabling factors for nurses and midwives' participation included being the majority among the health care workforce, and the position they occupy in the health care system. These enabling factors have also been reported through interviews under general participation where the central position occupied by nurses and midwives in the health care system as important communication link for the medical personnel and patients was presented as key for their involvement in decision making and implementation processes of MDGs.

The issue of staff being overworked and lack of resources in clinical areas which hinders complete participation was also mentioned as an inhibiting factor for participation, and it was reported from all three data collection methods. The issue of improved budget, and improved enrolment in nursing colleges and universities was one of the suggestions for improvement of nurses and midwives' participation in the future. Similar findings from survey, interviews, and FG included improving capacity, and support for nurses and midwives' participation by improving nurses and midwives' training to better their knowledge and skills, improve their confidence as well as the nurses and midwives' public image.

It is also important to note that nurses and midwives reported having fully participated in the implementation of MDGs. However, their understanding of participation was that of participation by doing normal clinical and education duties, and not participation as stake holders. This is to say that their participation was limited to those duties they perform as part of their everyday responsibilities. Participants denied having participated as stake holders where they are part of the decision-making and implementation decisions.

5.7.1: Summary of findings for phase 2

Phase two presented findings on nurses and midwives' participation, and data for this phase was collected through a Survey, Focus Groups, and Interviews. Findings have been presented in relation to general participation, enablers and inhibitors, response to UN and WHO's call for support to nurses and midwives, and in relation to strategies for future participation.

Most participants in the survey, FGs and interviews confirmed that nurses and midwives participated in MDGs implementation in general, but they did not participate as stake holders. It was also noted from the survey that doctors, policy makers and politicians participated more in the forums, workshops, and seminars. Respondents confirmed under-representation of nurses and midwives in forums, workshops, and seminars where important decisions are taken.

Responses from the survey, FGs and interviews also confirmed no obvious support from MOHSW or any other institution that was directed to nurses and midwives during the implementation of MDGs. The implementation of MDGs and attainment of goals would have been easier if nurses and midwives had been mobilised more effectively given that they make

the largest health care workforce, and that they are a key link between the doctors and patients.

Future strategies for participation in similar health care goals need to be directed towards improving nurses and midwives' skills, increasing enrolments of nurses and midwives at colleges and universities, support from their administrators and the improvement of confidence and their professional image. The next phase describes how the Framework was developed from Phase 1 and 2 data.

5.8: Phase 3: Participation in MDGs

This phase involved developing a framework that explained the current issues and plan for future implementation of SDGs by nurses and midwives. The framework (Figure 6.6) in this phase was developed from data collected on awareness and participation as shown in diagram 5.21 below. Frameworks are essential part of research; they show important domains (categories) and factors that are to be presented in research (Horowitz et al., 2019).

Frameworks may also serve to summarise literature as well as to depict relationships among the constructs used in a given research (Alyssa, Leanne, & Gwenyth, 2013). The framework in this study was developed following an analysis of the data collected in phases 1 & 2. It showed the categories and sub-categories and their relationship, which in turn explained the phenomenon (participation in MDGs and SDGs).

Figure 5.21: Phase 3 framework

The creation of the framework was preceded by data analysis in phase one (awareness) and phase two (Participation). Following data transcription, analysis, the reading and re-reading of transcribed responses in phases one and two, the data was then categorised into domains

that constituted phase three; and these domains were the context, level of participation and influencers as shown in figure 5.22 below.

It is the domains that formed the main components of the framework, and the domains, therefore, were the basis through which future practical strategies evolved, and these would contribute to effective nurses and midwives' participation in SDGs.

Figure 5.22: Framework for participation

Influencers

- Stakeholders (Nurse Leadership; Professional organisations)
- Self confidence
- MOHSW (N & M Directorate)
- Inclusive policy frameworks

Level of Participaton

- Cultural Impact
- Awareness Impact

Context

- Embedded in practice
- Incomplete participation
- Complete non-participation

- Shifting Culture
- Shifting Capacity

Need for essential changes
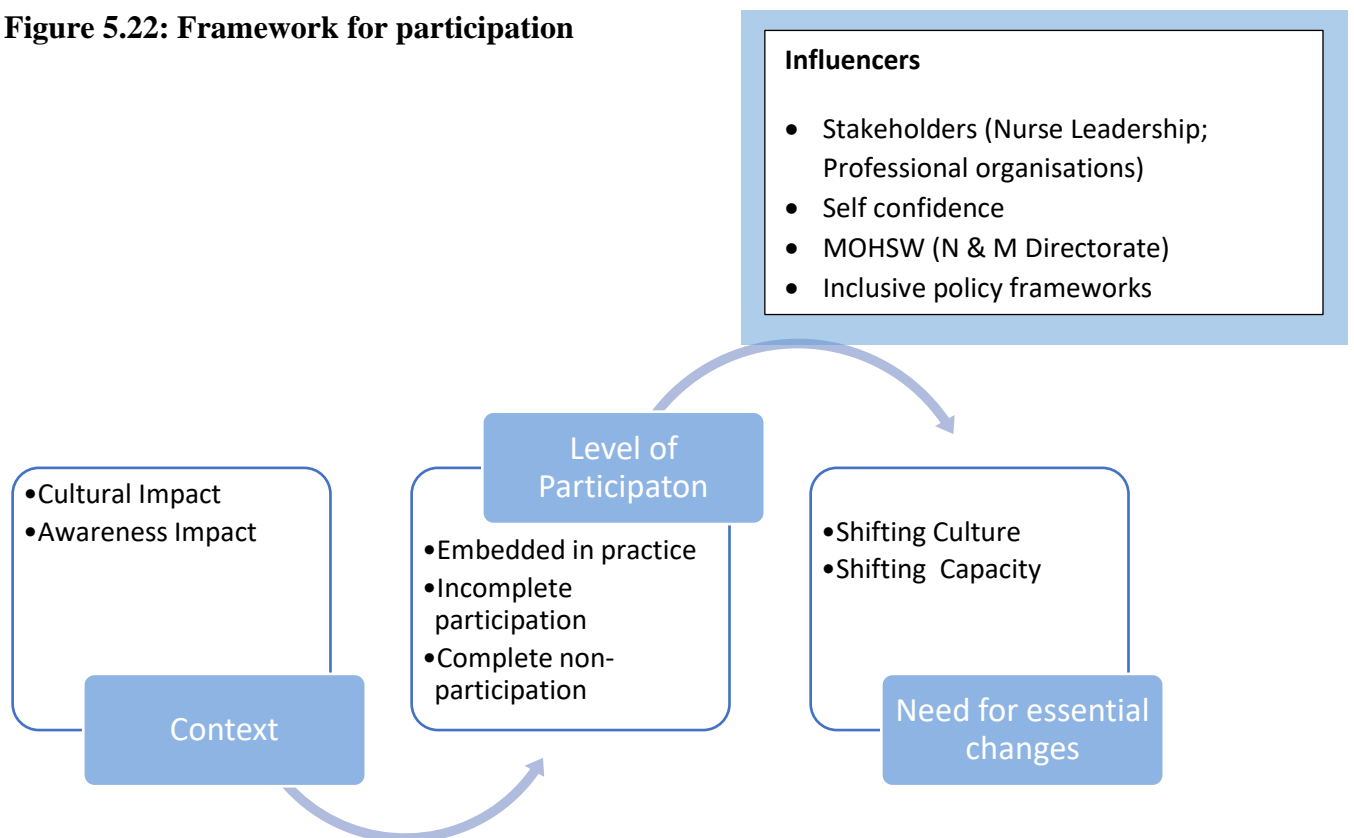
5.8.1: Context

The category context (Figure 5.23) covers the political, history and social set-up in which the nurses and midwives in Tanzania find themselves. This category highlights the understanding that each country's health care system may be unique in its structure; the background of its health care workforce; the process of health care delivery; and the inherent health care issues and culture. The category context includes two main elements namely cultural impact of the context and awareness impact of the context.

Figure 5.23: Cultural context
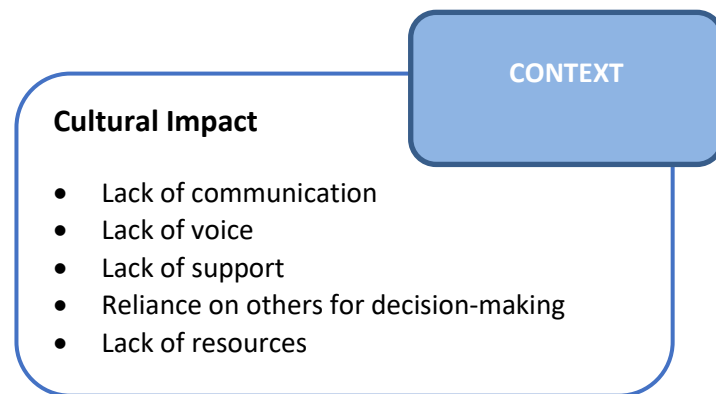
The category culture refers to people or society's behaviour, ideas, ideals, and customs. In the health care context, culture means values, assumptions, and actions that are considered acceptable for a given occupational group, and culture has direct impact on health care delivery and health care outcome (Beardsmore & McSherry, 2017). Cultural impact signifies the workplace relationships, the wider society's knowledge, belief system, values, lifestyle practices (which constitute the social norm) may have on health services delivery and workers' professional practice. Culture affects the dynamics and workplace interpersonal communication and collaboration (Goodman & Clemow, 2010). As Shaw argues:

> Although it is often organisational culture that is spoken about, organisations are made up of smaller 'workplace cultures', such as departments, wards, clinics, surgeries, and amongst teams. The workplace culture is 'the most immediate culture experienced and/or perceived by staff, patients, users and other key stakeholders . . . the culture that impacts directly on the delivery of care (Shaw, 2017, p. 57).

Culture also impacts on how employees' interpersonal communication, access to support systems including information for awareness, and resources. Awareness refers to the state of being conscious of the surrounding environment which, in turn generates knowledge and understanding that may guide behaviour and action required to attain goals (Salmon, Stanton, & Jenkins, 2017). In a work context, awareness specifically has impact on one's ability to directly perceive, feel, and act when accomplishing their day-to-day duties. The results from this study showed that there was shortage of funds for providing enough equipment and staff for effective implementation of the targets; and participants acknowledged having had no voice due to lack of empowerment and self-initiative.

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Following data analysis on awareness, and on participation, it was noted that the context in which Tanzanian nurses and midwives' practice impacts areas such as communication, professional voice, support systems and knowledge gap. These are some of the areas on which recommendations for possible future course of action will be based.

Figure 5.24: Awareness context
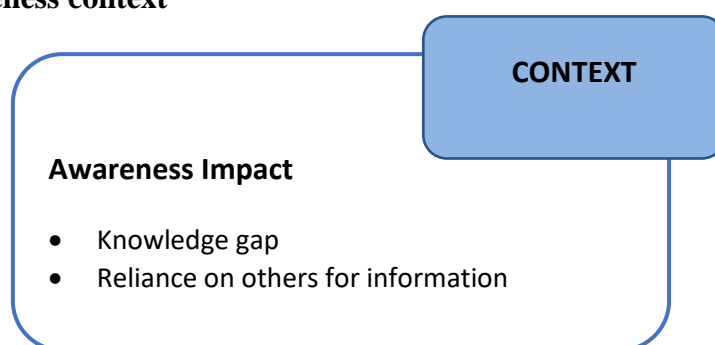
The results from phase one and phase two showed that nurses and midwives practised under work culture within the health care system that was not open to inter-professional cooperation and collaborative practices and opportunities for shared decision making. It was obvious that the working culture lacked awareness of common goals and lacked collaborative practices and opportunities for shared decision making. There was lack of communication and a knowledge gap between health care professional groups and those working in clinical areas. Participants also reported absence of a policy framework to guide the role of the various health care professionals in the implementation and attainment of the two goals. Again, the results show that although nurses and midwives in clinical areas received some support from their professional association, they did not receive enough support from the Directorate for Nursing and Midwifery services.

5.8.2: Level of participation

This category entails the involvement of nurses and midwives in the process of MDGs implementation. In this study, the operational meaning of participation is the extent to which nurses and midwives were involved in the activities such as decision making which aimed at reducing child mortality and improvement of maternal health between 2000 and 2015.

Figure 5.25: Levels of participation
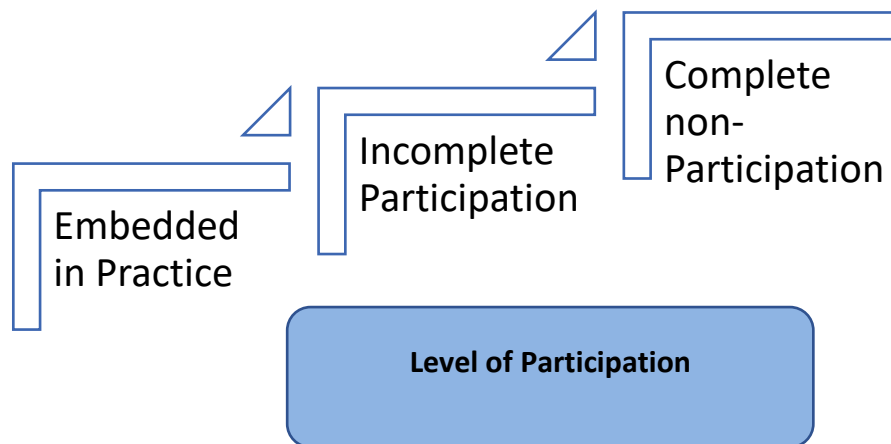
Participation is not only essential in accomplishing planned tasks, but in ensuring that work is done smoothly while focusing on agreed health care goals (Goodman & Clemow, 2010). Participation also entails deliberate and conscious input by nurses and midwives including active involvement in the planning, implementation, and evaluation of activities to reach Goal 4 and 5 of MDGs. By conscious and active input, it refers to what nurses and midwives did while being aware of the goals and targets of the MDGs 4 and 5, and not what they did as part of their everyday professional or clinical work.

The research results obtained through the survey, focus group discussions and interviews show that the participation by nurses and midwives in the implementation of MDGs 4 and 5 was part of their clinical and professional practice, and was described as either incomplete participation or complete non-participation (Figure 5.25). By incomplete participation it means that most respondents reported having taken part in some activities and duties related to reducing child mortality and improvement of maternal health besides their normal duties.

Clinical participants and nurse leaders confirmed having attended only work-place meetings to discuss implementation of MDGs 4 and 5, but not meetings at the district or regional forums where key implementation decisions were being made. In short, participants confirmed their participation, but not as stake holders as their participation was quite limited. This is an example of incomplete participation.

By complete non-participation it means that participants confirmed being unaware of implementation strategies, they were not part of the decisions about implementation plans, and not being able to witness any changes to the usual work that nurses and midwives performed. Although some participants reported having participated in the implementation of MDGs, but their participation was embedded in their practice. In other words, the tasks considered to be part of the participation process were part of their usual nursing and midwifery role. Other participants reported having received education and training during the MDGs implementation phase, but they were not able to relate the education or training sessions they received with MDGs implementation strategies. Respondents were also unable to confirm being aware of planned activities to achieve the goals between 2000 and 2015.

5.8.3: Participation influencers

Figure 5.26 is part of the proposed framework for improving participation. This figure shows elements that are understood to be influencers for future nurses and midwives' participation. Influencers, therefore are drivers that will positively enhance nurses and midwives' participation and the eventual attainment of the health care goals. In this study, influencers are macro and micro-level organisations in the health care system. Influencers may include individuals, institutions, organisations, policy framework, and initiatives that would support change, hence mobilise nurses and midwives by orientating them towards full participation and the achievement of the targets under SDGs phase and beyond. The Ministry of Health and Social Welfare (MOHSW), the nurses and midwives' professional associations, the MDGs implementation policy framework as well as initiatives by nurses and midwives themselves or through their leaders are included in this domain.

The Ministry of Health through the Nurses and Midwives' Directorate as well as other health care supporting institutions and Organisations may not only be essential in influencing participation, but also instrumental in shifting institutional culture and institutional capacity. For example, the Ministry of Health would create a policy framework that brings about change, more interactive work culture through such practices as Inter Professional Education (IPE), Inter Professional Collaboration (IPC), and interactive work practice. The policy framework would guide such areas as information dissemination, action, collaboration among various health care groups, and progress reporting. The cultural shift would also affect those safe practices as decision making, awareness, staffing levels, staff support systems, and job satisfaction.

On the other hand, shifting capacity would be enhanced through institutional and system changes in areas such as education and training to improve staff skills, more staff participation where they would voice their concerns individually or through professional Organisations as stake holders.

A stake holder is part of an organisation or business with an interest in that organisation or business. In this regard, nurses and or midwives' leadership and their professional Organisations in Tanzania are an example of stakeholders relevant to nurses and midwives' participation. Nurses and midwives' leadership or professional organisations are party to the implementation of MDGs, they can influence nurses and midwives' actions and participation through such interventions as information dissemination, provision of training and many other ways. It is the stake holder that would uplift the nurses and midwives' confidence through various empowerment initiatives and advocacy that would improve the nurses and midwives' participation and the creation of a more caring and quality health care environment.

Figure 5.26: Influencers to participation

> **Influencers**
>
> - Stakeholders (Nurse Leadership; Professional organisations)
> - Self confidence
> - MOHSW (N & M Directorate)
> - Inclusive policy frameworks
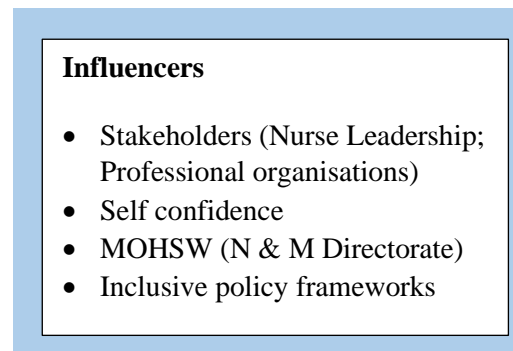
Figure 5.27: Need for essential changes

Shifting Capacity

Shifting Culture

- More decision making
- Interactive work culture
- Increase awareness
- Better coordination
- Implement better understood plans
- Organised workforce
- Improve support for N&M

- Increased voice
- Improved education
- Improved skills
- Improved self-confidence
- Improved budget
- Improved workload
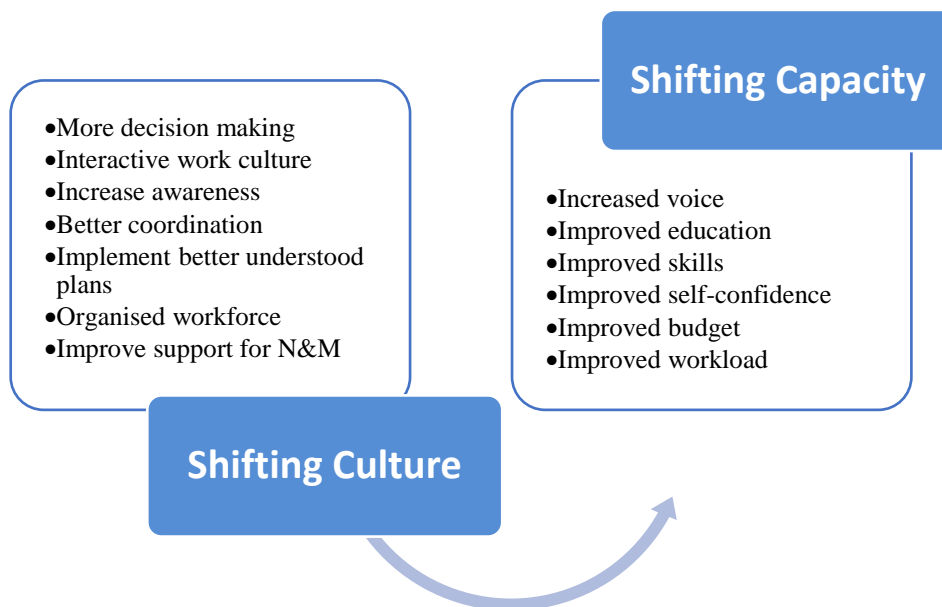
The need for essential changes (Figure 5.27) means instituting a system and work culture that creates environment for desired change. The desired changes will not only include improving work culture, but also improving nurses and midwives' capacity through education and empowerment that will give nurses and midwives the voice and confidence they need to effectively participate in SDGs. The shift in work or systemic culture is expected to improve communication, create more interactive work environment, involvement in decision-making, hence more organised and confident health workforce in Tanzania that will most likely attain envisaged health care goals. The need for essential changes was followed by substantiating

the proposed framework to gauge its appropriateness to the current the Tanzanian context. The details about substantiating the framework are discussed next.

5.9: Phase 4: Substantiating the framework

This section presents findings for data collected in phase four. The findings in phase four ascertained the relevance of the framework developed in phase three. After creating the visual framework in phase three, it was necessary to test it for its relevance to the current study, also to collect additional data through interviews that included strategies for future participation. Diagram 1 shows what phase four is about.

Figure 5.28. Phase 4 findings

The visual construction of the framework was emailed to nurse and midwifery leaders (also referred to as administrators) together with the explanation which detailed the categories that constituted the framework. Also emailed to administrators were interview questions developed from the categories of the framework. The interview questions were meant to capture information for recommendations, including the need for essential changes which is conceived to be the way forward for participation by nurses and midwives in future health care agenda.

5.9.1: Additional interviews

In addition to substantiating the framework, phase four involved conducting telephone interviews with purposefully selected Tanzanian nurses and midwifery leaders and academics, some of whom were interviewed in phases 1 and 2. The aim was to obtain data to fill any possible gaps in information collected during the first two phases. Interviews also aimed at obtaining administrators' input to be used as recommendations for future participation. Prior to interviews, the administrators were emailed the questions constructed

from the domains of the framework, and this was followed by interview appointments with each administrator on the day convenient with the interviewee. The findings for interviews conducted in phase four are presented in phase 5.

5.9.2: Relevance of the framework

As stated above, phase four first sought to ascertain the relevance of the framework developed in phase three. After the nurses and midwifery leaders (administrators) were sent the details about the framework with interview questions, and a telephone interview was scheduled with each administrator on the day convenient with them. During the interview, each interviewee was first asked one question; and this question aimed at testing the framework. The question asked was as follows:

> "Looking at the information emailed to you about the framework; What are your views about the relevance of this framework to the current study"?

As a general response to the above question, all five administrators interviewed confirmed that the categories of the framework were relevant to the study. Participants also added that the framework offered enough explanation about the Tanzanian nursing and midwifery context, and also that the domains covered essential information on participation and the influencers. Here is some of what the first participant said:

> "Generally, the diagram emailed looks fine; in my first interview with you I mentioned about the fact that our nurses did not have a voice; Until now, they are trying to find one. I'm sure we are evolving well; we are hopeful about the future" (INT1a).

> "We have complete trust in the role to be played by the nurses and midwifery directorate in effecting positive changes to our profession. As a leader, I can see we are moving in the right direction" (INT1b).

The second participant mainly talked about the details in the framework.

> "I looked at the diagram and the accompanying information; I think the details given explain the diagram quite well; we look forward to seeing the shift in the capacity as you outlined" (INT2).

The third participant had the following to share about the framework:

> "I agree with what you called in the framework 'incomplete participation'. Our nurses or midwives did not fully participate in MDGs; something needs to be done about their full involvement in internationally initiated health programs for our country; and as leaders we have a role to play in this" (INT3).

The other participant gave her views mainly in relation to the shifting culture of the framework.

> "I agree with the aspect 'shifting culture' as part of essential changes. Increased participation for nurses and midwives will have to start with information sharing among the health care professionals which will then enable them to be get involved in whatever implementation plans better known to them, and for better outcome" (INT2).

The last interviewee who gave views about the relevance of the framework based her observations on the shifting capacity. Here is what was observed:

> "The drawing you called framework summarises well much of what is to be done to better our profession. Our staff truly require education, skills, and confidence they can use to have a voice. The current situation also challenges us as nurse leaders to do something by way of contributing to advancing self-esteem in our profession, we must empower our junior staff, and we must learn from what is happening in other nursing and midwifery organisations in other countries to better our own" (INT5).

As stated above, the relevance of the framework was confirmed by all five administrators through telephone interview. Administrators repeated the need for nurses and midwives in Tanzania to have voice and through representation in various forums where decisions are made. The aspect of shifting culture was also emphasised, including the need for information sharing and education that will provide skills and confidence to nurses and midwives needed to effect changes and eventual attainment of the goals. As such, no negative feedback was received regarding the framework, instead administrators spoke in support of the proposed framework.

5.9.3: Summary for Phase 4

Phase four intended to test the relevance of the framework for this research. The framework was tested by asking the nurses and midwifery leaders and academics to give their opinion about the details of the framework and its pictorial representation emailed to them. The interview results show that the framework was relevant to the current study. All five interviewees were able to confirm the framework's relevance starting from the diagram itself and the domains that make the framework. They stated that the description of the framework was relevant, and that the aspects of shifting culture and shifting capacity will create conditions for improved nurses and midwives' participation in future. Practical strategies are discussed next.

5.10: Phase 5: Formulating practical strategies for future participation

This phase was about consulting with administrators in developing strategies to improve nurses and midwives' participation in future national and global health care goals. These administrators also substantiated the framework in phase 4. The interviews with the administrators followed the substantiation of the framework, and it were these interviews that formed the basis for the formulation of strategies for future participation by the nurses and midwives. Figure 1 below, offers a summary of phase five.

Figure 5.29: Future practical strategies

The framework was developed in phase three and was substantiated for its relevance to this study in phase 4. The framework was made up of key components namely the context, level of participation, and need for essential changes. The framework was essentially formulated to provide a visual reality of Tanzanian nurses and midwives' participation in MDGs, and to provide the basis on which future improvements could be based. It was therefore necessary to seek input from the nurses and midwifery administrators as well as academics through

additional telephone interviews. The administrators were asked questions in relation to the aspects of the framework namely the context, participation, and essential changes. From the interviews, themes were developed in relation to awareness, improvement of participation, and future changes (see table 5.8 below). The results from these interviews formed the basis on which strategies to improve future nurses and midwives' participation were formulated.

Table 5.8: Themes for future strategies

Raising Awareness	Improving Participation	Effecting Essential Changes
• Information sharing • Knowledge of the goals • Translating goals to practice	• The meaning of participation • Full involvement • Reflective Practice	• The leadership role • The use of IPE and IPC • Contribution of Technologies

5.10.1: Awareness raising

In defining awareness, the contributors to this discussion stated that awareness was about implementers of MDGs knowing about the goals, and how they would incorporate the goal targets in their everyday work. In this definition, an emphasis was placed on the importance of work meetings and other forms of communications in raising staff awareness, the implementation of a policy framework, and staff in workplaces being able to follow the framework. Further awareness strategies would need to include training on SDGs and related targets simply to make sure that the goals and targets were well understood by staff in administrative and in clinical areas, including how the goals could be translated into their daily nursing and midwifery practice. Three themes for the identified strategies were 'information sharing'; 'knowledge of the goals'; and 'translation of the goals to practice'.

Information sharing

There was an emphasis on the need for information sharing among health care staff across the health care system in all workplaces. According to participants, information sharing would mean that all professional staff including nurses and midwives would be made aware of what ought to be done, who would be responsible, and how the tasks or responsibilities would be implemented. Here is what was said:

"Awareness means knowing your situation, and this is what directs your actions….it is therefore imperative that staff across the health care sector are able to share information on such goals" (INT2). Another Interviewee added:

"Nurses and midwives do not have opportunities to access up-to-date literature or information within the health care system, and this is a systematic failure (INT4).

"Annual Nursing and Midwifery Day could be used to lift up awareness about the goals. These are specials days, if well planned which would enable a large gathering of nurses and midwives from all over the country, and media people are always present in these forums; the day would also uplift nurses and midwives' visibility" (INT1).

"Nurses and midwives could constantly share information with doctors and policy makers on how implementation plans are going. Even other health care professionals such as dietitians would be kept in the loop. …. What I'm saying here is that working together and knowing that each person is a professional in his/her domain is key to success" (INT4).

From the responses above, it was clear that lack of information sharing among various staff within the health care system created a gap that diminished their awareness in the implementation of the MDGs. Lack of awareness poses as inhibiting factor since it becomes difficult for nurses and midwives to direct their actions to activities such the keeping of records, or any other action that helps in meeting the targets. The annual forums for nurses and midwives will be used to fill some of the gaps for information that is not communicated to them in their workplaces.

The second theme is presented next.

Knowledge of the goals

Regarding this theme, participants who were interviewed based their recommendations on the importance of understanding the goals as a first step towards attaining them. The main idea was that it is easy to participate fully in something that you understand well, including being

aware of the policy framework that guides the implementation of the goals. Administrators also underscored the importance of training nurses and midwives through CPDs for maintaining currency of competences, being part of decision-making groups for implementation activities of the goals. The following are participants' statements in relation to this theme.

> "My recommendation is that I would first make sure that nurses and midwives understand the goals and the targets under those goals. Knowing goals and targets is not enough. I would teach them how one goal is related to another, including their targets" (INT3).

> "It is essential that nurses and midwives understand the policy that goes with implementation of MDGs, including being part of this policy development, making sure they understand the goals and contents of this policy, and how the policy is to be implemented to attain the goals (INT3).

> The use of CPD system would be an important educational tool for making sure that nurses and midwives in clinical and non-clinical areas understand the goals; and this system would improve the clinical updates, MDGs awareness, and implementation plans (INT5).

The participant's view was that it wasn't enough to just understand the goals but to also translate their understanding into concrete actions. It was evident from administrators' responses that correct and concrete actions could only come about if there was a policy to guide the actions of all employees involved in the implementation of MDGs 4 and 5. Lack of such policy no doubt leaves a room for having uncoordinated implementation plans. Future health care goals would therefore benefit from a policy framework for better coordination of activities, improved communication, and ownership of implementation plans and activities.

Translating the goals to practice

Interview participants understood the short coming of understanding the goals only in a theoretical sense. For effective participation and eventual attainment of the goals, administrators voiced the need for clinical and non-clinical personnel of the health sector to translate the knowledge of the goals into their everyday practice. In other words, they

recommended the need for nurses and midwives to apply their understanding of the goals to their everyday clinical and non-clinical duties in various settings. Here is what was said:

> "In future, it would be essential that nurses and midwives are taught how each goal and target is related to what they do in administration or clinical areas. For example, you may find a situation where nurses and midwives can verbalise the goals, but they cannot link or relate this goal to what they do every day. This needs to change (INT5).

> "The effective CPD system would also include both the theoretical and practical components, where staff would not only be taught about the goals or targets, but rather how the goals and targets are applied in clinical and non-clinical work settings" (INT1).

As discussed above, all healthcare employees, nurses and midwives included need to have a clear understanding of the goals, their key elements, targets, and how these elements of targets are related to employees' daily work responsibilities. Nurses and midwives would benefit from clinical education and the use of CPD system as a means of understanding the theory behind the goals, and how this theory could be translated into practice.

5.10.2: Improving participation

As shown in the table, two questions were asked during interviews as they were deemed necessary in providing the way forward for future participation. In responding to above questions, participants stated what they thought participation meant for nurses and midwives. They also emphasised the contribution of nurses and midwives associated to their full participation, and further added the issue of responsibility and accountability. Three themes were identified from participants' responses, and these were meaning of participation; need for full participation, and reflective Practice.

The meaning of participation

Participants were able to state what they thought 'participation' meant for nurses and midwives, especially in relation to implementation of MDGs. They thought that it would be necessary for 'participation' to be explained to nurses and midwives. Here is what they said:

"I think of participation to be how nurses and midwives take part in activities related to MDGs; this means that nurses and midwives are part of the planning and implementation processes of MDGs 4 and 5 (INT1).

"It is about being there among others, being present and visible among decision makers, and on the ground. In broader sense, effective participation includes performing both clinical, governance, coordination, and leadership duties to accomplish national MDGs 4 and 5 goals (INT4).

"Participation means being involved in the planning and implementation, and not only carrying out interventions or clinical activities (INT5).

The administrators' responses on the meaning of 'participation 'as presented above are in line with the content of the proposed framework. The administrators repeated the need for nurses and midwives' visibility, which is about being involved in the planning and decision-making. The importance of leadership was voiced, and this corresponds to measures for shifting capacity. It is by and large the role of leadership to provides the environment for junior staff in clinical areas to have education opportunities for improving their skills, competences and confidence. The theme of full involvement is presented below.

Full involvement

The importance of nurses and midwives' being involved in MDGs was emphasised despite the same having been mentioned in previous themes. Nurses and midwives' involvement would start with being informed of the key issues and the happenings in the workplace. Here is some of the responses from the administrators.

"In general, our clinical staff are supposed to know what is going on. We cannot just work; we need to work with purpose having known and having been part of the decision group of what we are doing and what we are aiming at achieving" (INT4).

"We noticed that nurses and midwives were not part of the decision-making group for a lot of activities. Here I am referring to those activities that were performed by nurses and midwives while aware of the existence of goals related to MDGs 4 and 5. We are

many and skilled, we want to be there when everything is being planned, implemented, and evaluated for better outcome (INT2).

According to administrators, participation and eventual attainment of the goals, starts with being informed about the plans, the activities, the happenings, the reviews, the progress, the issues that hinder progress, and what needs to be done. Apart from raising awareness of the goals and knowing what is happening around you helps to uplift the morale, empowers employees and brings synergy among various organisations and throughout the health care system. An aspect of improving participation included reflective practice. Administrators' response on reflective practice is discussed below.

Reflective practice

The responses on this theme centred around the need to maintain the positive aspects of the MDGs, and to learn from the challenges encountered. An emphasis was placed on information generation, information sharing, and putting in support systems to enhance nurses and midwives' clinical capacity. Here are some of the responses given.

> "For the future, we must learn from what did not go well and avoid it; and what went well to be continued. We have to evaluate our implementation strategies to inform ourselves of what is going well, and what is not going so well" (INT5).

> "SDGs implementation activities would not differ much from MDGs. We already know that MDGs phase lacked equipment and human resources, and these are among what must be addressed if SDGs targets are to be realised" (INT2).

> "It is a good thing to learn from the past experiences. There was information gap observed from MDGs phase. In future, it will be helpful to share information on operational strategies among different groups working for the Ministry of health; goals would be made clear by putting out posters for the goals and training through CPD points on SDGs for nurses and midwives. Each professional group to be given responsibilities, among which would be interventions, coordination, administration, and evaluation" (INT3).

The administrators' input around the reflective practice centred on the need to learn from the experiences of the MDGs. It was their views that what went well would be carried forward into SDG. Issues encountered such as poor communication within the health care hierarchy and among various groups of the health care team as well, lack of equipment would have to be rectified, and shared responsibilities would have to be improved.

5.10.3: Effecting essential changes

The participants' answers included a range of recommendations such as the need for professional standards, inclusiveness and transparency during the planning and implementation of the goals. Other responses included goals' ownership, the role of the nursing and midwifery leadership, the contribution of Interprofessional Education (IPE) and Interprofessional Collaboration IPC) in the realisation of the goals as well as the use of technologies to enhance communication and clinical interventions. Themes identified from participants' responses were "The Leadership role'; "the use of IPE and IPC"; and 'Contribution of Technologies".

The Leadership role

On this theme, the interviewees clearly pointed out the leadership's contribution. This was not only about the nursing and midwifery leaders, but also from leadership of all professional groups in health care. They reiterated the need for the health care leaders to work collaboratively in making sure that the goals are understood to various implementing groups, in issuing clear implementation policy and guidelines, and in empowering and supporting the nurses and midwives throughout all phases of the goals. The following are some of what was stated:

> "We acknowledge that there has been a leadership gap; our staff need to be empowered and supported in future care gaols; this will enable them to showcase their professional capacity and independence" (INT3).

> "The history of nursing is well known; we struggle to voice our abilities and concerns, but as a social and professional group, this will have to change. We must be able to demonstrate self-confidence and voice our concerns including what we can achieve if we are supported" (INT2).

"Although nurses and midwives are the majority in health care, they lack assertive skills in workplaces. They still feel women instead of feeling as professionals (INT4).

"Our Ministry of Health will have to issue policy and implementation guidelines for all staff in health care to use during implementation phase; and workplace leaders to carry out more elaborative meetings where clear explanation will be given to staff about such the goals and implementation strategies" (INT1).

The responses above contain views which were given to improve future participation. A gap in leadership was noted. In general leaders in the health care system did not give due support to nurses and midwives in clinical areas. Lack of support seems to have disempowered them in such a way that they lacked voice and confidence to voice their concerns. The policy framework to guide activities for implementation of the goals was also lacking. The administrators' views on IPE and IPC in relation to the future are presented below.

The use of IPE and IPC

Interviewees were able to point out gaps where education and cooperation among various health care workers could play a vital role in achieving future health care goals. They made recommendations based on what was observed as gaps during MDGs phase. This is what was said:

"During MDGs, I did not observe different professional groups having regular clinical updates. Nurses would benefit from CPD points and other joint educational sessions specific to the goals. These sessions would be attended by other professional groups to enhance understanding and smooth implementation of planned activities" (INT5).

"The implementation of SDGs is not only for one group. Activities for SDGs must be collaboratively planned, and collaboratively implemented. The synergy among different health care workers is essential in achieving those goals" (INT 2).

"Cooperation among staff is to be enhanced. Doctors and policy makers to know that nurses are there as professionals who have a portfolio to support the system, and not as mere implementers; …. At the end of the day, staff must learn to work together and share information. Mind you, MDGs were not for one professional group to achieve,

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health care workers must learn to work together and support each other for better results (INT2).

IPE and IPC initiatives were reported as important for attaining future goals. Participants reported the need for regular clinical updates as well as education sessions to improve their skills in the form of CPD points. The need for cooperation among professional groups in health care such as doctors, nurses and others were reported. These will be discussed further in chapter 6.

The theme about improvement in the use of technology was noted as one of the essential changes for the future and is presented below.

Contribution of technologies

The use of technologies and contemporary methods of communication was reiterated during the interviews. The need to learn from what happened during MDGs featured again among the responses from these interviews, and the short falls experienced during MDGs were to serve as a lesson for the future. These are some of the recommendations from participants:

> "Despite having not performed well during MDGs, we must know that it was an opportunity to brace ourselves for future goals, we must learn from what happened during MDGs, if SDGs are to be realised (INT1).

> "Staff must be trained to use technologies and technological equipment. The nurses and midwives in rural and remote areas would benefit from telehealth services for education, training, and support (INT2).

> "The issue of record keeping was one of the challenges experienced during MDGs phase. Our staff were overworked, and at times documentation of care given and progress made was not being kept. For SDGs, the use of electronic record keeping devices to replace manual records would be handy" (INT4).

The contribution of technologies as a way forward to attaining the goals under SDGs fits well with the shifting capacity proposed in the framework for future participation. The challenge of nurses and midwives being overworked, the problem of record keeping and documentation of events, and lack of equipment are areas that will require some improvement. Telehealth services will be essential in bridging the gap between rural or remote and urban areas. Nurses

and midwives in rural areas may benefit from the telehealth services for various clinical and educational programs.

5.11: Summary of findings for phase 5

Phase five presented findings which would be used to develop future strategies for nurses and midwives' participation in Tanzania's health care goals. Data for phase 5 was collected from additional interviews with nurses and midwives' administrators, as well as academics, some of whom were also involved in phase 1 and phase 2 interviews. Phase 5 findings have been presented in accordance with the key parts of the framework namely the context, level of participation, and the need for essential changes.

The findings showed the importance of joint ownership of the goals for different professional groups in health care. Findings also stressed the need for information sharing to enhance awareness and the role of nurses and midwifery leadership. The leadership needed to lobby and support staff in clinical areas to have education and training required to enable them acquire skills to cooperate effectively with other professional groups such as doctors and others.

An operational definition of 'participation' emerged during interviews, and the translation of the knowledge of goals into actual practice has been emphasised. The future cultural shift would include creating confidence and assertive skills among nurses and midwives through empowerment processes. Improvement in systems and telehealth technologies and acquisition of modern data management tools were also recommended to enhance more participation especially for nurses and midwives in rural areas.

5.12: Chapter Five Summary

Chapter five discussed the findings from survey, interviews and focus group sessions. The findings were presented to cover all the five phases of the data collection which included data on awareness, participation, the creation of the conceptual framework, the testing of the framework, and the proposing of strategies for future participation. Media was reported as being the main source of awareness, followed by meetings and information from colleagues. Results on participation were reported as either being incomplete participation or complete

non-participation, and it was reported that nurses and midwives received no obvious support from the MOHSW.

The analysis in phase one and two enabled the creation of the conceptual framework that was tested and from which strategies for future participation were proposed. The strategies proposed for future participation included aspects of shifting culture and shifting capacity. Under shifting culture issues such as involvement of nurses and midwives in the receiving essential information for more awareness and being able to participate in decisions and implementation strategies were proposed. Under shifting capacity improved education opportunities and competencies through CPDs were among the propositions from the administrators. Other aspects proposed under shifting capacity were improved nurses and midwives' workload, increased voice through representation and improved budget. The next chapter discussed the study's findings in relation to available literature.

Chapter 6: Discussion of Findings

6.0: Introduction

This study aimed to investigate and describe the factors that enabled or impeded participation of Tanzanian nurses and midwives in the implementation of MDGs between the year 2000 and 2015. The study also looked at the support that nurses and midwives in Tanzania received from the Ministry of Health and from the Nursing and Midwifery Associations in view of the UN and WHO's encouragement to become actively involved in the implementation process of MDGs 4 and 5. As such, the study envisaged that an understanding of those enabling and inhibiting factors, would help with identifying recommendations for improved participation of Tanzanian nurses and midwives in future global health care goals such as SDGs.

This chapter discusses findings for this study as presented in chapter five. These findings were presented according to the phases which corresponded with the methodological stages of the study. The first phase presented findings about nurses' and midwives' awareness of MDGs; phase two discussed findings on nurses' and midwives' participation; and phase three analysed the findings from the first two phases and allowed for the development of the framework for the study. Phase four tested the framework, and further highlighted the need to collect more data to identify recommendations for future participation discussed in phase five. This chapter compares findings in relation to relevant literature and existing theories, the conceptual, and theoretical framework, part of which were discussed in chapter two of this study.

It is worth noting that there is limited literature on this topic. The findings are compared to literature which relate to the awareness of MDGs, MDGs ownership, nurses and midwives' lack of voice, shortage of equipment, empowerment and support for nurses and midwives. It is believed that the conceptual and theoretical frameworks used for this study offer historical and philosophical perspectives which are relevant to nursing and midwifery. The Critical Social Theory, and the Social Identity Theory, which are used in this study can be used as true framework on how nurses and midwives can navigate the complex contexts and relationships, they find themselves into. These theories will also offer the way forward

through empowerment initiatives for nurses and midwives to realise opportunities available to them on capacity building around knowledge and skills acquisition without relinquishing their role of contributing to the strengthening of the health care systems. The Chapter summary is given at the end.

6.1: The study context

Tanzania, like many other countries in the world responded to the call by the United Nation's General Assembly (GA) in 2000 to implement the Millennium Declaration in which a blueprint with eight goals was agreed upon by world's Head of States and Governments attending the GA to be implemented by the year 2015.

Following the Millennium declaration, each country affirmed its commitment to mobilising all necessary resources to ensure attainment of the goals. Non-Governmental and Multilateral Organisations such as the World Bank, the GAVI Alliance, and International Monetary Fund committed to channel financial resources to developing countries to ensure acceleration and timely attainment of the goals within the specified time frame (Chopra & Mason, 2015; Lomazzi, Borisch, & Laaser, 2014b).

Immediately after the Millennium Summit in 2000, two documents were released by the UN and WHO. The documents entitled "The UN global strategy for women and children's health", and "the WHO's strategic directions for strengthening nursing and midwifery services" were released to encourage nurses and midwives to actively be part of the implementation process of the health related MDGs (Amieva & Ferguson, 2012). The two documents underscored the key role that nurses, and midwives play in ensuring that peoples' health are improved and the health care systems in various countries are strengthened. Additionally, the UN and WHO recommended that education and training programs be available for nurses and midwives, and also that collaboration among professional groups and stake holders be established as a strategy for attainment of the health-related goals.

6.2 The current Tanzanian context

The implementation of MDGs 4 and 5, which was the focus of this study were considered essential for Africa (Lomazzi et al., 2014b). The implementation of the two goals were adapted to the local context of Tanzania, and the government, particularly the then Ministry for Health and Social Welfare (MOHSW), now the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) made effort to improve access to maternal health services both in public and private sectors (Ojemeni et al., 2017). Material and human resources were also mobilised to ensure that reduction of infant mortality and improvement of maternal health was attained.

Despite these efforts by the Tanzanian government, the two goals and associated targets were not met (Ojemeni et al., 2017). The results from this study show that the challenges to this outcome included lack of awareness and ownership of the goals among health care professionals. There was lack of clear implementation strategies of the goals, the absence of collaboration among health care professionals, shortage of staff, funds and equipment in clinical settings, absence of information and data for measuring progress. Lack of encouragement and support from MOHSW, and the health care system through partnership with nurses and midwives, lack of empowerment, and training for skills acquisition by such as nurses and midwives were also among the challenges reported. The awareness of the goals by key stakeholders such as nurses and midwives, is an essential implementation and goals attainment strategy. In most countries, nurses and midwives constitute most of the health care workforce, and midwives can provide up to 87% of antenatal and postnatal care (Sandwell et al., 2018). Similar level of nurses and midwives' involvement in maternal and child health was reported in chapter 5 of this study.

Given the indispensable role of nurses and midwives in the attainment of such health goals and in strengthening of the health care system, it would therefore be important for MDGs information and awareness campaigns to have included nurses and midwives since they are instrumental in filling the gaps of a weak health care system. A weak health care system is characterised by fragmented and disjointed programs, underfunded health care programs, under-resourced health care facilities, and high maternal and neonatal deaths. Estimates demonstrate that only 64% of maternal care needs are met in Tanzania (Sandwell et al., 2018). The study participants reported low levels of Interdisciplinary Teamwork (IDTW), Inter Professional Education (IPE) and Inter Professional Collaboration (IPC) among health

care professionals particularly between nurses, midwives, and medical doctors. The two documents that were released by the UN and WHO following the advent of MDGs namely the UN's Global Strategy Directions for Women's and Children's Health (GSDWCH); and WHO's Strategic Directions for Strengthening Nursing and Midwifery Services (SDSNMS) intended to offer guidance and they highlight key areas of interventions for attainment of MDGs 4 & 5. GSDWCH encouraged government departments and other agencies to partner with key stake holders such as nurses and midwives in ensuring that services delivery to improve maternal and child health were effectively provided (Amieva & Ferguson, 2012). The documents also solicited support to nurses and midwives in areas of empowerment, leadership, participation in decision-making, and cooperation with other health care workers knowing that nurses and midwives have stake in the delivery of maternal and child health. During this SDGs phase, there is need to improve cooperation among different health care professionals in areas such as planning, implementation, decision-making, record keeping, and evaluation stages of the goals. It would seem apparent that lack of support for nurses and midwives, and the absence of collaboration among health care professionals was an inhibiting factor in Tanzania which worked against the attainment of MDGs 4 and 5.

6.3: Future participation

In this study, nurses and midwives expressed the desire to participate fully in future similar goals including SDGs. The proposed framework for future participation and participants' reporting from survey, FG and interviews, converged around the view that in the future, there would be a need for health care goals to be fully communicated to all health care professionals including nurses and midwives. It was further emphasised that it is only when those goals are well understood that they can be implemented effectively.

It was also noted that full participation for nurses and midwives would be enhanced by improved human and material resources, improved empowerment initiatives and support for nurses and midwives. The institutional cultural shift will need to create a favourable environment for information sharing among health care workers; education and training opportunities to improve staff skills; inter-professional education and cooperation for smooth implementation of the goals. Additionally, future strategies would help staff to acquire skills

to translate the knowledge of the goals to their daily practice, and to learn from the challenges encountered during the MDGs implementation phase.

6.4: The framework for future participation

The framework for this study as shown in the diagram below (Figure 6.6) was developed to summarise the findings about awareness and participation in MDGs. The framework also offers a way forward on how nurses and midwives' participation in Tanzania would be enhanced in the future. The summary of the findings as well as the future directions are presented in the form of key domains that make up the framework, and these domains are the Context; Level of Participation; and Influencers to Nurses and Midwives' Participation.

The Context

This domain consists of cultural and awareness impacts, and highlights the social and professional context in which nurses and midwives find themselves in. See Figure 6.1 below. In this study, the cultural and awareness impacts indicated that the settings where nurses and midwives practice lacked effective communication and the sharing of information among various professional groups. The health care system did not have enough resources (human and material), and the support to nurses and midwives was limited. There was evidence of a knowledge gap and lack of strategies for implementing MDGs. The experiences in South Africa discussed the challenges encountered in attaining health related goals, namely MDG 4, 5, and 6. One of the many challenges that made it difficult for South Africa to reach the targets for reduction of maternal and child mortality was lack of collaboration among health professionals, including traditional healers. Other challenges were lack of empowerment, low levels of skill and competencies, and the lack of monitoring of progress and record keeping (Mulaudzi et al., 2016). These challenges are like those reported by participants in this study, and the proposed future action has taken into consideration some of the challenges encountered in South Africa.

Figure 6.1: The study context
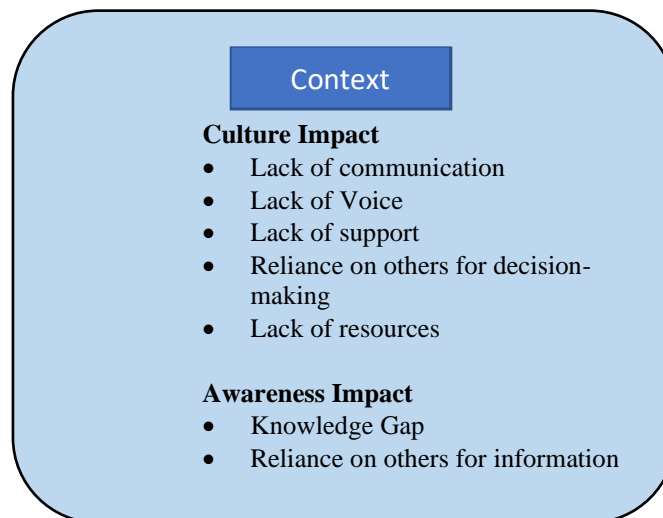
Nurses and midwives have relied on decisions made by other people. Limited communication about the decisions being made, was a barrier to their full participation in the implementation strategies.

Figure 6.2: Levels of participation
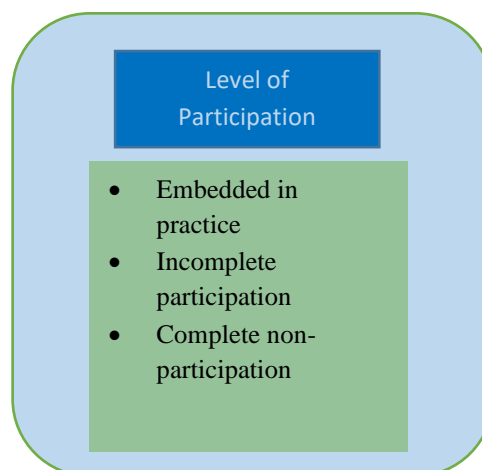
Level of participation is summarised in Figure 6.2 above. Figure 6.2 shows that nurses and midwives' participation was only 'embedded in their practice'. Nurses and midwives described their participation during implementation of MDGs 4 and 5 as "doing their everyday normal duties", which meant that their role during MDGs was the same as what

their role was at the time when there were no MDGs to be achieved. The level of participation by nurses and midwives in this study was also described as either incomplete participation, or complete non-participation. Incomplete participation meant that activities related to implementation of MDGs were undertaken by nurses and midwives only as part of their everyday clinical normal duties, and it was again confirmed that nurses and midwives were not part of the decision-making group for those activities.

Complete non-participation meant that nurses and midwives confirmed having no understanding of the goals, not witnessing any changes to their normal clinical duties, and being unaware of implementation strategies for MDGs.

Figure 6.3: Influencers to participation

The category influencers are made up of the concepts shifting culture and the shifting capacity, and influencers are drivers in the Tanzanian health care system for positive changes that will lead to more participation by nurses and midwives in national and global health care targets. The drivers of the change could include institutions, and organisations such as Tanzania Nursing and Midwifery Council (TNMC), policy framework, and any other initiatives that would bring about changes and enable nurses and midwives to be represented in key forums and meetings where key decisions are made. It is through representation that will give nurses and midwives a voice and visibility needed for using their full potential, hence their contribution to achieving envisaged targets under SDGs phase and beyond. The current ministry of health through the directorate of nursing and midwifery services, TNMC, nursing and midwifery academics would be expected to play a leading role in influencing

essential cultural changes and capacity building for improved future nurses and midwives' participation.

Figure 6.4: The shifting culture
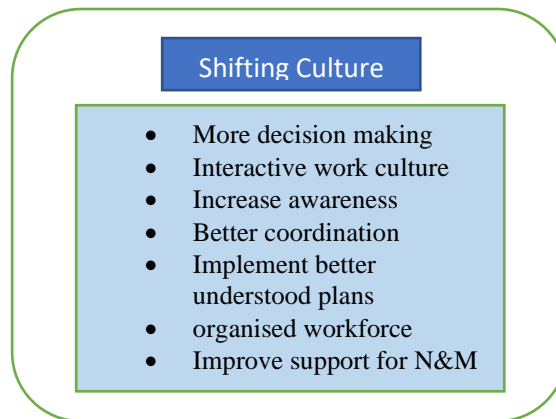
Shifting culture refers to the creation of inclusive workplaces environment within Tanzanian health system which is deemed favorable for nurses and midwives' participation in future health care goals such as SDGs. The changes therefore would include more interactive, supportive, and inclusive decision-making work environments; a workplace where information about future goals is shared among staff for awareness and for ease of implementation as shown in figure 6.4. Shifting culture would also mean having in place effective nursing and midwifery leadership committed to drive and to advance the nursing and midwifery knowledge and practice.

Figure 6.5: The shifting capacity
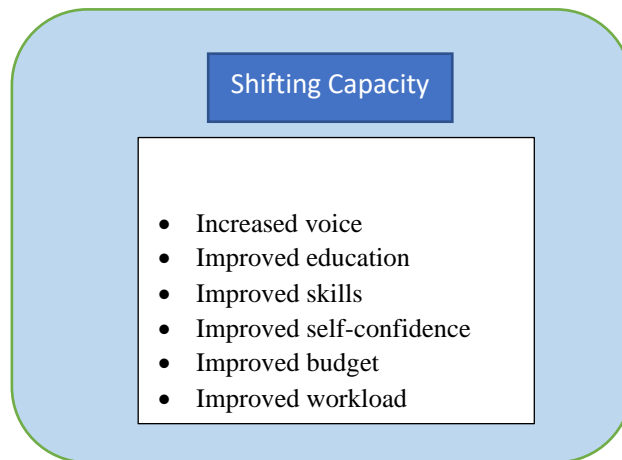
The framework also proposes shifting capacity. Capacity building is about recognising and effectively mobilising internal human and material resources and transforming those resources without relying on external assistance (Sandwell et al., 2018). These are measures to enhance employees' capacity and system changes in areas such as education and training to improve the nurses and midwives' skills, improved confidence for them to voice their concerns; and improved budget and resources to increase staff productivity and eventual attainment of the goals. Partnership with other local and international organisations and NGOs with the aim of empowering and supporting the nurses and midwives are also proposed. The figure about framework for improving participation shows a combined view of the three domains discussed above. The part that follows compares the study's findings with the relevant literature.

Figure 6.6: Framework for improving participation

Context

Culture Impact
- Lack of communication
- Lack of Voice
- Lack of support
- Reliance on others for decision-making
- Lack of resources

Awareness Impact
- Knowledge Gap
- Reliance on others for information

Level of Participation
- Embedded in practice
- Incomplete participation
- Complete non-participation

Need for essential changes

Influencers
- Stakeholders (Nurse Leadership; Professional (organisations)
- Self confidence
- MOHSW (N & M Directorate)
- Inclusive policy frameworks

Shifting Culture
- More decision making
- Interactive work culture
- Increase awareness
- Better coordination
- Implement better understood plans
- Organised workforce
- Improve support for N&M

Shifting Capacity
- Increased voice
- Improved education
- Improved skills
- Improved self-confidence
- Improved budget
- Improved workload

Improved Awareness

Improved Participation

6.5: Comparison of findings with literature

This study intended to investigate Tanzanian nurses and midwives' participation in delivering MDGs. The findings for this study were presented in chapter five to provide answers to the five research questions. As stated in chapter two, this study is unique in that there has been limited literature around the topic of the study at hand. The comparison of the findings is therefore presented to cover parts of the conceptual framework and the literature leading to the cultural and capacity shifts to enhance nurses and midwives' participation in future planning and implementation of health care goals.

6.5.1: Awareness of MDGs

The findings on MDGs awareness were that nurses and midwives in Tanzania became aware of the goals mainly from media sources, and to a lesser extent from workplace meetings and awareness campaigns that targeted health professionals such as nurses and midwives. It must be noted that media sources did not specifically target nurses and midwives, rather MDGs information was meant for the general public. Nurses and midwives were among the implementers of the goals, and therefore information received through media may not have effect on implementation strategies of the goals. In general participants described their workplaces as lacking awareness, lacking open communication about MDGs goals 4 and 5, they relied on others for information and on doctors for decision-making. They also perceived that there were insufficient human and material resources, they did not have a voice to present their needs in relation to MDGs, thus a feeling of no ownership of the goals to be attained. The findings from this study are consistent with the study by Puchalski et al. (2016) on barriers and facilitators of implementing evidence for maternal health in Low and Middle-Income Countries (LMIC) namely Kosovo, Myanmar, Tanzania, and Uganda. This study developed a list of barriers or challenges in the prevention and treatment of postpartum haemorrhage, pre-eclampsia, and eclampsia in maternal and newborn. For Tanzania, the identified barriers included lack of equipment and clinical supplies, the absence of coordination and collaboration of the resources for planned activities, the shortage of staff, high workloads, high staff turnover, the absence of effective supervision, lack of training opportunities to upskill the knowledge and skills for

implementers who are also stake holders, and lack of communication and information sharing (Puchalski Ritchie et al., 2016, p. 231).

Lomazzi et al. (2014) also studied the experiences, and achievements of Millennium Development goals in Africa, Tanzania included, and South Asia. It was generally observed that lack of information sharing, limited awareness and understanding of the goals among health professionals were among the reasons contributing to non-attainment of MDGs, as here stated:

> Indeed, it has been shown that understanding of MDGs among public health professionals was limited. This general lack of information and awareness represents an important challenge; there is absolute need for elaborate publicity and awareness about MDGs among key players if attaining of MDGs is to be a reality (Lomazzi et al., 2014b, p. 5).

Awareness which means a state of being conscious, and of being exposed to information about your surroundings, is essential in attaining planned activities, and ownership of the goals is essential in improving participation, accountability and implementation processes (Lomazzi et al., 2014b). In some literature, information sharing, and knowledge sharing are used interchangeably, and they refer to the exchange of daily work-related news, reports particularly with focus to planned Organisational activities (Heinström, Ahmad, Huvila, & Ek, 2020). Information sharing also refers to interactions among workplace colleagues, professional groups or between subordinates and supervisors (Zainuddin & Isa, 2019).

Awareness from information sharing, meetings or education and training has an impact on the employees' ability to directly perceive, feel, and act when accomplishing their day-to-day duties. Information sharing is viewed as an important asset in today's workplace settings characterised by collaborative and teamwork practices; it contributes immensely to employees' insights, knowledge (know-how), and is the key to the realisation of the organisation's strategic activities (Heinström et al., 2020).

Knowledge, which is a set of mental processes, competencies, or expertise may be generated from information sharing, and it is this knowledge that guides collective or individual actions. The absence of knowledge, therefore, creates a knowledge gap and absence of insight which is required to create desired actions. This is to say that the absence of knowledge (knowledge gap), may lead to no action, or no participation.

Workplace information sharing has also been linked to the sense of coherence (SOC) theory. According to this theory, SOC which has three components namely *comprehensibility* which means a person's ability to process and understand information, *manageability* – a person's ability to effectively use available resources, and *meaningfulness* which means a person's commitment (Carr, 2003), is useful in understanding how workers feel connected to their work place. It is emphasised that social connectedness not only underscores the importance of information sharing, but also how people with strong SOC can integrate knowledge, behaviour and insights into actions to improve their work environment (Heinström et al., 2020). Employees who attach meaningfulness to their work, display a sense of ownership for the responsibilities they are charged with are more likely to realise the workplace goals. Meaningfulness is further described.

> Meaningfulness describes a sense of worth in investing time, energy, and engagement in addressing life's challenges. In a work context, this can emerge as ownership of work and a drive not only to perform work tasks well but also to excel in order to achieve power, rewards, and prestige as well as intrinsic gratification (Heinström et al., 2020, p. 205).

As the results from this study have shown, and as echoed by Lomazzi et al.(2014), the sharing of information in workplaces, ownership, and knowledge about the goals to be attained, are to be emphasised as part of the planning and implementation strategies. The role of the nurses, midwives, and other health professionals in the attainment of the goals must also be taken into consideration.

6.5.2: The role of nurses and midwives in implementation of MDGs

The findings about participation of Tanzanian nurses and midwives are presented as embedded in practice, incomplete participation, and complete non-participation. These findings reveal that nurses and midwives' participation was partial and limited as it involved doing normal duties, having no understanding of the MDG goals and no active role in decisions about the implementation strategies.

Literature suggests that peoples' ability to attain organisational goals is determined by several factors including behavioural and motivational (Deci, 1992). Behavioural factors include information about the goals, which means a complete understanding of the goals, the competencies and strategies required to reach the goal. Deci (1992) further emphasises: "people will accept and work to attain goals when they understand what behaviours will lead to the goals, when they feel competent to do those behaviours, and when the goals are valent (primarily because of the separable consequences to which they lead)" (Deci, 1992, p. 168).

On the other hand, motivational factors refer to the inner drive, support, and self-determination to act towards the realisation of the goals. The factors are driven by such things as the relevance or how appealing the goals are to the implementers, and they have effect on the energy that people expend towards the realisation of the goals.

Partial and limited participation of the nurses and midwives, hence inability by Tanzania to attain MDGs 4 and 5 is likely to effect behaviour and motivational factors. These factors are opposed to the intentions accompanying the release of the documents by the UN and WHO after the Millennium summit. The documents had envisioned placing nurses and midwives at the centre, and as stake holders in the implementation process of the MDGs. The role of nurses and midwives was described as essential for the attainment of the targets associated with child and maternal health; and nurses and midwives were to be at the fore front in the health care policy development and reforms (Amieva & Ferguson, 2012); (Han, 2020).

The findings related to participation in this study are also contrary to the views expressed by the International Council of Nurses' Leadership for Change (LFC). The LFC program underscored the nurses' leading role in resolving many countries' health care problems, and it called on nurses to be actively involved in their countries' health care policy formulation (Ferguson et al.,

2016). LFC further states that, nurses and midwives have responsibilities as well as opportunities to optimise their participation in providing quality care to health services users, and in effecting and shaping health care systems changes.

In developing countries, for example, nurses and midwives deliver up to 90% of health care at the same or better quality, and more cost-effective service delivery compared to that of a primary care physician (Mills, 2013). In the South African context, 58.9% of nurses in the public sector and 41.1% in the private sector are responsible for providing up 82% of quality care to the population (Koen & Koen, 2016). It is further noted: "There is evidence to suggest that the poor status of women and midwifery in some Low- and Middle-Income Countries pose barriers for midwifery education to influence institutional and health system level" (West, Homer, & Dawson, 2016, p. 22)

Despite the nursing and midwifery role being deemed essential and core in health services delivery, and the implementation of MDGs 4 and 5 (Amieva & Ferguson, 2012); in reality the two professional groups are not yet recognised as key players at the health policy table as they lack voice and media coverage (Juergensen, Premji, Wright, Holmes, & Bouma, 2020). This statement is consistent with the findings reported in this study whereby participants reported their participation to be incomplete as it was only limited to doing normal duties, and they were not part of the decision-making group at the district, regional, and national levels. The findings showed that the medical doctors, policy makers, and politicians were the majority of those who participated in seminars, workshops, and forums where key decisions about how MDGs were to be implemented were made. In other words, despite nurses and midwives being recognised as key players in health care agenda such as MDGs, they were not at the centre of the planning and implementation of the decisions made about these goals.

There is a notable longstanding culture of governments excluding midwives when proposing and passing policies in the child health arena (Sandwell et al., 2018). The nurses and midwives are at times considered as doctors' assistants (Sandwell et al., 2018); and this is a professional, structural, or cultural constraint. Cultural constraints include notions of nursing or midwifery being regarded as merely an emotional support role and unpaid work for women; and structural constraints of exclusion associated with organisational culture (Beardsmore & McSherry, 2017).

Midwives and nurses as an occupational group remain at the fringes of the medical system; and at times they struggle with how they are portrayed by the medical profession and media. This is evident in such media programs as ER and Grey's Anatomy where nurses play a subservient role with very little shown for the audience to know about the real role of a nurse, while a physician is portrayed as dominant and indispensable health care worker (Foley, 2005). In, Pakistan nurses and midwives are not portrayed by the media as important health care professionals, rather as sexy and merciful angels (Abbas, Zakar, & Fischer, 2020).

Although it is beyond the scope of this study, it suffices to say that the patriarchal system is also one of the social-cultural factors which continue to put the nurses and midwives at the fringes of the decision-making table when it comes to health care policies. The system is reported to perpetrate the stereotyping and exclusion of women in various formal and informal professional networks in countries where the system is observed. In the patriarchal context, nursing is a role which is seen as subservient to the medical system, and a role which serves the needs of a man (Abbas et al., 2020). The care giving responsibility is well assigned to the feminine domain (Kellett, M. Gregory, & Evans, 2014). An example of the typical stereotyping attached to the nursing profession is described here: "The stereotypical portrayal and objectification of nursing has placed nurses in a subservient position to physicians and compelled them to give their emotional and physical labour to others, which has devalued the image of the nursing profession" (Abbas et al., 2020, p. 2).

The patriarchal forces do not have effect on female nurses alone, instead they affect male nurses as well, and this supports the discourse of high attrition rate of males in nursing schools and work settings (Kellett et al., 2014). In some countries which follow the patriarchal system, nurses and midwives who are predominantly women struggle to have their intellectual capabilities recognised. Even in countries where the nursing and midwifery profession is accepted as essential in strengthening the health care system, exclusion of nurses and midwives from professional participation is reported (Kellett et al., 2014); and therefore a lot still needs to be done to get nurses and midwives to be accepted as equal players at the health care policy table.

Nurses and midwives work in complex health care systems which require their leaders to understand this complexity and to be able to support the junior staff and colleagues through their day-to-day work-related challenges.

6.5.3: Leadership role in nursing and midwifery

The work environment where nurses and midwives find themselves in is quite challenging. There is a body of literature that points to the challenges that nurses and midwives face day by day in their work environments and in health care structures. These issues include oppression and suppression from medical dominance and media (Aspinall, Jacobs, & Frey, 2021; Choi, Goh, Adam, & Tan, 2016; Foley, 2005); shortage of staff, high workloads in clinical areas, lack of resources and equipment (Choi et al., 2016); (Ojemeni et al., 2017), lack of support (Sandwell et al., 2018); lack of voice which excludes them from health care decisions (Beardsmore & McSherry, 2017), to mention just a few. The above-named challenges require nursing and midwifery leadership that can turn some, if not all those challenges around to enable nurses and midwives to be treated as an important, noticeable, and deserving health care group.

The findings from this study have identified that some of the challenges mentioned above, also existed in Tanzanian clinical areas and the health care system. Lack of voice, shortage of resources and equipment, high workloads, lack of support, and lack of effective cooperation and the sharing of information between nurses, midwives and doctors are some of the issues that participants reported as being among the challenges they experienced during MDGs phase. The proposed framework has included nursing and midwifery leadership as one of the aspects that can influence meaningful changes for the better by acting on system and workplace culture as well as creating partnerships with Organisations in similar situation to enhance nurses and midwives' capacity.

The term 'leadership' has been defined differently, but the definition given by Adapa & Sheridan is preferred. It states as follows.

> Leadership has been defined as a process that involves exerting influence on followers, It also consist of power dynamics in which leaders are bestowed authority and legitimate power by the organisation, largely because of their technical, human, and conceptual skills (Adapa & Sheridan, 2017, p. 17)

Leadership literature and theories discuss different types of leadership styles such as Charismatic Leadership, Transformational Leadership, Value-based Leadership (VBL), Authentic Leadership, and others. It has been observed that authentic leadership, servant leadership, and congruent leadership styles are part of VBL (James, Bennett, Blanchard, & Stanley, 2021a). Authentic leaders are those who truly observe their values, and they influence employees to do just the same. They have high level of self-awareness, they are transparent, and they are inclusive, and above all, they make decisions after they have gathered information and input from their followers (Regan, Laschinger, & Wong, 2016).

It has now been made clear by the International Council of Nursing (ICN); and also, the International Confederation of Midwives (ICM) that nurses and midwives are at the centre of the health care reforms currently underway in various countries; and leadership is of utmost importance in effecting these reforms (MacPhee, Skelton-Green, Bouthillette, & Suryaprakash, 2012). According to McPhee et al. (2012), leadership education for nurses and midwives requires every support, given the current mandate for nurses and midwives to be on the fore front of health system changes. The reminder about the role being played by nurses and midwives in saving lives and improving the quality of living for millions of people in the world seems logical and straight forward.

People who are familiar with what nurses and midwives do every day, will not cast any doubt about supporting, and empowering them to take leadership positions to strengthen the health care systems, the nursing and midwifery professions at every level, and in every structure of the organisation. It would, however, seem logical too to think about 'leadership', a terminology which, except in recent decades when mentioned was never associated with a female figure. Adapa and Sheridan (2017) observe that most people associate top level leadership with men. It is further observed that even when women make it into top-level managerial or leadership positions, the discourse around them is often highly gendered.

The literature is clear about the exclusion of women from various leadership positions, but again the definition of leadership includes the existence and influence of followers in leadership (Adapa & Sheridan, 2018). This therefore means that, a leader has people he/she represents as followers, and therefore the existence and influence of the followers cannot be underestimated.

Although the leadership role may be highly gendered, nurses and midwives' leadership roles are essential in improving the health care systems. The reasons are clear; nurses and midwives make up most of the health care workforce; they have followership; and it is understood that competent midwives can comfortably do up to 87% of antenatal and postnatal care that mothers require (Sandwell et al., 2018). It is again through knowledgeable and committed leadership that nurses, and midwives can slowly move away from the exclusion in decision making, being undermined by the media, and they can overcome many other challenges they face in the workplaces. Given this background, still a question may be asked: How can the nurses and midwives do it, especially in the context of Tanzania?

Nursing and midwifery leadership may be used as an instrument to empower the followers; to improve the workplace or organisational culture; to improve workplace Inter-Professional Cooperation (IPC) and Inter-Professional Education (IPE); and employees' job satisfaction. Figure 6.7 below is used to show how leadership may have influence on empowerment, organisational culture, IPC, IPE, and job satisfaction. The diagram reflects the conceptual framework discussed in chapter two. These concepts as shown in the diagram below when influenced by effective leadership, will mitigate the inhibiting factors which were reported by participants in this study, and will lead to more participation by nurses and midwives in future health care goals.

Figure 6.7: Leadership influence
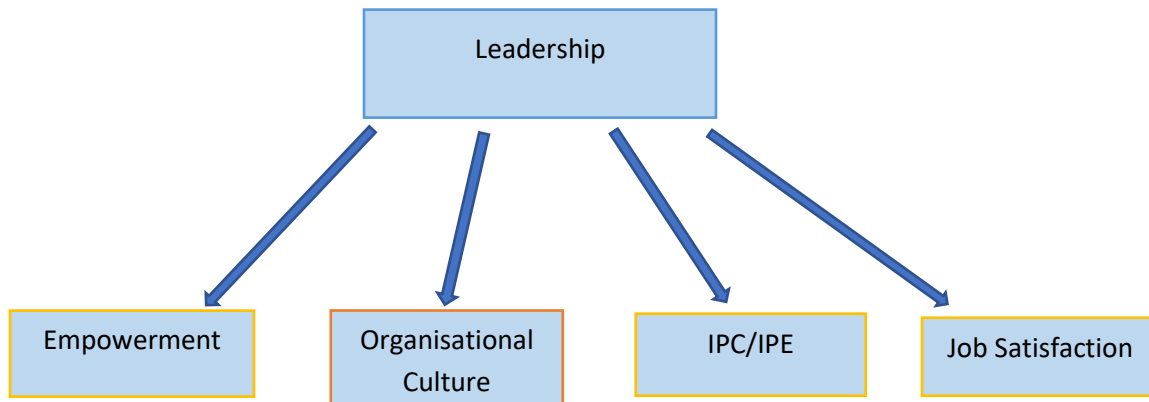
6.5.4: Leadership and empowerment

Empowerment is not an easy term to define (MacPhee et al., 2012), given that it has evolved over time and also that the definition may be used to refer to levels of empowerment such as the individual, organisational and community or collective level (Friend & Sieloff, 2018). Empowerment is used to refer to power sharing, autonomy, opportunity to influence and participate in decisions, ability to master and feel comfortable in a work environment and self-actualization in line with an organisation's goals. It is the amount of autonomy and authority that enables an employee to feel motivated and confident to have positive impact on an organisation that is desired, not autonomy which leads to employee's overconfidence and arrogance.

Literature associates social, structural and organisational empowerment with nurses or midwives' leadership (MacPhee et al., 2012). Literature supports the view that nurses and midwives who are in leadership positions are able to empower others, they can influence workplace culture and improve communication skills, they can influence decisions on organisations' budget hence availability of equipment, and clinical supplies (Friend & Sieloff, 2018; James et al., 2021a; MacPhee et al., 2012). Effective leadership is also associated with giving voice to followers, ownership of work responsibilities, a sense of belongingness, and reduced burn-out (James et al., 2021a).

Psychological empowerment has effect on intrinsic factors such as motivation, meaning, competence, self-determination, and impact (Friend & Sieloff, 2018; Tibandebage, Kida, Mackintosh, & Ikingura, 2016). Meaning relates to how an employee attaches importance to her/his responsibilities. Self-determination entails how an employee feels is in control of his responsibilities; and impact means how an employee feels he or she can influence outcome in the work setting. Through leadership skills, a nurse or midwife can navigate the organisation structures to influence or negotiate decisions to secure opportunities for followers, including access to information, resources, and support. It is the success through these areas such as access to resources or information that employees feel empowered. Here is what has been observed in Tanzanian hospitals: "A key source of poor maternal hospital care is disempowerment of nurses-midwives and that even within very severely resource-constrained environments, good management can empower staff to do better" (Tibandebage et al., 2016, p. 380).

Tibandebage's observation is consistent with the findings from this study which demonstrate that there is still some work to be done around empowerment for nurses and midwives' leaders in Tanzania. Nurses and midwives often lack the confidence to voice their concerns such as the shortage of clinical supplies in workplaces, their involvement in decision making, and demonstrating ownership of the MDGs. We also know that nursing and midwifery leaders in Tanzania require organisational, psychological, and institutional support, also education and training support to help in boosting their confidence in their ability to influence changes in their workplaces. Once they are empowered, they are more able to support their colleagues and the nursing and midwifery workforce.

It has been noted that VBL style is much more suited to the health care environment and to nursing and midwifery given that care and compassion are core values in the health care setting (James, Bennett, Blanchard, & Stanley, 2021b). Despite this notion, the complexity of the health care work environment and culture at times warrants the application of a leadership style that suits a given work context, and not necessarily VBL. What would be most important is for nurses and midwives in leadership positions or through training, to be exposed to all leadership theories. It is true that VBL focuses on values, compassion, ethical behaviours and judgement (James et al., 2021b); and these are values promoted in nursing and midwifery. However, the leaders in nursing and midwifery would benefit from understanding and having the knowledge of other

management theories such as authentic leadership, servant leadership, congruent leadership, charismatic leadership, and others.

The understanding of the different leadership styles may enable them to opt for a leadership style or combination of styles that fit their work context. The leadership skills such as communication skills, emotional intelligence, and value judgment can all be found across various leadership styles. The importance of leadership on empowerment cannot be underestimated. Nursing and midwives' empowerment, therefore, is known to reduce high workloads, and it has positive effect on staff autonomy, cohesion, and organisational culture (Tibandebage et al., 2016).

In Tanzania, nurses and midwives' empowerment would be crucial to the challenges that the profession currently faces. It is lack of empowerment initiatives that may be contributing to those challenges such as lack of voice and lack of participation or decision-making in matters that affect the nursing and midwifery practice. The onus is therefore upon the nursing and midwifery leaders in Tanzania to create conditions that will get their profession out of these huddles. One of such initiatives would be to partner with reputable International NGOs or local Organisations such as Tanzania Media Women Association (TAMWA) which has experience in championing gender equity and women's advocacy in those professions dominated by men such as media. TAMWA has so far created a good foundation for normalising women empowerment in Tanzania to such an extent that women's empowerment has become part of the norm in various structures such that, this initiative can no longer be reversed (Madaha, 2014b).

6.5.5: Leadership and organisational culture

Leaders such as managers, CEOs, or Directors of nursing are part of the formal structures of an organisation. They can have influence through planning and implementing workplace policies which reflect roles and responsibilities and ensure accountability. Providing clear guidelines for communication; promoting cooperation and support systems for employees is crucial. Workplace culture and organisational culture are a product of its leadership. It is the leadership that influences 'how things are done here', including workplace social relationships, and support systems (Aspinall et al., 2021). Good leadership can create positive environments for supportive clinical practices, cooperation between individual and professional groups, can enhance critical thinking, encourages a fair go and a spirit of being responsible for individual actions. At a micro level, positive workplace culture has a direct influence on patient or client- centred care which is an outcome of desired clinical practice (Tibandebage et al., 2016).

In organisations where negative culture such as lack of support, apathy, and inflexible policies, organisational culture becomes a constraint to creating an effective and quality performing organisation (Quinn, 2015). Transformational leaders can enact change and can improve the morale of staff and the quality of practice. Transformational leaders are leaders who can instil positive values, desires, aspirations, can motivate and energise employees and orientate them to desired goals (Choi et al., 2016). Nurses and midwives who apply transformational leadership principles aim to satisfy the needs of the employees at the same time focussing on improving the morale among the followers (Aydogmus, Metin Camgoz, Ergeneli, & Tayfur Ekmekci, 2018). It is a combination of the positive effects of transformational leadership which lead to loyalty, respect, and trust. Studies have also linked the successes from leadership to workplace job satisfaction, and this is discussed next.

6.5.6: Leadership and job satisfaction

In nursing literature, job satisfaction "is related to the physical, mental, and emotional effort needed to perform their task;….it relates to better care outcomes, organisational efficiency, and reduced waste of human capital" (Carlos Do Rego Furtado, Da GraÇA CÂMara Batista, & JosÉ Ferreira Silva, 2011, p. 1049). Although job satisfaction is linked to many other factors such as remuneration, autonomy, and opportunities for promotion, it is also agreed that leadership plays a vital role in bringing about workplace job satisfaction (Carlos Do Rego Furtado et al., 2011); (Aydogmus et al., 2018); (Regan et al., 2016). Health care leaders who involve their peers in decision-making, work quality reviews, constantly engage with subordinates are said to improve employees' job satisfaction (Chan, 2019). Employees with high job satisfaction display strong engagement to their workplace, are highly motivated, they display vigour, and are supportive to one another. Job satisfaction, therefore, reduces employees' feeling of being overworked due to the support available around them, leading to lower levels of staff turnover.

Although this study had no focus on job satisfaction, the study presents a workplace where nurses and midwives lack voice and have insufficient resources to do their work, are overworked, are not involved in decision-making, are not effectively at the centre of information sharing, and don't own the plans for work to be accomplished. The findings from this study have a correlation to consideration of the impact on work-place job satisfaction. Job satisfaction creates the energy from individual and professional support available to staff which will bring about teamwork, inter-professional cooperation, and the quest to acquire more skills through education and training which ultimately, influences quality patient care.

6.5.7: Leadership and IPC/IPE

Inter-professional Collaboration (IPC) has been observed to be an important approach in addressing several health-care issues to improve the health care system. IPC refers to collaboration of health care professionals that is based on agreed performance of tasks and shared responsibilities for the purpose of accomplishing shared goals (Karam, Brault, Van Durme, & Macq, 2018). IPC's shared responsibilities are in areas of patient care, mutual respect,

communication, and education. Inter-Professional Education (IPE), on the other hand signifies how members of different professional groups learn from, and interact with each other with the intention of realizing their workplace goals and for meeting the needs of their patients (Zidek & Medland, 2020). IPC and IPE frameworks are essential in health care as they create partnerships between various health care professionals, particularly nurses, midwives, and physicians. The importance of IPC and IPE is built from the premise that there is an observed power struggle between various levels of the health care system, settings and organisations where physicians' dominance over other groups seems obvious (Karam et al., 2018). Inter-professional collaboration starts with IPE and socialisation (Yancey, 2018). Health care professionals come together to learn from each other about how they can work collaboratively in the workplace or within the organisation.

Homeyer et al.(2018) outlines the advantages of IPE as "increasing mutual respect and trust; improved understanding of professional roles and responsibilities; effective communication; increased job satisfaction; and positive impact on patient outcomes" (Homeyer, Hoffmann, Hingst, Oppermann, & Dreier-Wolfgramm, 2018, p. 2); and Regan et al. came up with the advantages of IPC to be "shared responsibility for client care; knowledge; trust and mutual respect among and between health-care professionals; and good communication" (Regan et al., 2016, p. 55).

The indispensable role of effective and positive leadership, particularly nursing leadership is recognised in creating IPE and IPC in various health care settings (Karam et al., 2018). Leadership is responsible for creating and enforcing effective communication to be used between professional groups; can enact inter-organisational policies; is responsible for creating interactive, supportive, and teamwork environment. Communication therefore enables collaborating groups to share information, through face-to-face meetings and through correspondences, that helps to build trust, respect and strengthens relationships.

The theory around IPE and IPC has a link to workplace culture. An understanding of the importance and role of IPE and IPC assists leaders to put in place measures that may enhance collaboration, information sharing, and employees are empowered to have voice. The findings from this study demonstrated the gaps in IPE and IPC areas. The nursing and midwifery education in Tanzania, does not seem to have fully incorporated programs on IPC and IPE in the curriculum or training packages which enhance their application into practice. The same seems to be the case for education programs for Tanzanian health care professionals. Once IPE and IPC are part of the curriculum within the Tanzanian health care system, and to nursing and midwifery curriculum, there is a chance that the challenges associated with the shifting workplace culture and shifting capacity will be made easier. The introduction of IPE/IPC curriculum is also expected to improve workplace relationships and will strengthen the Tanzanian health care system.

Until such time nursing education has IPE and IPC components, there could still be challenges to do with effective communication, shared responsibilities, mutual respect, and trust. The application of the findings to relevant theory is discussed next.

6.6: Application of findings to theory

This research uses theory as a basis for reflection of the findings for the study with a view to contributing to the discussion of the existing theories. The Critical Social Theory (CST), the Social Identity Theory (SIT), and Nursing and Management Theory (MNT) are used in this chapter to enrich the study. Findings from this study are included in a different colour to signify the additional concepts that would enhance these theories.

6.6.1: The critical social theory

CST is the main theory used to reflect on the findings presented in chapter five. CST is used to critique and explain various social contexts to create a clear understanding of those contexts, followed by action for improvement if needed. CST attempts to explain the social power dynamics, and contradictions within social structures, and to propose the required action (Fuchs, 2017). The CST was chosen as the main theory to anchor this study as it sufficiently explains the

challenging environment in which nursing, and midwifery professions find themselves in Tanzania. CST therefore provides the framework and tool for critical reflection, empowerment, liberation, and emancipation from oppressive forces entrenched in the society or in workplaces. The figure below diagrammatically represents the scope that is covered by the CST.

Figure 6.8: The framework for CST
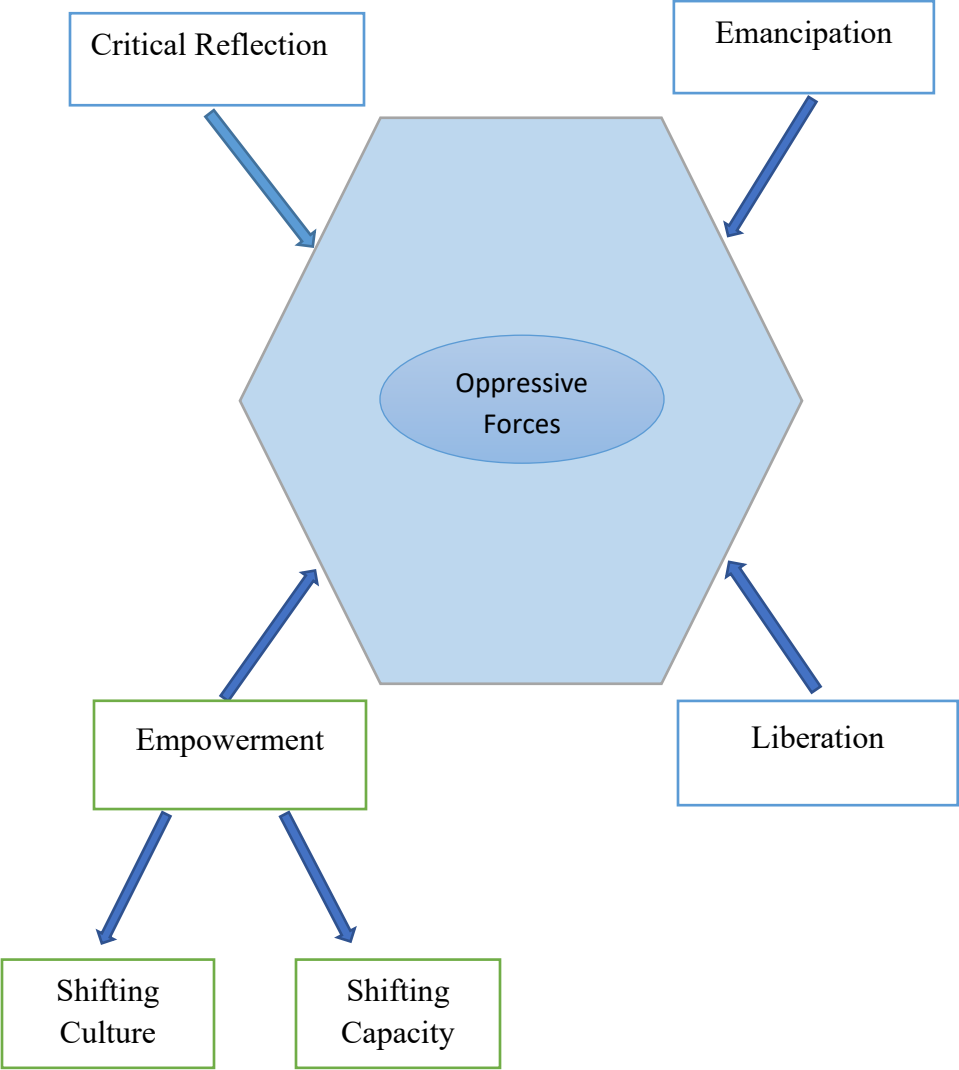
The complex environment where nursing and midwifery exist is not only characterised by issues related to social justice, lack of power and oppression, it is rather a social phenomenon which is entrenched in the global health care system (Lapum et al., 2012). This indeed poses a serious challenge to nursing and midwifery. The approach to dealing with this entrenchment requires nurse leaders and nurses to be aware of the position they are in, it requires a deep understanding of self which is a question of identity, and then knowing how to disentangle themselves from this web. It is further emphasised: "CST not only draws our attention to the underlying principle of oppression, it can also open the possibilities for learning about self and others from a place deep within" (Lapum et al., 2012, p. 28).

The CST's framework provides the tool for nurses and midwives to fully reflect on their plight. The reflection helps in understanding who nurses, and midwives are (professional identity) including a deep understanding of their strengths and weaknesses. The theory further calls nurses and midwives to act in the social and professional contexts, by acting against conditions leading to oppressive conditions by using a critical reflection tool. The action process for disentanglement has been given different names by different authors. It is referred to as liberation from oppression (Lapum et al., 2012); as emancipation (Duchscher, 2000); and as process for enlightenment, empowerment, and social justice (Manias & Street, 2000).

The framework used in this study proposes the need for cultural shift and shifting capacity for improved participation by nurses and midwives in future health care goals. These shifts require some changes to be made in workplaces (workplace culture), and in education by incorporating aspects of IPE and IPC. CST identifies three areas in which knowledge or skills from education is acquired. These cognitive orientations are referred to as technical interests, practical interests, and emancipatory interests (Wilson-Thomas, 1995, p. 573). According to Habermas (1971), technical interests refer to scientific knowledge, practical interests are educational skills required for communication and interactive purposes, and emancipatory interests are those skills related to understanding self, your abilities, constraints, and what you need to do to get out of those constraints. In other words, emancipatory interests are the knowledge, skills and awareness that leads to action which can release someone from constraints to a position of freedom, having a voice, and achieving professional recognition.

The CST therefore provides a tool for critical reflection on what needs to be done as part of the cultural and capacity shifts proposed in the framework of this study. CST provides awareness around those challenges that nurses, and midwives face namely oppression, segregation, disempowerment, lack of voice, and others. The principles underlying the CST may assist in bringing some positive changes, not only to the nursing and midwifery participation and the strengthening of the nursing and midwifery profession in Tanzania, but also in other contexts.

The call to action provided by the CST theory, will therefore be manifested, not only in the acquisition of practical/scientific and communicative knowledge, rather in the understanding and resolving social and professional constraints. This is what will get the nurses and midwives to a point of emancipation and the mastery of the social and professional context. A clear understanding of self as a social and professional group, with the help of the Social Identity Theory (SIT), and the Nursing and Management Theory (NMT) is also important.

6.6.2: The social identity theory

The SIT provides the basis through which individuals, organisations and professional groups identify and classify themselves. The SIT provides an individual with the personal and social positioning in relation to others (Willetts & Clarke, 2014). The SIT, not only provides the framework for personal and social identity, but also the acceptance of consequences of that identity and belongingness (Willetts & Clarke, 2014); (Ashforth & Mael, 1989). According to Ashforth & Mael (1989), the individual and group or social identities are essential in realising the group goals as well as the goals of the organisation. The behaviours, and successes shared from social and professional identities are essential in bringing coalition, oneness, strength, empowerment, and voice among group members. The uneasy relationship that nursing and midwifery professions have had with the medical profession over the years (Willetts & Clarke, 2014) would be improved through an understanding and application of the SIT.

The nursing and midwifery leadership would use the oneness from SIT framework as a platform for having a voice, and for inter-personal and inter-professional recognition and negotiation for

their current position in health care. Even in Western countries, nurses and midwives have put in a lot of effort to be where they are. Despite all these efforts, nursing and midwifery still experience obscurity about their social, professional identities and their professional contribution.

The literature is clear about the role to be played by SIT in providing the platform and voice very much needed for nursing and midwifery recognition which for many years were unable to be defined when compared to other professional groups in the health care context (Willetts & Clarke, 2014). It is the personal and social or group identities that would get nurses and midwives into the public discourse where such subjects as knowledge, values or principles that govern nursing and midwifery practice, as well as accountability would be discussed. It is emphasised further: "The public discourses construct identities and that these discursively constructed identities themselves become social realities….discourses associated with curriculum and pedagogy reveals nursing to be relatively weakly bounded discipline with poorly defined and articulated body of knowledge" (Fealy et al., 2018, p. 2159).

Although this study had no focus on nursing and midwifery identity, the SIT provides some areas of reflection as to what could be the weak link that may require to work on if nursing and midwifery professional stance is to be improved. This study has referred to nurses and midwives being the majority in the health care workforce. Yet still, being the majority has not stopped them from being excluded in decision-making forums, and as a result, they still lack voice. The nursing and midwifery leadership in Tanzania could use the knowledge and principles of the SIT to leverage oneness, coalition, solidarity, and cohesion, to influence and assert themselves to bring about cultural changes in workplaces and in the health care system. For this to happen, it will require a dynamic and motivated leadership committed to bringing about changes to the profession as proposed in the framework for future participation.

6.6.3: The nursing and management theory

This theory explains realities pertaining to the context in which management and nursing exist. The NMT explains and describes nursing activities and management functions in their day-to-

day work environment. Through NMT, nurse managers are provided with the framework to guide their work, how to manage their work environment, at the same time advancing the nursing practice (Sieloff & Raph, 2011).

The theory further outlines the functions and role of the managers in nursing and midwifery arena beyond mere clinical and leadership responsibilities to include the functions related to work environment that supports professional practice and patient outcomes. These functions include empowerment, engagement, enabling, and enhancement of the nursing work environment which are explained by the Structural Empowerment Model (SEM) shown in the diagram below.

Figure 6.9: The structural empowerment model
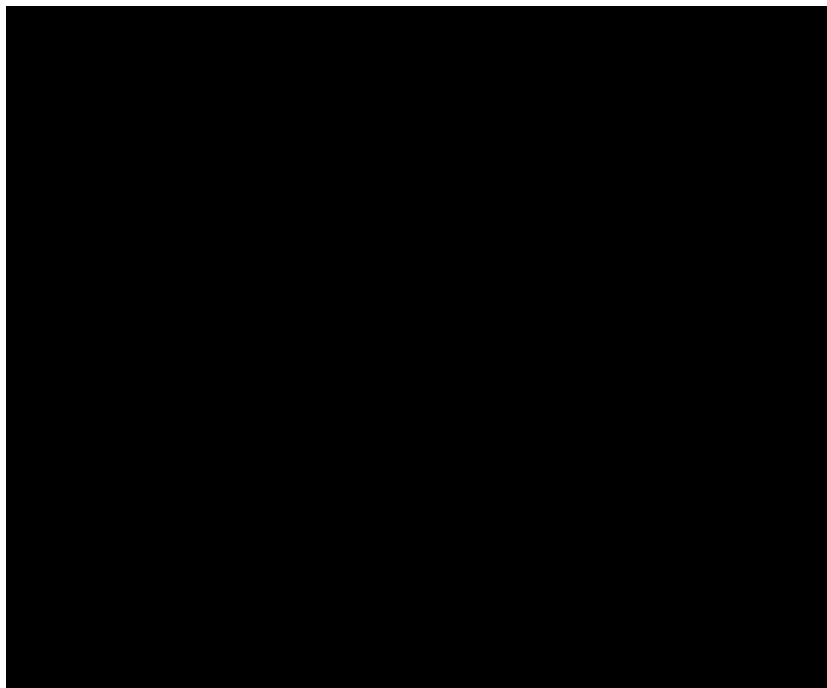
Source: Shelley Moore (2014).

According to the SEM, nursing leadership are key influencers for structural empowerment and various other factors which affect the nursing practice environment (Spence Laschinger, 2008). According to Tinkham (2013).

> Structural empowerment includes the organisational structure, personnel policies and programs, professional development, support, community outreach, and the health care organisation's promotion of positive nursing image. Structural empowerment centres on the idea that executive leaders can influence the professional practice of staff members by providing an innovative environment that supports collaboration and professional development (Tinkham, 2013, p. 253).

Structural empowerment, is concerned with employees' opportunities, access to organisational resources, the sharing of information, professional collaboration, and organisational support to boost their confidence, morale, autonomy and productivity (Nursalam et al., 2018).

The SEM recognises that a workplace is structured in such a way that management allows employees to have access to information and resources, which in turn contributes positively to employee empowerment. The SEM further recognises that empowered employees find meaning in what they do, they display autonomy and creativity, are involved in workplace decisions; they have opportunity to grow professionally, and they have greater contribution to the organisation and better services to the clients (Spence Laschinger, 2008; Tinkham, 2013).

As depicted in the SEM, the nursing and midwifery managers create conditions to empower nurses and midwives and give them a voice. Through IPE initiatives, nurses and midwives can effectively engage or participate in workplace activities and responsibilities to enhance their capacity and authority to solve clinical and professional challenges. Nurse managers can also enhance access to information and information sharing, access to resources and materials, collaboration, participation in decisions, having and the promotion of a positive nursing image. Through reflective practice, nurses and midwives have confidence, not only to be part of the

decision making, but also can improve their critical thinking and social skills. These are some of the findings reported by participants in this study; and these findings are in line with the SEM.

The NMT stems from the background that nursing has been a disadvantaged profession in the health care system; and this situation elicits the necessity to provide nurse managers with the framework to guide their actions which eventually will disentangle the nursing profession from the web of disadvantage. Literature is clear about the need to value nursing knowledge, and also the need to display actions and behaviours which will help to move away from oppression (Sieloff & Raph, 2011).

The NMT calls nurse managers to develop a critical mind to enable them to become aware of both the organisational, business and profit models, at the same time maintaining their contribution to advancing the nursing profession. The rationale, therefore, for nursing and management theory, as described in literature is "to offer relevance to work environments eager to foster nursing self-management and professional autonomy, ..and lack of nursing theory framework fosters oppressed group behaviour"(Sieloff & Raph, 2011, p. 979).

NMT as a concept contributes significantly to the delivery of quality health care services and its framework brings solution to several issues that hold back advancement in the health care sector. In the UK health sector, the NMT framework has been referred to as a 'third way', to signify that the current initiative of full utilisation of nursing capacity, cooperation and collaboration with other professions in health services delivery is expected to take the health care sector to a new level (Hewison & Stanton, 2002).

Nurse managers are called to adopt a critical practical perspective which strikes a good balance between their managerial and leadership roles with that of advancing the interests of their profession. The clear understanding of, and correct utilisation of the nursing and management theory will not only advantage the nursing profession but will also foster partnership with other stake holders within Tanzanian health care system, and eventual realisation of future health care goals including SDGs. This study has therefore added to the SEM three more concepts namely IPE, Giving Voice, and Reflective Practice as shown in the diagram below. By applying the SEM and NMT, nursing and midwifery leaders in Tanzania are expected to have a good

understanding of their context, including the challenges and opportunities for their profession. The findings from this study provides a platform for nursing and midwifery leadership to work from. Knowing that cultural environment withing Tanzanian health care system posed as an inhibiting factor for achieving MDGs 4 and 5 and knowing that nurses and midwives are the majority in their health care system makes them to appreciate it as an enabler. The SEM and NMT will therefore be the tools to be used for achieving the proposed changes as shown in the framework for future participation.

Figure 6.10: Improved structural empowerment model
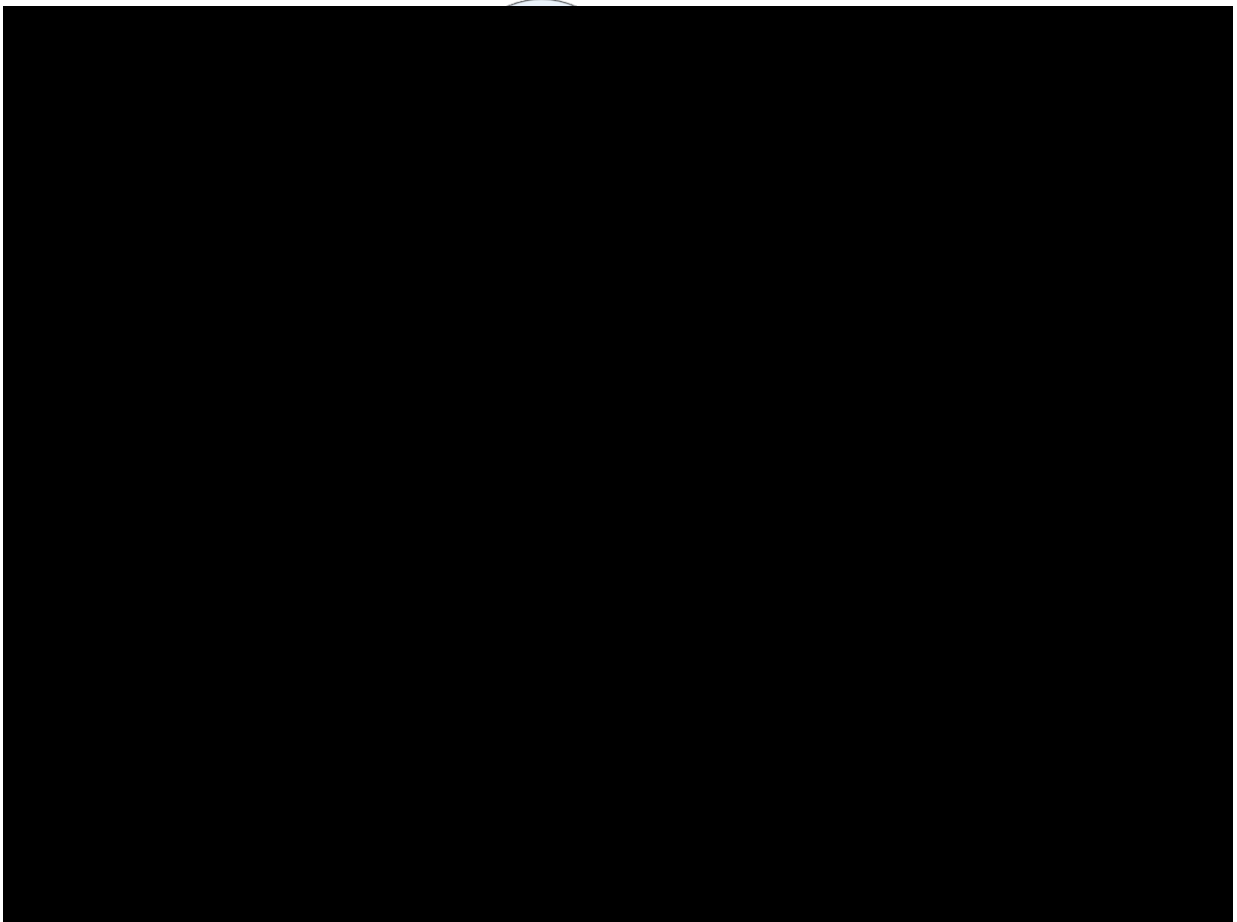
Adapted from Moore (2014).

6.7. Chapter six summary

This chapter discussed the findings of this study by describing the framework related to awareness, participation, and the Tanzanian context. The discussion of the findings was carried out in comparison with the relevant literature and conceptual framework. The challenges faced by nursing and midwifery include the dominance of the medical model, society culture such as the patriarchal system, suppressive work environment and unfavourable organisational culture, shortage of staff, high workloads, insufficient equipment and material supplies, lack of support, and lack of voice. Strong and committed nursing and midwifery leadership is required to empower staff and navigate the work environment and promote changes that will enhance advancement of the nursing and midwifery profession through practical strategies and action using the framework from Critical Social Theory, Social Identity Theory, and Nursing and Management theory. This study has added three concepts namely IPE, giving voice, and reflective practice to the current theory of SEM. The clear understanding and application of the CST, the SIT, and the new SEM by Tanzanian nurses and midwives will have positive impact which will not only advance nursing and midwifery, but also future realization of health care goals.

Chapter 7: Recommendations and Conclusion

7.0: Introduction

This study has contributed new knowledge about inhibiting and enabling factors to enhance the participation of Tanzanian nurses and midwives in MDGs during the period 2000 to 2015. The overall aim was to investigate, describe, and understand those factors with the intention to use the knowledge gained to improve nurses and midwives' participation in future national and global health care goals such as SDGs. This chapter will first summarise the framework and practical strategies for future participation, followed by a brief about the knowledge gained from this study. Implications for nursing practice, nursing education, nursing research, and nursing and midwifery leadership in relation to future health goals are discussed. The chapter ends with study limitations and final thoughts.

7.1: The framework for future participation

The framework for this study summarised the gaps in awareness and participation in the implementation of MDGs and offers a way forward on how nurses and midwives' participation in Tanzania can be enhanced in the future. A review of the context demonstrated that the settings in which nurses and midwives' practice, lacked effective communication, professional collaboration and inefficient information sharing about the implementation strategies for attaining the targets under MDGs 4 and 5. The health care system did not have enough human and material resources required for implementation of MDGs in clinical areas. Nurses and midwives had limited mobilisation, support, and participation in key decisions, including the implementation strategies. These limitations minimised their ability to use their full potentials, and this situation could be one of the reasons why the goals' targets were not attained.

Given the gaps mentioned above, nurses and midwives' participation in MDGs was reported to be mainly embedded in their practice. Their participation was mainly limited to doing their everyday normal duties; otherwise described as incomplete participation, or complete non-participation. The proposed framework, therefore, offers strategies for future participation which is discussed in section 7.3.

7.2: New knowledge gained through this study

The aim of this study was to investigate the enabling and impeding factors for nurses and midwives' participation in achieving MDGs. The study was premised on the fact that following the declaration of MDGs in 2000, the United Nations and the World Health Organizations issued documents that encouraged nurses and midwives to take an active role in the implementation of the health-related goals namely MDGs 4 and 5.

Firstly, the new knowledge that this study has contributed relates to revealing the enabling factors that impact on the nurses and midwives' participation in MDGs in the context of Tanzania. The findings from interviews, focus groups, and surveys have demonstrated that enabling factors pertaining to nurses and midwives were that nurses and midwives are closer to patients, and they are the link between patients; they are the majority of the health care workforce; they have administrative, clinical, and managerial knowledge and skills required for the implementation of planned health care goals. These are the factors that would be put to use as resources to attain the envisaged goals.

On the other hand, collected data revealed that the impeding factors included lack of a clear understanding of the goals to be implemented; and participation was limited to undertaking clinical work leading to incomplete participation. Nurses and midwives did not receive the required support, or empowerment, and encouragement to actively participate in the implementation of planned activities. Nurses and midwives were not sufficiently represented in the decision-making forums, and they experienced shortage of human and material support which at times led to being overworked. Also, there was lack of cooperation and information sharing among health care professionals; and not much of the information was directed towards improving the nurses and midwives 'capacity through provision of clinical training and educational support for the acquisition of required skills.

Secondly, following the MDG declaration and subsequent call by the UN and WHO in two published documents, there has not been enough research about nurses' and midwives' participation in MDGs in various countries. This study, therefore, adds to the scarce available literature describing the participation of nurses and midwives in MDGs, particularly in Tanzania.

Lastly, this study has identified strategies to improve and guide more participation of nurses and midwives in future global or national health care goals. This knowledge is presented through the framework used in this study which acts as guide for future strategies, and for helping nurses and midwives' cultural change and capacity building.

7.3: Strategies for future participation

Practical strategies for future participation by nurses and midwives were compiled through input from Tanzanian nursing and midwifery administrators and academics. The input from the administrators and academics was deemed essential since they are experienced people on the ground, they have knowledge about Tanzanian health care system, they have analytical, administrative, and clinical skills to contribute to the discourse on national and global health care goals. It was also identified that administrators who are also leaders, are influencers who could play a critical role in empowering nurses and midwives to have a voice in various health-related activities and decisions. The proposed future practical strategies were in line with the proposed framework for enhancing future awareness and participation. Areas covered in the framework, therefore are context, participation, cultural and capacity shifts.

In relation to context, the proposed strategies were that information sharing among staff at various levels of the health care system was an essential aspect. It was information sharing and effective communication among all stakeholders that would bring about the awareness and understanding of the goals and associated targets, strategies to be implemented, responsibilities, and accountability, improvement of skills and competencies. Additionally, a clear understanding of the goals would make it easy for staff in clinical and non-clinical areas to incorporate the goals and targets in their everyday work. Nurses and midwives were reported to be lacking voice in major decisions that affected their practice, including lack of representation in meetings and forums where major decisions about implementation strategies were made.

Understanding the concept of 'participation' was an essential aspect in proposing strategies for the future. Participation was understood to be involvement in decision-making, and involvement in the implementation of planned activities. Participation also meant nurses and midwives being part of the communication network for all plans, decisions and implementation strategies. It was

observed that effective future participation in SDGs would require learning from the successes and mistakes encountered during MDG implementation phase.

Strategies for effective participation in the future would require changes in workplace culture and improvement in staff capacity. Proposed cultural changes would be associated with introduction of IPC and IPE programs and curricula in colleges and workplaces. It was hoped that the introduction of IPC and IPE programs would create synergy among various health care groups, which in turn would be a catalyst for attaining future goals such as SDGs. Improved capacity would also include providing skills to staff through training; availability of equipment through improved budget; record keeping; effective coordination and record keeping; improved workloads through more nurse and midwife recruitment and training; and the use of technologies such as telehealth services particularly in rural areas. Nurses and midwifery leaders are key to these strategies.

7.4: Implications of the study

This study has provided new and significant insight into the enablers and barriers for Tanzanian nurses and midwives' participation in the Global Millennium Goals which were promulgated by the UN General Assembly in 2000. The contribution from this study has implications for Clinical Practice; Nursing Education; Nursing and Midwifery Research; and Nursing and Midwifery Leadership.

7.4.1: Implications for nursing and midwifery practice

The Critical Social Theory (CST) and Social Identity Theory (SIT) were used to discuss and reflect on the findings as well as the context in which nurses and midwives find themselves so that future actions may be taken. According to CST, nursing practice entails the application of scientific knowledge, the communicative or practical knowledge, and the critical or reflective knowledge. CST therefore is a tool to guide future education and acquisition of skills. SIT on its part, assists nurses and midwives to know who they are as a professional group, including knowing their strengths and weaknesses. It is this self-awareness that helps nurses and midwives

to navigate the complexity of the health care system which is full of challenges that nurses, and midwives must be aware of if they are to improve their nursing and midwifery practice.

This is how nurses and midwives' expectations are summed up. "With ever-changing processes and procedures and continuing advances in care, nurses are required to meet expectations placed on them by patients, management and the profession, in community and hospital settings, providing even more complex patient care to a range of people in a variety of environments" (Peate, 2018, p. 531). The dynamic environments, therefore, requires nurses and midwives to acquire a wide range of skills to enable them to carry out their clinical, and non-clinical responsibilities. There are many models that demonstrate what nursing practice entails. One of those models was developed by Lydia Hall, and the model is called "The Lydia Hall Model". This model is made up of three key components namely Care, Core and Cure. According to Hall's model, nursing practice is a humanistic activity involving hands and body (care); a relationship activity (core); and a scientific and knowledge activity (cure) (Pearson, 2007). In short, the care, core, and cure model of nursing practice, is about the application of the acquired hands-on skills, relationship skills, and the scientific knowledge to improve the patients' condition.

In today's complex health care system, nursing and midwifery practice requires acquisition of innovative and relationship skills beyond those intended to care for a patient. Nursing and midwifery practice must position itself to withstand a constantly evolving health service environment where health care is increasingly viewed as a commodity with increasing political and strategic influences. The interplay of political, business, and humanistic factors therefore means that nursing and midwifery practice adopt skills that will not only be based on humanistic care, core, and cure elements, rather the skills that will be in line with the everchanging environment. Communication and people skills, for example are relationship skills which go beyond the mare patient care where hands and body are used. In contemporary world, people skills are required to understand and deal with those other factors that have impact on nursing and midwifery profession, and the health care delivery in general.

This study has evoked insights about nursing and midwifery participation, and the study has discussed how participation in MDGs 4 and 5 is related to the context in which Tanzanian nurses and midwives carry out their practice. The results have shown that Tanzanian nurses and midwives face challenges related to lacking voice, insufficient resources, exclusion in key decision-making, as well as many other challenges that affect the nursing and midwifery profession. As Tanzanian nursing and midwifery is part of the global nursing and midwifery community, its practice will have to adjust to the current context characterised by global health care goals whose implementation needs nursing and midwifery voice and representation in various health care forums. Critical reflection on the context will require education and reflective skills that go beyond mere scientific and clinical knowledge, to include relational and emancipatory skills, in order to have a clear understanding of the social, political, and economic processes that affect health care delivery.

The SIT has been used in this study to assist nurses, midwives and their leaders in Tanzania to know that they already have an advantage of being knowledgeable and skilled enough to carry out the day to day clinical and administrative responsibilities needed to attain SDG's targets. Nursing and midwifery is also known to be the most trusted profession with the largest workforce globally (Peate, 2018). Being aware of the above-mentioned advantages is a good starting point, and hence is a step forward in advancing the nursing and midwifery practice. Besides implications for nursing and midwifery practice, there are also implications for nursing and midwifery education.

7.4.2: Implications for nursing and midwifery education

As already noted, the current nursing and midwifery's practice environment requires that nurses and midwives are equipped with the scientific knowledge and other professional and functional skills to enable them to carry out their clinical and non-clinical work confidently and efficiently. The findings from this study necessitated the development of the framework which will assist to guide areas requiring critical review and attention for future educational endeavors.

Tanzania has come a long way so far to professionalise the nursing and midwifery education. In 1989, Muhimbili University of Health and Allied Sciences (MUHAS), which is the main

University for health professionals opened its doors to the nursing and midwifery degree qualifications. Prior to 1989, all nursing and midwifery qualifications (diploma or certificate) were offered in public, private, and faith-based colleges. After the 1990s, private Universities in Tanzania were also allowed to offer bachelor's degrees in nursing, midwifery, also in nursing management. The aim was to address the shortage of qualified health care personnel, and to respond to the challenges that Tanzanian health care system faced which included the national population growth which needed improved and acceptable health care services from knowledgeable nurses and midwives (Mkony, 2012).

The scientific knowledge offered through the university, not only provides confidence to nurses and midwives, but also assists them in understanding the components of care, core, and cure. The professionalisation of nursing and midwifery education needs to go further and address those social political, structural contextual processes which will improve communication, give voice, support, and allow increased involvement in decision-making to nurses and midwives, at the same time lessen nurses and midwives' reliance on others for information. The education, therefore which provides knowledge and skills in those areas is essential in attaining future health goals including SDGs.

The findings from this study identified lack of IPC and IPE initiatives among health care professionals, insufficient clinical material resources, insufficient research involvement by nurses and midwives, gaps in clinical data management and recording for evaluating progress, and lack of empowerment strategies for nurses and midwives.
The findings therefore, offer an opportunity to critically examine the gaps within nursing and midwifery education, the aim being to re-focus on the actual challenges Tanzanian nurses and midwives experience within the current national and global health care system.

Nursing education must provide more places for entry into post-graduate studies, practical and technical skills in areas such as communication, relationships, negotiation, conflict resolution, advocacy, assertiveness, problem solving and self-consciousness, to mention just few. These are skills that can provide solid knowledge and opportunities to the profession. Post-graduate courses will allow more acquisition of research and more critical thinking skills. Assertiveness

training may be a solution to lack of voice, incomplete participation, gaps in communication, and improved advocacy. Assertiveness skills which are normally based on emotional and thought expressions, are instrumental in creating professional relationships, interactions, and positive work-place behaviors (Azizi, Heidarzadi, Soroush, Janatolmakan, & Khatony, 2020).

Earlier, the need for scientific knowledge in nursing practice was acknowledged. However, besides scientific knowledge, it is essential to reiterate the importance of knowledge and skills required to understand and critique the social context. It is the social critique that acts as a tool for understanding society and its work-place structure. The social critique brings awareness and it acts as lenses through which potential forces holding back professional advancement or factors for inclusion and exclusion may be visualised.

The nursing and midwifery professionals work collaboratively with other health care professions. The complex participatory, and collaborative contexts are part of the nursing and midwifery work environment. This environment therefore requires that nurses and midwives have both conceptual and critical thinking skills for participatory democracy. It has been observed that:

> Nurses that have the capability to think critically are more self-confident, have a broader perspective, are creative, flexible, have an inquiring mind and act with common sense, logically, honestly, and also with an open mind (İlhan, Sukut, Akhan, & Batmaz, 2016, p. 72)

The capability to think critically as well as self confidence among nurses and midwives who work in clinical areas may be enhanced through IPE and IPC programs. These IPE, IPC programs and curriculum changes will not only benefit nursing and midwifery but will also bring about positive impact to the health care system in general.

7.4.3: Implications for nursing and midwifery research

One way of actively getting involved in global health dialogue is through research. From the time when nursing and midwifery education started being offered at Universities in Tanzania, the nursing and midwifery curricula emphasised the development of research skills starting from undergraduate through to post graduate studies. Nurses and midwives in administration and in

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clinical areas were being encouraged to incorporate research skills in their day-to-day care delivery and responsibilities including documentation and management of records as part of best practice. There is evidence from the UK and elsewhere in the world which shows that nurses are leading initiatives to transforming people's lives through action research in various clinical and non-clinical areas (Jelfs, 2017).

This study recommends incorporation of research in all nursing and midwifery education and clinical practice in Tanzania. This recommendation does not mean that no research is being conducted by nurses or midwives in Tanzania, but it simply means that research curricula could be critically examined particularly for institutions that offer post-graduate nursing and midwifery qualifications to identify potential gaps, and to ensure that graduates from those institutions have required skills to understand research. Additionally, this recommendation is about putting in place policy, budget and scholarship that allow academics in nursing and midwifery areas to carry out research and publications that contribute to available literature in the field.

As reported in the findings for this study, the timely records keeping, and appropriate documentation of care given during the MDG phase would be essential for research and for evaluating the attainment of the MDG targets. It is therefore the nursing and midwifery leadership that would be responsible for creating conditions favorable for incorporating research as part of the nursing and midwifery practice in Tanzania.

7.4.4: Implications for nursing and midwifery leadership

In the previous chapter, the role of nursing and midwifery leadership was discussed, and the point was made that nursing and midwifery leadership is central for giving guidance and support to nurses and midwives, as well as paving the way for a strong and reputable nursing and midwifery profession. It can also be mentioned that the proposed framework to improve participation in future health care goals very much depends on the contribution from nursing and midwifery leadership. It is this leadership that will take the front seat in understanding the context, create, shape, or influence the work culture favourable for nursing and midwifery practice, and the creation of empowering structures, or support systems within the Tanzanian health care system. The nursing and midwifery leadership is also expected to outline education

and skills acquisition that will enable nurses and midwives to carry out their clinical and non-clinical duties confidently, while also maintaining and protecting the space for nursing and midwifery practice. This could be done through a thorough review of curricula in nursing colleges and universities; lobby for curricula and policy changes, cooperation with national stakeholders; empowerment strategies; and partnerships with local and international stakeholders and organisations. The WHO is one example of an international stake holder that already has a strategic plan and framework that empowers and supports nurses and midwives in an effort to improve global health and is committed to attaining SDGs targets (Upvall & Leffers, 2014). This is also true for the International Council of Nurses and International Confederation of Midwives. Empowerment, for example, could be used for making the difference, and for sustaining nursing and midwifery practice in the current changing health care environment. In an organisational context, empowerment initiatives would include abilities to access information, resources, or support to enable employees to do their work effectively (Tibandebage et al., 2016). It is further observed: "A body of research argues that empowerment of nurses, that is, enabling nurses to act, to obtain power, influence, is essential in professional development and effective health care" (Tibandebage et al., 2016, p. 380).

The contribution of the nursing and midwifery leadership in a contemporary health care environment goes beyond empowerment, giving guidance or support to nurses and midwives. There is a dimension of pedagogic influence, relational initiatives and partnerships intended for capacity building within the profession. Capacity building refers to "abilities, behaviours, relationships, and values that enable individuals, groups, and Organisations at any level of society to carryout functions or tasks and to achieve their development objectives over time" (Upvall & Leffers, 2014, p. 149). Effective capacity building for the creation of conducive nursing and midwifery environments will undoubtedly require nursing and midwifery leadership to focus, not only on nurses or midwives, but also on influencing organisational and system change. This micro (staff and patients), meso (organisational), and macro (system) influences is an essential process for professional sustainability (Asthana, Jones, & Sheaff, 2019). In a health context, capacity building should be understood to have both, national and international dimensions.

At the national level, capacity building initiatives are directed towards improving available local human, infrastructural and health care services (Koto-Shimada, Yanagisawa, Boonyanurak, & Fujita, 2016). This involves improving education institutions, improving knowledge, skills, having access to equipment and facilities to foster positive changes and efficiency. Capacity building also allows people to become more resilient and participants in decision-making, work collaboratively with other health care professionals, have access to information, resources and to have a voice.

At the international level, capacity building emphasises connectedness, collaboration, partnerships, and the sharing of information, resources, and solutions to health care challenges and research initiatives between and among countries (Upvall & Leffers, 2014). Global capacity building is therefore an essential component of the nursing and midwifery leadership. It is this component that requires high level communication, collaboration, self-awareness, cultural competencies, and negotiation skills. Through capacity building programs and initiatives nurses and midwives will be able to perform beyond mere bed side skills. The analytical knowledge of the context, practical, negotiation, collaborative, and partnership skills will undoubtedly make nurses and midwives equal contributors and participators in future national and global health care goals.

7.4.5: Implications for health care policy

There were many social economic and political challenges that contributed to MDGs 4 and 5 not being attained by many LMIC (Mukuru et al., 2021). One of the challenges encountered during MDGs in many countries was the absence of a policy framework to guide the implementation of the goals, and this challenge was reported at national and global levels (Waage et al., 2010b). The initiatives for reduction of child mortality and improvement of maternal health which were the targets for MDGs 4 and 5 respectively are part of the Universal Health Coverage (UHC). The UHC entails basic health services to the people without incurring any financial cost, and PHC is an important part of PHC (Ajuebor et al., 2019).

In its efforts to strengthen the health workforce globally, the Global Strategy on Human Resource for Health (GSHRH) works with WHO, the International Council of Nurses (ICN), and

International Confederation of Midwives (ICM) to strengthen nursing and midwifery profession. GSHRH also advocates for enactment of policy frameworks to guide implementation of various health global targets related to UHC, PHC, MDGs, and SDGs (Ajuebor et al., 2019).

The findings for this study uncovered a gap in policy framework to guide the implementation of MDGs 4 & 5. The findings uncovered lack of awareness, lack of information sharing, lack of empowerment to nurses and midwives, as well as the absence of cooperation and collaboration through IPC programs. The gap in policy framework therefore might have had negative impact to nursing practice and the outcome envisaged under MDGs 4 & 5. The need to attain SDG 3 (good health and wellbeing), therefore gives a reason for putting in place comprehensive policies to guide the implementation of health targets. The study carried in Uganda confirmed that one of the factors leading to inability for Uganda to attain the targets under MDG 5 was the absence of comprehensive and effective policy framework for interventions (Mukuru et al., 2021). While it is understood that nurses and midwives constitute the majority of the health care workforce in most countries, they still experience unique challenges such as lack of participation and representation in key-decisions, lack of representation in policy-making bodies, and the profession is not supported in areas such as IPC and IPE programs (Ajuebor et al., 2019). It is therefore hoped that a comprehensive policy framework designed around the guide for interventions to be performed, the sharing of information among various professional groups in health care, cooperation and collaboration, empowerment and wider participation of nurses and midwives, as well as leadership and accountability, will benefit Tanzania, and it will increase the chances of attaining the targets under MDGs 3.

7.5: Summary of recommendations

The following summarises the recommendations made from this study.

7.5.1: Nursing practice

- An understanding of the strengths and weaknesses of the nursing and midwifery profession; crucial in deciding the way forward for the future implementation of health care goals and SDGs.

- The creation of a policy framework, planning and consultative processes, institutional support, and mobilisation of nurses and midwives which will enable participation in SDGs and other important national health care goals.

- The Government of Tanzania through the Ministry of Health, Community Development, Gender, Elderly and Children to recruit and train adequate numbers of nurses and midwives to provide services at all levels of the health care system, including the rural and urban settings. This will help to cover the gap of high workload experienced by nurses and midwives. High workload was reported in the findings as one of the inhibiting factors in realising the MDGs targets. The absence of this gap will no doubt enable nurses and midwives to effectively participate in the SDG implementation plans and activities.

- Tanzania Nurses and Midwives Council, Tanzanian National Nursing Association, and Tanzanian Midwives Association to create empowering conditions required for nursing practice in Tanzania and the use of CPD credits in such areas as SDGs, assertive communication, clinical competencies, and others. This will be essential in increasing awareness on SDGs, and it will give voice to nurses and midwives important for effective participation in health and professional-related programs.

- The use of events such as annual nursing and midwifery day will increase awareness about SDGs since these are special days with specific themes that attract the presence of large gathering of nurses, midwives, and media.

7.5.2: Nursing and midwifery education

- Design curriculum for nurses and midwives that goes beyond scientific knowledge to allow acquisition of analytical, critical, and reflective skills.

- Curriculum for nurses and midwives that will include modules about IPE and IPC and how these can be applied in current practice and through student placements.

- Higher education to have emphasis on relational, negotiation, partnerships, and research skills necessary for cooperation in national, international, and global health initiatives.

- To incorporate, in nursing and midwifery curricula the modules on critical social theory, the social identity theory, and other related theories so they may use these theories for reflective practice.

- To offer more postgraduate and professional development programs. Postgraduate education will not only give to nurses and midwives analytical knowledge and research skills, but also will enhance the standing of the nursing and midwifery profession. Professional development skills (CPD) are important in maintaining the professional credentials and competencies essential for clinical practice.

7.5.3: Nursing and midwifery research

- More research is needed to investigate the participation of nurses and midwives in the implementation of MDGs and SDGs in as many Low and Middle-Income Countries (LMIC).

- The research on how effective WHO's Global Strategic Directions for Strengthening Nursing and Midwifery (2016 – 2020) would also be essential in evaluating the uptake of these initiatives in various countries.

- A comparative study between pre-and post MDGs/SDGs and how Tanzanian nursing and midwifery has adjusted its professional practice.

- Access to research infrastructure and facilities including well-resourced libraries and data bases, research funding and available scholarships for postgrad education.

7.5.4: Nursing and midwifery leadership

- Plans to improve leadership and skills capacity for leaders of the nursing and midwifery organisations in Tanzania. This would include benefiting from ICN's strategies such as the annual Global Nursing Leadership Development Program.

- Lobby to establish a culture in workplaces and within the health care system that gives voice and participation to nurses and midwives.

- Empower nurses and midwives as part of the process to attain gender equity and rights already underway in Tanzania.

- Establish partnerships with local organisations such as Tanzania Media Women's Association (TAMWA) and other NGOs with experience in addressing women's rights, advocacy, and professional equality in Tanzania.

- Utilise the principles and understanding of the SIT and CST to effect positive changes that benefit the nursing and midwifery profession and practice in Tanzania

7.5.5: Implications for health care policy

Enact comprehensive policies to guide implementation of SDGs. Policies that will give clarity to areas such as responsibilities, communication, and collaboration between health care professionals.

To enact policy/policies that will not bypass or under-utilise the contribution of nurses and midwives in the implementation of SDGs and future health care goals

Support the initiatives, and collaborate with other international NGOs such as GSHRH, ICN and ICM in their effort to offer support and strengthen the nursing and midwifery profession.

Policy that ensures equity in access to health care through UHC and PHC services especially for people in rural and remote areas.

Put in place platforms that allow nurses and midwives to be represented in key policy decisions, or platforms that will enable them to make recommendations to policy makers on matters related to health care services' delivery.

7.6: Study limitations

This study has some limitations that must be acknowledged. The first limitation is that the data collection methods used in this study (survey, interviews, and focus group discussions) were conducted in Kiswahili which is the national language of Tanzania. Although the participants who contributed to the data collection understood English and Kiswahili very well, there was potential risk that some words could lose meaning during translation and data transcription.

The next limitation was that the results for this study were based on a single case study, and the data were collected from five hospitals in two regions of Tanzania. The findings from this single case study may therefore not be generalisable for all hospitals, regions, and districts in the whole of Tanzania.

Yet another limitation was that there was limited information about the hospitals involved in this study as outlined in section 3.14. For example, there were limited, or no information related to staffing, the population that the hospitals serve, and other important details that would have enriched the study.

The final limitation is that participants in this study were nurses and midwives who worked only in medical-surgical wards, antenatal, and postnatal clinics in hospital settings. The study did not include nurses or midwives working in areas such as operating theatre, community settings, primary health care, and any health service level below a district hospital. Only data collected from Kabanga hospital involved few nurses and midwives who also provided community outreach services in the hospital's catchment areas. Although nursing and midwifery services may be similarities between the settings involved and those not involved in this study, it is important to note that the views given by participants may not represent the views of all nurses and midwives who worked in areas not involved in the study.

7.7: Final thoughts

This study examined the participation of Tanzanian nurses and midwives during the phase of Millennium Development Goals (2000 to 2015). Out of the eight Millennium goals, this study limited itself to goals 4 and 5 (Reduce child mortality, and Improvement of maternal health, respectively). A reference to nurses' participation was also made in relation to the documents that were released by the UN and WHO to affirm their support to the nursing and midwifery professional group as key stake holders in global health.

Despite this acknowledgement by the UN and WHO, not everyone agreed with their view, and as a result, nurses and midwives continue to experience various challenges, including being sidelined when it comes to matters related to health care policy and important decisions. Nursing and midwifery as a profession still has a long way to go before it can overcome the obstacles which limit advancement in the profession, and its professional practice.

Tanzania may learn from nurses and midwives in other countries that have gone through similar experiences as those currently holding back the advancement of the nursing and midwifery profession in Tanzania. This study has recommended what could be done to improve participation for nurses and midwives; and also, to improve the nursing and midwifery image in Tanzania. The responsibility remains with the Tanzania Midwives Association, Tanzania National Nurses Association; and Tanzania Nursing and Midwifery Council (TNMC) to play a leading role in strengthening and positioning the nursing and midwifery profession to a point where it is recognised as equal player and partner in advancing the health care system in the country and globally. This responsibility is by no means easy, and as such it should be considered as a process. Each nurse leader will have to play their part in making sure that there is collaboration among various health care professionals. Nursing and midwifery leaders will be required to empower, educate, and provide required competencies to nurses and midwives, they will advocate for cooperation and stand for their participation in decision-making in order that the common goals for the health care system are attained. Although changes may be slow, but their consistent effort will eventually take the nursing and midwifery profession to the desired outcome. The following are motivational words that sum up future directions:

The Nursing Profession, that so-called "sleeping giant" is widely awake and ready to race ahead in clearly defined strategic directions. You are waiting for the starting gun. Even more so, you are waiting for someone to let up the reins that hold you back, the constraints that keep you from performing with the full set of competencies for which you were educated, trained, and licensed……Given the enormous complexity of health challenges faced as the world transitions to the post-2015 era, no one…… dares to ignore the full contribution that the nursing profession can make……the starting gun has sounded (Rosa, 2017, p. 17).

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Appendices

Appendix 1: The survey questionnaire

THE UNIVERSITY OF
NOTRE DAME
A U S T R A L I A

Answer all questions from part 1 to part 6.
Tick the relevant option and give additional information as per questions.

PART 1: <u>Participants Details</u>

1. What is your gender?
   - Male
   - Female

2. What is your age?

   18 – 28 years
   29 – 38 year
   39 – 48 years
   49 – 58years
   59 – 68years
   69+years

3. What is your employment status

   Permanent full time
   Permanent part-time
   Contract
   Casual

4. How long (in years) have you been nursing?

   0 – 5
   6 – 10
   11 – 15
   16 – 20
   21 – 25
   25+

5. What is your designation?

   Enrolled Nurse
   Assistant Nursing Officer;

Nursing Officer; Midwife ☐

6. In which of these regions do you work?

Dar-es-Salaam; ☐
Kigoma ☐

PART 2: <u>MDG's Awareness</u>

1. Have you heard about "Millennium Development Goals"?
   Yes ☐
   No ☐

2. If you answered "YES" in the above question, how did you hear about them?

   From my supervisor and colleagues ☐
   From work meetings
   From workshops/forums ☐
   From newspapers/TV/magazine/internet ☐
   From other sources. ☐
   Please name them
   ……………………………………………………………………………………………
   ……………………………………………………………………………………………
   ……………………………………………………………………………………………
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3. Have you heard about the target to reduce the under 5 years mortality rate set by the government of Tanzania?
   Yes ☐
   No ☐

4. If you answered "YES" in question 3 above, how did you hear about it?

   From my supervisor and colleagues ☐
   From work meetings ☐
   From workshops/forums ☐
   From newspapers/media/internet ☐
   From other sources. ☐
   Please name the source
   ……………………………………………………………………………………………
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5. Have you heard about the target to improve maternal health set by the government of Tanzania?

    Yes   ☐

    No   ☐

6. If you answered "YES" in question 5, how did you hear about it?

    From my supervisor   ☐

    From work meetings   ☐

    From Colleagues   ☐

    From workshops/Seminars/forums   ☐

    From newspapers/magazine/internet   ☐

    From other sources.   ☐

    Please name the source

…………………………………………………………………………………………

…………………………………………………………………………………………

……………………………………………………………………………………..

7. Do you read articles about nurses' role and responsibilities in other countries?

    Yes   ☐

    No   ☐

8. If "YES", why do you like to know about nurses' role and responsibilities in other countries?

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………………………………………………………………………………………..

9. If you answered "NO" in question 7, would you like to read about them?

    Yes   ☐

    No   ☐

    Please give reasons for your answer

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………………………………………………………………………………………..

……………………………………………………………………………………….

10. How important would information about nurses' role and responsibilities in other parts of the world be to you?

Not important at all	☐
Somehow important	☐
Important	☐
Quite important	☐

PART 3: <u>Participation in MDGs</u>

1. Did you participate in implementing the MDGs?

Yes	☐
No	☐

2. If you answered "YES" to the above question, how did you participate?

………………………………………………………………………………………………
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3. If you participated in implementing the MDGs why did you participate?

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4. If you did **not** participate in implementing the MDGs what were your reasons?

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5. Did you get involved in work meetings to discuss how to improve child health and keeping records such as immunization, births and deaths?

Yes	☐
No	☐

6. If you participated in work meetings mentioned in question 5, what were the reasons given for keeping the records?

....
....
....
....
....

7. Did you get involved in work meetings on how to improve antenatal and postnatal care record keeping?

Yes

No

8. If you participated in work meetings mentioned in question 7, what were the reasons given for maternal care record keeping?

…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

9. Did you participate in seminars/workshops/forums outside your work area to discuss how to improve maternal or child health and record keeping?

Yes

No

10. Who participates in the seminars/workshops/forums outside your work to discuss how to improve maternal or child health and record keeping?

Assistant Nursing Officers

Nursing officers and Midwives

Doctors

Policy makers

Politicians

Other people.

Please mention if you know their job titles

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……………………………………………………………………………………
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PART 4: <u>Inhibitors to participation</u>

1. Do you think nurses and midwives fully participated in the implementation of MDGs related MDGs 4 & 5 (maternal and child health?)

    Yes

    No

2. If "YES" to question 1, why do you think nurses and midwives fully participated?...
    ....
    ....
    ....
    ....

3. If you answered "NO" to question1, what were the reasons for nurses and midwives not to have fully participated in MDGs 4 and 5 (maternal and child health)……………………………………………………………………………………
    ……………………………………………………………………………………………
    ……………………………………………………………………………………………
    ……………………………………………………………………………………………..

4. Do you think nurses and midwives were among decision makers on matters related to MDGs 4 and 5 (maternal and child health) in their work places?

    Yes

    No

    Please give reasons for your answer………………………………………………..
    ……………………………………………………………………………………………
    ……………………………………………………………………………………………
    ……………………………………………………………………………………………
    ……………………………………………………………………………………………
    ……………………………………………………………………………………………

5. Do you think nurses and midwives were among decision makers on matters related to MDG 4 & 5 (maternal and child health) at district or regional or national levels?

    Yes

    No

Please give reasons for your answer

…………………………………………………………………………………………

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6. Which of the factors listed below would have been important in improving nurses and midwives' participation in MDGs 4 & 5 (improved child and maternal health)?

You can choose more than one factor

Better education ☐
Experience in health care policy ☐
Experience in health care planning ☐
Support to nurses and midwives ☐
Better nurses and midwives' image ☐
More opportunities for nurses ☐

PART 5: Future Participation

3. In future, how would you like to see nurses and midwives participate in important health related decisions in workplaces?

Less participation ☐
Same participation as today ☐
More participation. ☐

Please give reasons for your answer

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4. In future, how would you like to see nurses and midwives participate in important health related decisions at district, or regional or national levels?

Less participation ☐
Same participation as today ☐
More participation ☐

Please give reasons for your answer

……………………………………………………………………………………

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PART 6: <u>Response to the United Nations and the World Health Organisation support for nurses and midwives</u>

5. In recent years, did you observe nurses and midwives being encouraged to participate in decisions related to MDGs 4 and 5?

    Yes
    No

2. In recent years, have you observed nurses and midwives being encouraged to participate more in decisions that are important to their work and to nursing?

    Yes
    No

3 If you answered "YES" to the above questions 1 and 2, who encouraged nurses to participate?
    ……………………………………………………………………………………
    ……………………………………………………………………………………
    ……………………………………………………………………………………
    ……………………………………………………………………………………
    ……………………………………………………………………………………

4. If you answered "NO" to questions 1 and 2 above, why do you think nurses and midwives were not being encouraged to participate?
    ……………………………………………………………………………………
    ……………………………………………………………………………………
    ……………………………………………………………………………………
    ……………………………………………………………………………………
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COULD YOU PLEASE INDICATE IF YOU ARE WILLING TO PARTICIPATE IN THE FOCUS GROUP DISCUSSION?

Yes
No

Appendix 2: The focus group questions

THE UNIVERSITY OF
NOTRE DAME
AUSTRALIA

Focus group questions will be formulated to collect information related to improving child and maternal health (MDG 4 & 5). These questions are intended to supplement information obtained from the survey in order to satisfy research questions as follows:

1. Do you think nurses and midwives in Tanzania fully participated in MDGs 4 & 5 implementation?

   Je, unadhani kuwa wauguzi na wakunga hapa Tanzania walishiriki ipaswavyo katika utekelezaji wa malengo ya maendeleo ya Millenia number 4 na number 5? (kuboresha afya ya uzazi ya akina mama na watoto)?

2. Did nurses and midwives participate in MDGs 4 & 5 as stake holders?

   Je, unadhani wakunga na wauguzi walishiriki katika utekelezaji wa malengo ya Milenia kama wadau?

3. Do you believe that nurses and midwives were sufficiently mobilized and given enough support during the implementation of MDG 4 & 5?

   Je, unaamini kuwa wauguzi na wakunga walihamasishwa vyakutosha na kupewa msaada unaotosha katika utimizaji wa malengo ya Millenia numba 4 na namba 5 (kuboresha afya ya uzazi ya akina mama na watoto)?

4. What would you recommend being done in order to improve the nurses and midwives' participation for future implementation of similar goals?

   Ungependekeza nini kifanyike katika kuboresha ushiriki wa wauguzi na wakunga katika utekelezaji wa baadaye wa malengo ya maendeleo kama ya Millenia?

Appendix 3: Interview questions

THE UNIVERSITY OF
NOTRE DAME
A U S T R A L I A

The interview questions for non-clinical staff will cover themes related to how information about MDGs 4 & 5 was communicated to nurses and midwives. Also nurses' participation in those MDGs inside and outside their work places; future participation in future health related goals goals; and the support to nurses and midwives.

1. How did nurses and midwives first hear about Millennium Development Goals?

   Je, unadhani wakunga na wauguzi walipataje taarifa ya malengo ya Milenia kwa mara ya kwanza?

2. Do you think nurses and midwives fully participated in MDGs 4 & 5?

   Je, unadhani wauguzi na wakunga walishiriki ipasavyo katika utekelezaji wa malengo ya Milenia namba 4 & 5?

3. Did nurses and midwives in Tanzania participate in decisions related to MDGs implementation activities as stake holders?

   Je, unadhani wauguzi na wakunga walishiriki ipasavyo katika maamuzi na shughuli za utekelezaji wa malengo ya Milenia kama wadau?

4. How were the nurses and midwives encouraged, mobilized and supported by MOHSW as part of the implementation of MDGs

   Je, unadhani wauguzi na wakunga walihamasishwaje na Wizara ya Afya na ustawi wa jamii na kupewa msaada wanaostahiri katika mpango mzima wa utekelezaji wa malengo ya Milenia?

5. What would you recommend being done in order to improve the nurses and midwives' participation in future implementation of similar goals?

   Ungependekeza nini kifanyike katika kuboresha ushiriki wa wauguzi na wakunga katika utekelezaji wa baadaye wa malengo ya maendeleo kama ya Milenia?

Appendix 4: Ethics approval from Notre Dame University

THE UNIVERSITY OF
NOTRE DAME
AUSTRALIA

CELEBRATING
25 YEARS
1989 - 2014

19 Mouat St (PO Box 1225) Fremantle WA 6959
+61 8 **9433 0555** | enquiries@nd.edu.au

30 August 2016

Dr Carol Piercey & Mr Peter Taratara
School of Nursing & Midwifery
The University of Notre Dame, Australia
Fremantle Campus

Dear Carol and Peter,

Reference Number: 016127F

Project title: "Participation of Tanzanian nurses and midwives in the implementation of millennium development goals 4 and 5: The reduction of child mortality and improvement in maternal health: A case study."

Your response to the conditions imposed by the university's Human Research Ethics Committee, has been reviewed and assessed as meeting all the requirements as outlined in the *National Statement on Ethical Conduct in Human Research* (2014). I am pleased to advise that ethical clearance has been granted for this proposed study.

All research projects are approved subject to standard conditions of approval. Please read the attached document for details of these conditions.

On behalf of the Human Research Ethics Committee, I wish you well with your study.

Yours sincerely,

Dr Natalie Giles
Research Ethics Officer
Research Office

cc: A/Prof Caroline Bulsara, SRC Chair, School of Nursing & Midwifery

Appendix 5: Ethics approval from National Institute for Medical Research

THE UNITED REPUBLIC OF TANZANIA

National Institute for Medical Research
3 Barack Obama Drive
P.O. Box 9653
11101 Dar es Salaam
Tel: 255 22 2121400
Fax: 255 22 2121360
E-mail: headquarters@nimr.or.tz

Ministry of Health, Community
Development Gender, Elderly & Children
6 Samora Machel Avenue
P.O. Box 9083
11478 Dar es Salaam
Tel: 255 22 2120262-7
Fax: 255 22 2110986

NIMR/HQ/R.8a/Vol. IX/2334

27th October 2016

Peter Taratara
University of Notre Dame, Australia
C/O Dr Edith Tarimo, School of Nursing, MUHAS
P O Box 65004, DAR ES SALAAM

**CLEARANCE CERTIFICATE FOR CONDUCTING
MEDICAL RESEARCH IN TANZANIA**

This is to certify that the research entitled: Participation of Tanzanian Nurses and Midwives in the Implementation of the Millennium Development Goals 4&5: The Reduction of Child Mortality and Improvements of Maternal Health: A Case Study, in Kigoma (Taratara P *et al*) has been granted ethical clearance to be conducted in Tanzania.

The Principal Investigator of the study must ensure that the following conditions are fulfilled:

1. Progress report is submitted to the Ministry of Health, Community Development, Gender, Elderly & Children and the National Institute for Medical Research, Regional and District Medical Officers after every six months.
2. Permission to publish the results is obtained from National Institute for Medical Research.
3. Copies of final publications are made available to the Ministry of Health, Community Development, Gender, Elderly & Children and the National Institute for Medical Research.
4. Any researcher, who contravenes or fails to comply with these conditions, shall be guilty of an offence and shall be liable on conviction to a fine. NIMR Act No. 23 of 1979, PART III Section 10(2).
5. Site: Maweni and Kabanga Hospitals in Kigoma region

Approval is for one year: 27th October 2016 to 26th October 2017.

Name: Dr Mwelecele N Malecela

Signature
**CHAIRPERSON
MEDICAL RESEARCH
COORDINATING COMMITTEE**

Name: Prof. Muhammad Bakari Kambi

Signature
**CHIEF MEDICAL OFFICER
MINISTRY OF HEALTH, COMMUNITY
DEVELOPMENT, GENDER, ELDERLY
&CHILDREN**

CC: RMO   **Kigoma**

         DED Kigoma
         DMO Kigoma

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Appendix 6: Ethics approval from Muhimbili University

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
OFFICE OF THE DIRECTOR OF RESEARCH AND PUBLICATIONS

P.O. Box 65001
DAR ES SALAAM
TANZANIA
Web: www.muhas.ac.tz

Tel G/Line: +255-22-2150302/6 Ext: 1016
Direct Line: +255-22-2152489
Telefax: +255-22-2152489
E-mail: drp@muhas.ac.tz

Ref. No.2016-10-18/AEC/Vol.XI/296   18th October, 2016

Mr. Peter Taratara,
c/o Dr. Edith M. Tarimo,
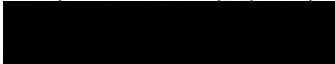Department of Nursing Management,
School of Nursing,
MUHAS.

Re: Approval for Ethical Clearance for a PhD Study Titled "Participation of Tanzanian Nurses and Midwives in the implementation of the millennium development goals 4 & 5: The reduction of child mortality and improvement of maternal health: A case study"

Reference is made to the above heading.

I am pleased to inform you that the Chairman has on behalf of the University Senate, approved ethical clearance of the above mentioned study, based on recommendations of the Expedited Review Sub-Committee of the Senate Research and Publications Committee meeting held on 28th September, 2016.

The validity of this ethical clearance is one year effective from 28th September, 2016 to 27th September, 2017. You will therefore be required to apply for renewal of ethical clearance on a yearly basis if the study is not completed at the end of this clearance. Permission to publish your study findings should be sought from appropriate authorities at MUHAS.

You will be expected to provide adverse events report where applicable, six monthly progress reports and a final project report upon completion of your study.

Dr. Joyce R. Masalu
Ag.Chairperson, Senate Research and Publications Committee

c.c. Dean, School of Nursing, MUHAS.

Dear Sir/Madam

My name is Peter Taratara. I am an Australian registered nurse currently practicing in Western Australia and am enrolled in a PhD program at the University of Notre Dame in Western Australia. The purpose of my research is to investigate nurses and midwives' participation in the implementation of the Millennium Development Goals 4 and 5 (reducing child mortality and improving maternal health) in Tanzania.

It is hoped that the findings of this study will assist in understanding factors that facilitate or inhibit nurses and midwives' participation in key health agendas. It is anticipated the research will propose strategies to improve the nurses' participation in future similar health goals, as well as enriching the available literature on the UNs and the WHOs call to enhance nurses and midwives' visibility in key health decisions. This is vital since nurses and midwives are the largest group among the health care professionals who can play a prominent role in goals implementation decisions.

This letter seeks your permission to be interviewed by the researcher Peter Taratara. The type of questions that will be asked during the interview will cover areas related to how information about MDG 4 & 5 was communicated to nurses and midwives, how they participated in MDGs in and outside their workplaces, as well as how the UNs and the WHO's call was received. The interview will be conducted at a place and time at your convenience. It is anticipated that the interview will take between 30 – 60 minutes.

I can be contacted on the e-mail ▮▮▮▮▮▮▮▮▮▮ or on the phone………………..should you have any questions or need clarification.

Thank you in advance.

Yours sincerely

Peter Taratara
PhD Candidate

Appendix 8: Letter to non-clinical staff – Kiswahili

Mpendwa Bwana/Bi,

Jina langu ni Peter Taratara na ni mwanafunzi wa shahada ya uzamivu katika chuo Kikuu cha Notre Dame Australia. Ninafanya utafiti kuchunguza ushiriki wa wauguzi na wakunga katika kutekeleza malengo ya maendeleo ya milenia namba 4 na 5 (kupunguza vifo vya watoto chini ya miaka 5 na kuboresha afya ya uzazi ya akina mama) ndani ya Tanzania.

Ni mategemeo yangu kwamba matokeo ya utafiti huu yatasaidia kuelewa sababu zilizohamasisha au kukwamisha ushiriki wa wauguzi na wakunga katika agenda muhimu za masuala ya afya. Inategemewa kwamba utafiti huu utapendekeza mikakati ya kuboresha ushiriki wa wauguzi / wakunga katika malengo ya baadaye yanayofanana/ fananisho ya afya na pia kuboresha mafundisho yaliyopo kwenye muitiko wa Umoja wa Mataifa (UN) na Shirika la Afya Duniani (WHO) katika kuboresha muonekano wa wauguzi na wakunga katika maamuzi muhimu yanayohusu afya. Hii ni muhimu kwa sababu wauguzi na wakunga ni kundi miongoni mwa makundi makubwa ya wataalamu wa afya, na wanaweza kuwa na mchango mkubwa kwenye maamuzi kama hayo.

Hii barua inakuomba ushiriki katika mahojiano ya ana kwa ana. Karatasi ya maelezo ya mshiriki imeambatanishwa na kila kitu unachopaswa kufahamu kuhusu utafiti huu.

Napatikana kupitia namba ya simu……… au peter.taratara1@my.nd.edu.au na karibu kwa maswali yoyote uliyonayo.

Natanguliza shukurani.

Peter Taratara

Mwanafunzi wa shahada ya Uzamivu

Appendix 9: Advertisement to participate in research

BLOCK MANAGERS   09.02.2017

MNH

- KIBASILA
- MWAISELA
- MATERNITYBLOCK I& II
- NPC
- SEWAHAJI
- OBS OT

PLEASE ASSIST

WANAHITAJIKA WAUGUZI 3 KUTOKA KILA
BLOCK MAJIRA YA SAA TANO SIKU YA
4/2/2017 JUMANNE BOARD ROOM KARIBU NA DNS
OFFICE KWA AJILI YA INTERVIEW KUHUSU
MILLENIUM DEVELOPMENT GOAL.

KUSHIRIKI INTERVIEW HII NI VOLUNTARY

KAZI NJEMA.

<div align="center">**Appendix 10: Consent form**</div>

THE UNIVERSITY OF
NOTRE DAME
A U S T R A L I A

Title of the Study: Participation of Tanzanian nurses and midwives in the implementation of Millennium Development Goals 4 & 5 - The reduction of child mortality and improvement of maternal health; A Case Study.

- I agree to take part in this research project.
- I have read the Information Sheet provided and have been given a full explanation of the purpose and objectives of this study, the procedures involved and of what is expected of me.
- I understand that I will be asked to:
  Complete a survey and participate in focus a group discussion, or be interviewed in regard to the study topic
- The researcher has answered all my questions and has explained possible problems that may arise as a result of my participation in this study.
- I understand that I may withdraw from participating in the project at any time without prejudice.
- I understand that all information provided by me will be treated as confidential and will not be released by the researcher to a third party unless required to do so by law.
- I agree that any research data gathered for the study may be published provided my name or other identifying information is not disclosed.

Name of participant			
Signature of participant		Date	

I, the Researcher confirm that I have provided to the above participant the Information sheet concerning this research project. I have explained to the participant what the research involves, and I and have answered all questions asked about the research.

Signature of the Researcher		Date	

THE UNIVERSITY OF
NOTRE DAME
A U S T R A L I A

A case study of Tanzanian nurses and midwives' participation in the implementation of the millennium development goals 4 and 5: The reduction of child mortality and improvement of maternal health

Dear staff member:

You are invited to participate in the research project described below.

What is the project about?
The purpose of this study is to investigate the factors that facilitated, or inhibited Tanzanian nurses and midwives from fully participating in implementing the Millennium Development Goals 4/5. Additionally, it will investigate factors underlying the possible underutilization of the WHO and UN's support to nurses and midwives in implementing these goals.

The objectives are to:
- assess nurses and midwives' awareness of the MDGs 4/5;
- identify factors that influenced Tanzanian nurses and midwives participation in the implementation of the MDGs 4/ 5;
- compare and contrast nurses and midwives awareness of the MDGs 4/5 and their participation in implementing the goals between the designated city and regional hospitals;
- investigate factors underlying the possible underutilization of the WHO and UN's support of nurses and midwives in implementing the MDGs 4/5
- propose strategies to support nurses and midwives participation in future healthcare development goals.

Who is undertaking the project?
This project is being conducted by Peter Taratara and the research will form the basis for the degree of Doctor of Philosophy at The University of Notre Dame Australia, under the supervision of Dr Carol Piercey in Australia and Dr Edith Tarimo in Tanzania.

What will I be asked to do?
If you consent to take part in this research study, it is important that you understand the purpose of the study and the tasks you will be asked to complete. Please make sure that you ask any questions you may have, and that all your questions have been answered to your satisfaction before you agree to participate.

Nurses and midwives who agree to participate in this study will be expected to:

- Give their consent to participate in the study. The consent may be given verbally or in writing (by signing the consent form). Participation in focus group sessions and verbal recording of participants' responses will require giving written consent.

- Complete survey questions about nurses and midwives' awareness and participation in MDGs 4 and 5. The questions will need about 30 minutes to complete;
- Participate in focus group discussion which will be recorded. The discussion will be centered on nurses and midwives' participation in those MDGs;
- Volunteer attendance at a focus group discussion. It is expected that there will be between 6 to 10 participants and last between 20 and 30 minutes. The discussions will take place at the participants workplace in the staff meeting/common room and be recorded;
- There will be no cost or remuneration for participating in the study.

Single interviews with the presidents of the TZ Nurses and Midwives Council, Chief Nursing Officer and hospital administrators will be conducted at a mutually agreeable time and location. The agenda for the interviews will concern the objectives of the study.

Are there any risks associated with participating in this project?
There are no foreseeable risks in participating in this study. However, should you experience distress from participating, a counselor can be provided with no expense incurred.

What are the benefits of the research project?
The benefits from this research will be to propose ways by which nurses and midwives may participate more in future health care activities similar to MDGs. Also, the study will enrich the available literature in this area of research

What if I change my mind?
Participation in this study is completely voluntary. Even if you agree to participate, you can withdraw from the study at any time without discrimination or prejudice.

Will anyone else know the results of the project?
Information gathered about you will be held in strict confidence. This confidence will only be broken if required by law. No participant names will be identified and only the researcher and the supervisors will have access to the information. This will be used for the purposes stated above and stored on a password protected computer where it will be kept for five years. You will not be identified in any future publication. Documents will be kept safely under lock and key and in a locked case in transit between Tanzania and Australia.

Will I be able to find out the results of the project?
Once I have analysed the information from this study, I will provide a summary of the findings to the hospital. You can expect to receive this feedback in an appropriate timeframe possibly within two years.

Who do I contact if I have questions about the project?
If you have any questions about this project please feel free to contact either myself, Peter Taratara; phone number ███████████ ; e-mail ███████████ or my supervisors Dr Carol Piercey Phone: ███████████ /email: ███████████ and Dr Edith Tarimo Phone: ███████████ ; e-mail: ███████████ . My supervisors and I will be happy to discuss any concerns you may have about this study.

What if I have a concern or complaint?
The study has been approved by the Human Research Ethics Committee at The University of Notre Dame Australia (approval number #######) and the Tanzanian National Institute for Medical Research (approval number #######). If you have a concern or complaint regarding the ethical conduct of this research project and would like to speak to an independent person, please contact Notre Dame's Ethics Officer at (+61 8) 9433 0943 or research@nd.edu.au. Any complaint or concern will be treated in confidence and be fully investigated. You will be informed of the outcome.

How do I sign up to participate?
If you are happy to participate, please sign the consent form.

Thank you for your time.

Yours sincerely,

Peter Taratara
PhD Candidate

THE UNIVERSITY OF
NOTRE DAME
A U S T R A L I A

MAELEZO KWA WASHIRIKI–WASIO WATOA HUDUMA HOSPITALINI

Mpendwa

Unakaribishwa kushiriki katika utafiti ufuatao:

Ushiriki wa wauguzi na wakunga wa kitanzania katika utekelezaji wa malengo ya maendeleo ya milenia namba 4 na 5: Kupunguza vifo vya watoto na kuboresha afya ya uzazi ya akina mama

Utafiti unahusu nini?

Madhumuni ya utafiti huu ni kuchunguza mambo yaliyohamasisha au kukwamisha wauguzi na wakunga wa ki-Tanzania kushiriki ipasavyo katika kutekeleza malengo ya maendeleo ya milennia namba 4 na 5 (MDGs 4/5). Haya malengo mawili yanahusu kupunguza vifo vya watoto na kuboresha afya ya uzazi ya akina mama. Kwa nyongeza, utafiti utachunguza kama kuna mambo yaliyosababisha wauguzi na wakunga kutotumia ipaswavyo ushauri wa shirika la afya duniani (WHO) na Umoja wa mataifa (UN) katika kutekeleza haya malengo.

Ni nani anafanya huu utafiti?

Huu utafiti unafanywa na Peter Taratara na utafiti utamchangia kupata shahada ya Uzamivu ya Chuo Kikuu cha Notre Dame Australia, chini ya usimamizi/uangalizi wa Dkt. Carol Piercey wa Australia na Dkt Edith Tarimo wa Tanzania

Nitaulizwa kufanya nini?

Unakaribishwa kushiriki katika mahojiano ya ana kwa ana. Maswali yatalenga jinsi ambavyo taarifa za malengo ya maendeleo ya milenia 4/5 yalivyowasilishwa kwa wauguzi na wakunga.

Mahojiano yatafanyika katika mazingira, mahali na muda rafiki na yanategemea kuchukua muda wa saa moja.

Je, kuna madhara yoyote yanayohusiana na ushiriki katika huu utafiti?

Hakuna madhara yoyote yanayotegemewa. Hata hivyo, endapo utapata kusononeka kwa vyovyote kutokana na kushiriki kwako; mshauri nasaha anaweza kukupatia msaada bila gharama yoyote.

Ni nini faida ya utafiti huu?

Ni mategemeo kwamba matokeo ya utafiti huu yatasaidia kuelewa mambo yanayoweza kuhamasisha au kukwamisha wauguzi na wakunga kushiriki katika agenda muhimu za afya. Ni mategemeo kwamba utafiti utapendekeza mikakati ya kuboresha ushiriki wa wauguzi/wakunga katika malengo ya afya yanayofanania kwa baadaye, pamoja na kuboresha taarifa zilizopo juu ya miito ya Umoja wa Mataifa na Shirika la Afya Duniani ili kuinua muonekano wa wauguzi na wakunga katika maamuzi muhimu ya afya. Hii ni muhimu sana kwa sababu wauguzi na wakunga wanachangia sehemu kubwa sana ya wataalamu wa afya na wanaweza kutoa mchango mkubwa sana katika maamuzi kama hayo.

Je, itakuwaje kama nikibadilisha nia yangu?

Kushiriki katika utafiti huu ni hiari kabisa. Hata kama umekubali kushiriki, unaweza kusitisha kushiriki kwako saa yoyote bila kubaguliwa au kuhisiwa vibaya. Kama ukijiondoa kwenye utafiti baada ya mahojiano kuanza, unaweza kuamua kufuta taarifa zote ulizotoa.

Je, mtu mwingine anaweza kujua matokeo ya utafiti huu?

Taarifa zitakazokusanywa kuhusu wewe zitahifadhiwa kwa umakini. Umakini huu utavunjika tu pale itakapohitajika kisheria. Hakuna jina la mshiriki litakalotumika na ni watafiti pekee watakaokuwa na uwezo wa kuona taarifa zako. Taarifa hizi zitatumika tu kwa madhumuni yaliyotajwa hapo juu na kuhifadhiwa kwa neno la siri kwenye computa ambako zitatunzwa kwa miaka mitano. Hutaweza kutambulika katika machapisho yoyote ya baadaye.

Je, nitaweza kujua matokeo ya utafiti huu?

Mara uchambuzi wa matokeo ya utafiti huu yatakapokamilika, niwapatia watawala wa hosiptali husika muhtasari kwa ajili ya kusambaza. Unaweza kutegemea kuona mrejesho ndani ya miaka miwili.

Ni nani nitakayewasiliana naye kama nina maswali juu ya utafiti huu?

Kama una swali lolote kuhusu huu utafiti tafadhali jisikie huru kuwasiliana na mimi Peter Taratara kwa simu au peter.taratara1@my.nd.edu.au Au, unaweza kuwasiliana na Dkt Carol Piercey (61) 448264005 au carol.piercey1@nd.edu.au au Dkt. Edith Tarimo kwa simu au . Wasimamizi/waangalizi wangu na mimi tutafurahi kujadiliana na wewe masuali yanayohusu utafiti.

Je kama nina malalamiko?

Utafiti huu umepata kibali kutoka katika kamati ya maadili ya utafiti ya chuo kikuu cha Notre Dame Australia (Kibali namba 016127F) na Taasisi ya taifa ya tafiti za Afya Tanzania (Kibali numba ……………). Pia utafiti huu umepata kibali kutoka kamati ya maadili ya utafiti ya Chuo Kikuu cha Afya na Sayansi Shirikishi Muhimbili (Kibali numba ………). Kama utakuwa na malalamiko yoyote kuhusu maadili ya uendeshaji wa utafiti huu, na ungependa kuongea na mtu anayejitegemea, tafadhali wasiliana na Ofisa wa maadili Notre Dame kwa (+61 8) 9433 0943 au research@Nd.edu,au. Au unaweza kuwasiliana na mwenyekiti wa kamati ya maadili ya tafiti Muhimbili kwa (+255 22-2152489) au drp@muha.ac.tz Malalamiko yoyote yatafanyiwa kazi kwa uhakika na upelelezi kamili utafanyika. Utafahamishwa matokeo ya upelelezi.

Nitajisajili namna gani ili nishiriki?

Kama umeridhia kushiriki, tafadhali onyesha utayari wako kwa mtafiti, mtawala wa hospitali au ofisi ya meneja wa wauguzi. Ushiriki utakulazimu kuweka sahihi kwenye fomu ya ridhaa.

Asante kwa ushirikiano wako
Wako, Peter Taratara
Mwanafunzi wa Shahada ya Uzamivu