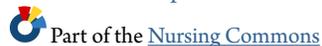

Theses

2017

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

Yan Ing (Jenni) Ng
The University of Notre Dame Australia

Follow this and additional works at: <https://researchonline.nd.edu.au/theses>



COMMONWEALTH OF AUSTRALIA
Copyright Regulations 1969

WARNING

The material in this communication may be subject to copyright under the Act. Any further copying or communication of this material by you may be the subject of copyright protection under the Act.

Do not remove this notice.

Publication Details

Ng, Y. (2017). The effect of continuing professional development from the perspective of nurses and midwives who participated in continuing education programs offered by Global Health Alliance Western Australia: A mixed-method study (Master of Philosophy (School of Nursing)). University of Notre Dame Australia. <https://researchonline.nd.edu.au/theses/152>

This dissertation/thesis is brought to you by ResearchOnline@ND. It has been accepted for inclusion in Theses by an authorized administrator of ResearchOnline@ND. For more information, please contact researchonline@nd.edu.au.



Chapter 2: Literature Review

2.1 Introduction

The previous chapter was related to background information about CE and CPD provided in Tanzania by WANMs and received by TNMs. The literature about CE and CPD in nursing, shows that education can make a significant difference in professional practice and patient care. Central to this is a lifelong commitment to education, whereby NMs need to build their knowledge foundation by engaging in ongoing education throughout their careers (Garafalo, 2016). Such education programs are generally provided through the workplace to ensure convenience for the health staff, and no fee is charged for participating in the programs. The focus of education and training for NMs is essentially to ensure a well-educated workforce to support the growing healthcare system (Dickerson, 2010; Garafalo, 2012, 2016).

Dickerson (2010) pointed out that it is easy to lose sight of the bigger picture of CE that enhances professional development, when NMs and other health staff are caught up in the busy daily operations of a hospital. This is true in all contexts of health, whether in an advanced healthcare system or unit in the developed world or in under-resourced wards in less privileged nations. However, the literature addresses the significance and influence of CE, which benefits health service providers, staff and patient care outcomes. According to Bamberger, Rao, and Woolcock (2010), there is heightened criticism that suggests that foreign aid organisations report mainly outputs (quantity), rather than outcomes (quality). Considering the financial, physical and human resource input of foreign aid and international development projects into developing countries, the need to measure the effectiveness of such projects is important.

Given that the current study focused on the effectiveness and sustainability of CPD for NMs who participated in education programs provided by GHAWA in Tanzania, this chapter reviews the current frames of reference regarding continuing NM education in a mainstream and international development context, including how learning is sustained in that context. This chapter begins by describing nursing from a global standpoint, and further describes nursing in developing countries, focusing on Tanzania as an example. The notion of CE and CPD in Tanzania is discussed, including the sustainable work of

CPD that is guiding the future of healthcare. Figures 1 and 2 depict visual representations of the concepts covered in this chapter. Figure 1 represents nursing and midwifery from an international perspective and how nursing in Tanzania fits within a global context. Figure 2 discusses the CPD and education process model and will be explained in Section 2.3.

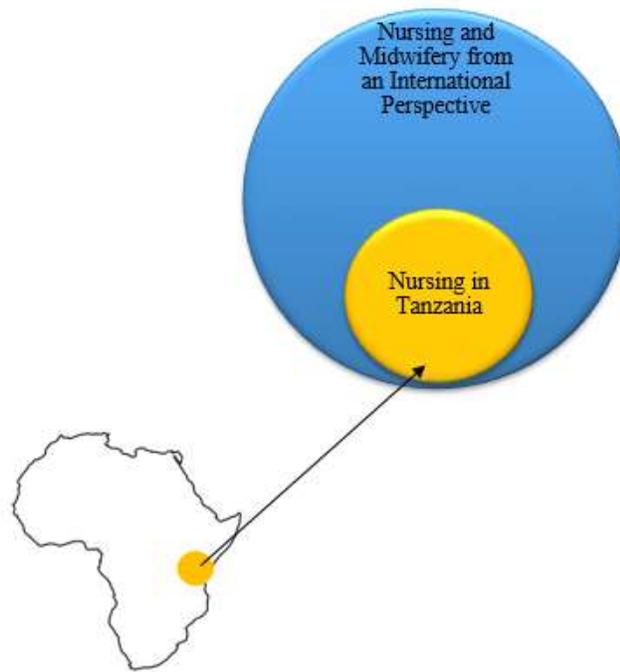


Figure 1: Nursing and Midwifery – An International Perspective

2.2 Nursing and Midwifery – An International Perspective

According to the *Global Strategic Directions for Strengthening Nursing and Midwifery 2016–2020* document published by the WHO (2016), there is a current estimate of 43.5 million health workers worldwide, of which 20.7 million are NMs. In many countries, more than 50% of health workers consist of NMs. These numbers may seem large, suggesting a reasonable ratio of nursing and midwifery personnel to the population; however, the challenge of shortages exists globally. The WHO (2017) reported that there are fewer than three NMs per 1,000 population in 48% of its member states (countries), and 27% reported to have less than one. For instance, India has two per 1,000 population, China has 1.6, Zambia has 0.7, Pakistan has 0.6, Afghanistan has 0.4, Malawi has 0.3, and Somalia has 0.1 (WHO, 2017). In comparison, Australia has 12.3 nursing and

midwifery personnel per 1,000 population (WHO, 2017). Nawafleh (2014) purported that, in Jordan, where the nursing density is 2.8 per 1,000 population, inadequate numbers of nurses and midwifery personnel have caused the standards of nursing care to deteriorate.

An estimated decline of 7.6 million NMs by 2030 has been predicted, with worse numbers in the African and Eastern Mediterranean Regions, if the current trend continues (WHO, 2016). Considering the increase in disease burden, population growth and aged care, complex health issues will inevitably follow. In addition, of the 38 million deaths each year that are related to non-communicable diseases, an estimated 74% of these deaths occur in low- and middle-income countries (WHO, 2016). Health workers, including NMs, play a significant role in promoting health and delivering essential care. They are also a central part of supporting health service delivery, and providing care throughout the life span, from birth to assisting older people in primary and community settings.

To keep pace with the progressive world of emerging disease outbreaks and contemporary technology, NMs must stay abreast of new knowledge, and be educated and competent to provide the effective care that the population needs. To achieve such goals, the focus is on CE (Australian Nursing and Midwifery Council [ANMC], 2009; Dickerson, 2010; Garafalo, 2012; MoHSW, 2014; WHO, 2016). Optimising the capabilities of the workforce and working with regulatory bodies, education and practice institutions can create sustainable inroads and developments. This is described further in Sections 2.3 and 2.4.

From this global account, nursing and midwifery in developed and developing nations share similar challenges and concerns. The differences are generally related to a matter of scale, based on health economics, equitable access and the social determinants of health. The area of nursing in developing countries is very broad; thus, for this study, and to provide context to readers, this literature review considers Tanzania as an example of nursing in developing countries, as described in the following section.

2.2.1 Nursing in Tanzania

It should first be acknowledged that the terms ‘nurses’ and ‘midwives’ are used interchangeably in Tanzania. The researcher’s work experience in this country revealed that midwives are often referred to as nurses. Thus, the literature identified in this section

includes midwives under the nursing umbrella. While this would be unacceptable in Australia, it is commonplace in Tanzania and other African countries.

Moyo and Mhamela (2011) described that prior to the nineteenth century, nursing care in Tanzania was learnt by apprenticeship and hands-on care in tribe and home settings. The missionaries arrived in the late 1800s and were particularly active in caring for the sick. As these religious societies spread to the country, Catholic nuns for example became common health care practitioners who went on to establish hospitals and nursing schools. It was not until the 1970s, when nursing specialty programs in areas such as paediatrics, psychiatric and operating theatre nursing were established (Moyo and Mhamela, 2011). In the 1990's, Tanzanian nurses were able to obtain nursing qualifications at Degree and Master's level for the first time. This prepared nurses with enhanced knowledge and skills to provide care for their unique population health needs, including diseases such as HIV/AIDS, malaria, tuberculosis, diarrhoea diseases, malnutrition and maternal/perinatal conditions (Mella, 2003; Kwesigabo et al., 2012).

Tanzania has a ratio of 0.4 nurses per 1,000 population (Kaaya et al., 2012; Manzi et al., 2012; WHO, 2017). While the population size of Tanzania consistently expands, at 2.7% in 2015 (Tanzania National Bureau of Statistics, 2016), the country continues to face a severe shortage of skilled workers in the health sector (Khamis & Njau, 2014; Kurowski et al., 2007; Kwesigabo et al., 2012; Manzi et al., 2012; Nartker et al., 2010; Shemdoe et al., 2016; Songstad, Rekdal, Massay, & Blystad, 2011; Tanzania MoHSW, 2007, 2014). A health workforce human resources review in Tanzania conducted by Kurowski et al. (2007) estimated that an increased ratio of 1.2 nurses per 1,000 population—as the minimum staffing level—was required by 2015, with the assumption of increase training efforts and capacities. A workforce crisis was declared by Tanzania's MoHSW (2007) in 2008, with plans to increase the number of students enrolling in healthcare disciplines at training institutions, increase the recruitment of health workers, and increase health financing for human resources (MoHSW, 2014). To date, according to statistics available from the WHO (2016), the ratio remains at 0.4 nursing and midwifery personnel per 1,000 population.

Compared with the global average of more than 10 NMs per 1,000 population in developed countries such as Australia, the United States, Sweden and Ireland (Buchan & Aiken, 2008; Health Workforce Australia, 2013; WHO, 2016), there is a critical need to

increase the number of skilled health workers in Tanzania (Kaaya et al., 2012; Kwesigabo et al., 2012; Manzi et al., 2012; Nartker et al., 2010; Songstad et al., 2011). Tanzania relies on a range of health workers to staff health services, and, according to Kwesigabo et al. (2012), only a small proportion of the people who provide clinical care are professionals trained as doctors, nurses, pharmacists and dentists. The 2014 to 2019 MoHSW strategic plan indicated the efforts to increase the human resources for health in Tanzania and upgrade workers' skills through CPD for the health workforce.

The dire shortage of NMs in Tanzania has resulted in understaffing and work overload. The study by Haggstrom, Mbusa, and Wadensten (2008) highlighted that, as a result of these factors, coupled with the challenges faced by NMs on a daily basis (such as limited medical resources), Tanzanian nurses suffer from workplace distress and ethical dilemmas. In addition, Leshabari et al. (2008) explained that health workers are often confronted with the limited availability of protective gear, safety equipment and (in some cases) access to clean water to safeguard them from infectious disease. These factors cause major workplace issues that have a detrimental effect on staff (Leshabari et al., 2008; Shemdoe et al., 2016).

Despite the difficulties faced by these NMs, Nartker et al. (2010) identified that healthcare workers in Tanzania were keen to learn and 'wanted more training for themselves in order to perform their jobs competently' (p. 2). However, Kaaya et al. (2012) described that, once health professionals in Tanzania are given their licence to practice, there are no requirements for individuals to update or improve their skills or knowledge. Consequently, the notion of CE and access to CPD are limited. This subject is covered further in the following section.

2.3 CE and Professional Development

The focus of CE is to enhance the professional development of NMs (ANMC, 2009; Dickerson, 2010; Nurses and Midwives Board of Australia [NMBA], 2010). CE essentially comprises short training programs that facilitate training and expertise. It is sometimes referred to as in-service or professional development training provided for individual practitioners. The literature purports that CE assists with updating knowledge and improving individual skills, which subsequently improves standards and enhances healthcare delivery (Aiga & Kuroiwa, 2006; Nartker et al., 2010).

In an era of constant change in healthcare, including scientific and technological advances, it is critical to build on the foundation of NMs' professional development through lifelong learning engagement in CE, consisting of both formal and informal learning (Garafalo, 2016). CPD is attained by means of continually maintaining, improving and broadening one's knowledge, expertise and professional competence (NMBA, 2010). It is an ongoing process, and developments are contingent on each individual's area of interest (Dickerson, 2010; Garafalo, 2012).

Garafalo (2012) explained that CPD requires a partnership between the learner and teacher, and, to be effective, it is important to identify individuals' knowledge gaps and learning needs. Garafalo used formative and summative evaluation processes to identify learning needs, comments and feedback including topic suggestions from those who participated in the study, for planning future CE programs. Garafalo found that CE enabled the understanding of best practice, thereby resulting in nurses' improved performance to give quality care for patients. This subsequently facilitated advancement of the profession. Manzi et al. (2012) purported that, from an organisational perspective, the systematic approach of CPD as a whole enables the workforce to become an effective and efficient component of the healthcare system.

As part of this interactive process of CPD and CE, knowledge and skills development are gained through support and ongoing commitment (Garafalo, 2012). In view of the description above, Aiga and Kuroiwa (2006) and Manzi et al. (2012) further highlighted that the continual process of CE promotes ongoing professional development. This process model is simplified and illustrated in Figure 2.

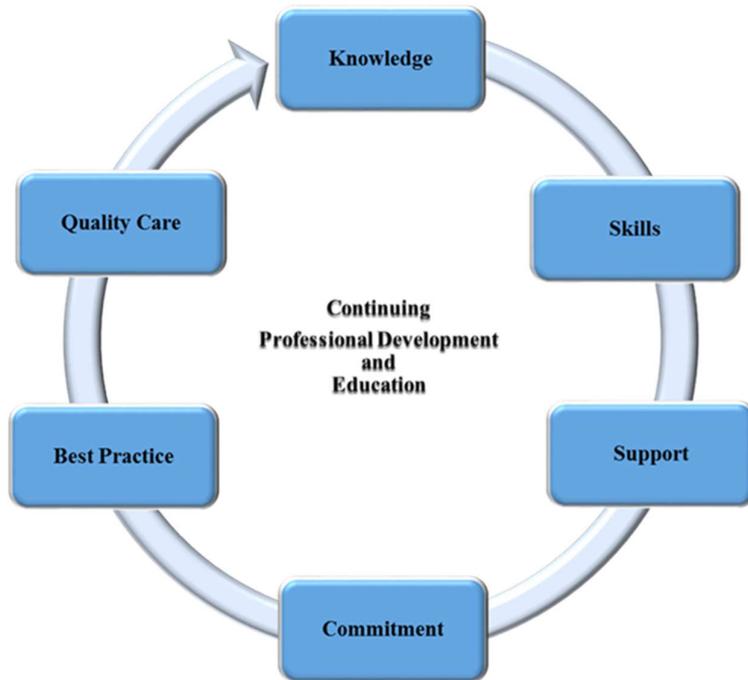


Figure 2: CPD and Education Process Model

In addition, Aiga and Kuroiwa's (2006) study in Ghana revealed that the information learnt from the CE opportunities delivered in the country was shared and disseminated to other staff in duty stations within hospitals. However, this was confined to a select group of people, as Aiga and Kuroiwa (2006) also found that some health workers were reluctant to share the education, as they identified it 'exclusively as their privileged knowledge and skills' (p. 277). Despite this, Aiga and Kuroiwa recommended that equal access and opportunities to CPD and CE would enhance the knowledge and skills of health workers, thereby improving quality of care and reducing costs. The aim of this study was not to consider perceptions about participation in CE by the healthcare workers in Ghana.

In the context of access to education within the workplace and the broader developments of CPD, CE is linked to the efforts of 'train the trainer'. Nyamathi et al. (2008) found in their study that a nurse-led train the trainer education program regarding HIV, improved the knowledge of nurses in India. As an educational intervention, 10 master trainers trained 100 trainees over a short period. A pre and post-test demonstrated overall improvements in knowledge of HIV amongst the cohort. The 'train the trainer' strategy was effective in providing knowledge transfer and equipping the nursing workforce to prevent HIV transmission particularly in areas responding to the crisis.

‘Train the trainer’ was also used in another study by Kalisch, Xie and Ronis (2013), where three nurses in the acute care setting at three hospitals underwent a training program and later taught nursing staff in their respective unit about teamwork and missed nursing care. Testing the efficacy of the intervention, the study found a higher level of nurses’ satisfaction with teamwork that resulted in a significant decrease in missed care events. The studies by Nyamathi et al. (2008) and Kalisch, Xie and Ronis (2013), both highlighted the positive impact of CE on patient safety and ultimately quality care.

To provide an orderly understanding of CE and CD from a Tanzania context, Figure 3 illustrates the factors that support and sustain nursing CPD in Tanzania.

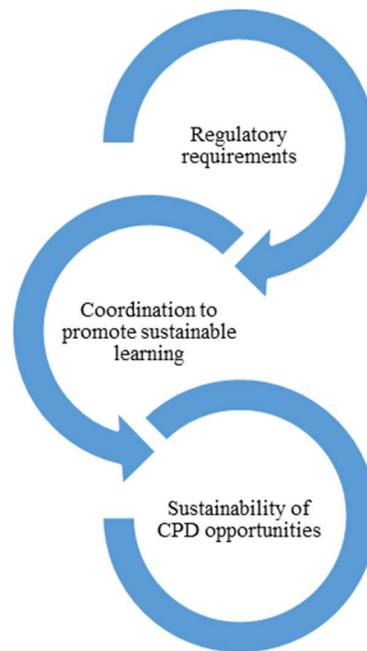


Figure 3: Factors that Support and Sustain Nursing CPD in Tanzania

2.3.1 Regulatory Requirements

As stated in Section 2.2.1, there is no history of CPD being a mandatory requirement to maintain professional registration in Tanzania (Kaaya et al., 2012). Although in 2014, the Tanzania Nursing and Midwifery Council (TNMC) endorsed national CPD guidelines for NMs in Tanzania, the extent to which these are viewed as mandatory is questionable. This document, supported by the MoHSW and the country’s National Nurses Association, defined CPD as a range of purposeful education that serves to improve performance after individuals’ initial basic training (TNMC, 2014). It was further identified by the TNMC

(2014) that, under the *2010 Tanzania Nursing and Midwifery Act*, CPD was mandatory and NMs were required to provide evidence of CPD attendance when renewing their professional practising license. However, there is limited information and understanding about the awareness of and compliance with this ruling by local NMs in the country. According to Tanzania's MoHSW (2014), it was noted that, while some health workers have attended CPD training, it is not uncommon to find staff who have not attended CPD. The literature argues that, to support existing nursing and midwifery staff, access to CE to update knowledge and skills that align with contemporary best practice is vital for providing quality care and health service delivery (Aiga & Kuroiwa, 2006; Nartker et al., 2010). This opinion was acknowledged by the Tanzania MoHSW (2014). The process for coordinating CPD is described in the following section.

2.3.2 Coordination to Promote Sustainable Learning

An evaluative study in Uganda by Kemp and Tindiweegi (2001) demonstrated that, consequent to receiving CPD, nurses working in a regional hospital will educate others, who then go on to teach other people, thereby expanding the influence of the initial education. The project, supported by two United Kingdom-based organisations, aimed to describe the creation of professional development programs for nurses at a regional teaching university hospital in Mbarara, Uganda. Kemp and Tindiweegi (2001) described that it took two years to establish the foundation of planning for NMs' staff development in the hospital. As a result of the abolishment of an onsite nursing school, as well as nurses' lack of development because they had no access to CE and professional development, it was critical to develop a strategic approach to build nurses' skills. A wide range of nursing and midwifery education topics was delivered to staff in the hospital. Based on the merits of individuals, selected NMs were then identified and given training in specialist skills, such as paediatrics, accident and emergency work, peri-operative and sexual health care. They were required to complete specific education modules. The results of the evaluation indicated that the morale of the participating nurses increased as a result of completing all modules, and there were signs of improvements in patient care within the hospital. Subsequently, priorities were established to collaborate and continue the development of nurses in the clinical setting. The coordination of this sustainable education model could lead to gradual improvement in the wider health population (Kemp

& Tindiweegi, 2001). This CPD philosophy resonates with GHAWA as it strives to deliver CE that is sustainable for NMs in Tanzania.

In an effort to address the acute shortage of health professionals in Tanzania, Kaaya et al. (2012) initiated an enquiry to reform health professionals education in Tanzania to increase the intake of students at universities. While the authors professed that the study is still ongoing and will take over a decade to complete, preliminary information shows that there were inadequacies in the training of health professionals, and that Tanzania ‘lacks a formal system for coordinating CPD’ (Kaaya et al., 2012, p. 3). Consequently, there are no requirements by professional authorities to update skills and knowledge after gaining the initial licence to practice. The lack of CE, compounded by the shortage of nurses, negatively affects professional standards and eventually health outcomes (Kaaya et al., 2012). The early stages of this study have highlighted that actions to enhance the educational environment to promote sustainable learning, alongside the development of strategic partnerships to scale-up health professional education, are paramount.

2.3.3 Sustainability of CPD Opportunities

Sustainability is viewed as the act of being able to progress and maintain the current and future generation’s needs (WHO, 2008). According to Ahluwalia et al. (2010), it is the ‘process or outcome of an activity or set of activities post-project implementation’ (p. 41). The key goal of the GHAWA collaboration in Tanzania was to ‘not only provide education with the intent to improve patient care, but also to support the sustainability of any knowledge gained to ensure improvement’ (Jones, Carville, Michael, & Gower, 2012, p. 5). The program intervention of GHAWA in Tanzania was to provide CE that was relevant to the context, needs, working conditions and available resources of Tanzanian healthcare settings. Thus, aspects of a ‘train the trainer’ approach—which gives trainers the knowledge and skills to interact and provide education and training effectively—were built into the training and delivery process when providing CE in Tanzania (Jones et al., 2012).

An evaluation study conducted in Malawi by Walters and Furyk (2010) supported the view of providing a ‘train the trainer’ approach in education, as it enables and ensures that the role of the nurse in CE is sustained while nurses continue to support other staff towards practice improvement. In partnership with a United Kingdom–based children’s

hospital, 51 Malawian paediatric nurses were provided nursing education in best-practice injection techniques, and given structured education packages (Walters & Furyk, 2010). Many of these nurses had not received professional development in this area for more than 20 years, and were routinely giving injections to children in the dorsogluteal muscle. The study was evaluated through questionnaires that assessed the nurses' knowledge of intramuscular injections for paediatrics at a tertiary referral hospital in Blantyre, Malawi. Following the delivery of education, observations of the nurses' practice (specifically their injection sites and techniques) were also conducted as part of the study, and 84% of intramuscular injections were found to be given in children's thighs—that is, the vastus lateralis and rectus femoris muscle. As a result of time constraints and limited resources, only one local nurse learnt the role of providing CE. This was undertaken to ensure the sustainability of the intervention after the departure of the United Kingdom aid support. While the study was small and would have benefited from a follow-up re-assessment at a later time to evaluate its sustainability, the study showed that change can be implemented with the aid of a simple teaching package to improve standards in a resource-limited environment. This similar approach was undertaken by GHAWA in Tanzania, where it facilitated the developmental abilities of the Tanzanian NMs attending CE. The intention of the program was to support 'growing their own' workforce and the maintenance of CPD mentality. By doing so, it was anticipated that the education programs delivered by GHAWA would enhance the sustainable development of CE when GHAWA eventually ceased activity in Tanzania.

CPD is essential and mandatory to maintain professional registration in developed nations, such as Australia (ANMC, 2009; Ross, Barr, & Stevens, 2013). While it remains debatable to mandate CPD for registration in other countries and states, such as those in the United States, consensus in the literature articulates that, to provide a consistently high level of patient care, the concept of CPD linked to ongoing education is an essential and virtuous obligation of all nurses (Fleet et al., 2008; Ross et al., 2013). In developing countries, medical missions, aid and development programs use their healthcare expertise and educational resources to influence practice (Ahluwalia et al., 2010; Lofmark & Thorell-Ekstrand, 2009; Nartker et al., 2010; Ott & Olson, 2011). This aligns with components of the MDGs to improve health in developing countries (United Nations, 2000; WHO, 2008). Aside from the 'train the trainer' approach, Ott and Olson (2011) purported that, to provide services and foster sustainable programs in underserved

nations, other factors are vital, such as partnerships with government, local universities, healthcare facilities and other non-profit health organisations. In light of this, GHAWA considered these factors when assessing the needs and developing sustainable CE with partners in Tanzania.

2.4 Summary

This chapter has provided an overview of the relevant studies and literature related to nursing and published information about CPD in Tanzania. Much of the literature in this area indicates the dire shortage of human resources for health and medical resources, which affects workers' ability to practice safely. Although the scale of the issues differs depending on the country, these concerns are shared by other nations. There also appears to be a disparity in awareness about CPD and its requirement for renewing professional practice licensure in Tanzania.

It is clear and widely understood that CPD facilitates the upskilling of knowledge and skills to improve NMs' performance to give quality care. In the case of underserved nations, where resources are scarce, medical missions and international aid programs operating in developing countries use their healthcare expertise and educational resources to influence practice. However, there is limited research examining how CPD is sustained in the context of a developing nation. Further study in this area is needed to better understand the sustainability of CPD services provided by international missions, and, more importantly, to guide resource-poor areas to build their own capacity, so they can continue to provide professional development opportunities that will ultimately benefit their workforce at large. The following chapter presents the methodology used for this study.