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

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Chapter 5: Discussion of Findings

5.1 Introduction

The purpose of this research was to evaluate the effectiveness and sustainability of CPD from the perspective of the NMs who participated in the CE programs offered by GHAWA. The NMs from WA who went to Tanzania in 2013 as education facilitators of GHAWA, and the TNMs who participated as education attendees of the program were the research participants of this study. The findings that emerged from the one-on-one and focus group interviews indicated themes related to the barriers and enablers for providing CPD education in Tanzania. In addition, the outcomes of the program and views regarding the sustainability of CPD in Tanzania were identified.

As described in Chapter 3, this evaluative study used quantitative and qualitative designs informed by a mixed-method approach. Two phases were implemented. Phase one was undertaken through a descriptive quantitative method, where the focus was to review and confirm the range of education programs provided by GHAWA in Tanzania during 2013. This was followed by phase two, which employed one-on-one and focus group interviews, and was divided into two stages. Stage one was completed with a selected group of WANMs, while stage two was completed with relevant TNMs.

The findings were used to describe the research participants' perceptions and experiences of CPD in Dar es Salaam, Tanzania. This chapter discusses a summary of the findings from both cohorts. A comparison of the WANMs' and TNMs' perspectives will follow, which will then be further compared with the literature.

5.2 CPD from the Perspective of WANMs and TNMs

The findings from the interviews are detailed in the three subsections below. First, the opinions of the WANMs are summarised, followed by the views of the TNMs. A comparison of the findings from the two groups is undertaken towards the end of this section.

5.2.1 WANMs' Perceptions of CPD in Tanzania

A total of 12 NMs from WA were identified as GHAWA educators who provided CE in Dar es Salaam, Tanzania in 2013. Of this, six consented to participate in this study. Through focus group and one-on-one interviews, the WANMs described that they were initially faced with issues related to language barriers. Although the TNMs are educated in English, the language issue was mainly limited to the NMs who worked in the peripheral areas of Dar es Salaam. This made it challenging for the WANMs to provide education. The findings also indicated that, because of a sense of disparity regarding race and resources, some of the TNMs who attended the education sessions showed initial resistance to their international counterparts. This was explained in Chapter 4.

The WANMs approached the challenge with open communication. After some perseverance, this communication process created a level of connection with their Tanzanian peers. The application of reflective practice further helped them unearth factors related to the barriers and enablers associated with CE and CPD, and the limitations in the TNMs' ability to provide best practice and CE in their workplace.

As described in Chapter 4, the initial challenges encountered by these WANMs in Tanzania were minor compared with the tough conditions in which the TNMs worked. The NMs in Tanzania were confronted by extreme lack of resources associated with staff, time and equipment. The shortage of staff, insufficient medical supplies and large patient workloads hampered their ability to care for patients in an appropriate and timely manner. These conditions further inhibited the local NMs' ability to extend themselves to provide education to their peers. The NMs were expected to facilitate the provision of CPD in their workplace within the existing structure that had no supervision and monitoring of practice to maintain standards. This was identified as a major issue that could hamper building workforce capacity and further prevent the sustainability of CPD in Tanzania.

It was also expressed that the NMs in Dar es Salaam did not have a choice about where they worked. They were regularly moved to work in different areas within their hospitals. The findings suggested that this arrangement minimised the opportunity for clinical specialisation. The findings also indicated that the TNMs had limited critical thinking skills, which suggested an area of weakness that narrowed the local staff's capacity to extend their practice.

Despite these barriers, the WANMs felt the education programs offered by GHAWA for CPD gave opportunities for local NMs in Dar es Salaam to examine their existing practices. Through reflective practice and upon establishing relationships, the enthusiasm of the local NMs amplified, and those NMs who were motivated felt empowered by their learning, and demonstrated notable evidence of positive changes that were observed by the WANMs during their short stay. While the WANMs stated that the education provided should be basic and relevant to the local context, it nonetheless gave the local NMs the confidence to make changes in their workplace, including to their own clinical practice. Role modelling and a commitment to ongoing support of CPD to reinforce practice were further perceived as significant elements to create sustainable change from the perspective of WANMs.

5.2.2 TNMs' Perceptions of CPD

Based on the quantitative findings, a retrospective review of the data showed that 129 NMs from eight organisations in Dar es Salaam, Tanzania, attended CE provided by GHAWA in 2013. These organisations comprised two teaching institutions and eight healthcare services. The focus group interviews conducted in Dar es Salaam with this cohort occurred in December 2015. As per the sampling process described in Chapter 3, 33 NMs from seven (of the eight) organisations participated in this study. The reason for conducting interviews with this cohort was to ascertain their personal experiences and perceptions of the CPD that was offered to them by the WANMs.

The TNMs described the extreme shortage of staff, lack of equipment and heavy workload of 'many sick patients' as the major issues limiting them from attending CPD sessions. However, they were keen and motivated to learn and impart their learning gained from CPD with their peers. As a result of the situation in their healthcare system, they could not always afford the time 'to do more' than give care to their patients. To them, attending and providing CPD was secondary to their clinical role. Moreover, access to CPD was limited or unavailable in some organisations. However, despite these hurdles, they recognised the importance of CPD, particularly in relation to understanding how to use medical equipment appropriately and provide best practice in nursing and midwifery. The majority wished to learn and valued education. A small number of participants stated that financial and food incentives, such as refreshments, could enhance the rate of staff attending education sessions.

Given that all the participants of this study had previously attended CE provided by GHAWA, prominent and positive effects on the individuals and their practice were evident in this study. Various examples were given in Chapter 4, which demonstrated that CPD gave the TNMs the tools to think critically about their practice, manage the available resources in their unit more effectively, demonstrate the confidence to question, apply necessary skills and changes in their workplace, and initiate practices that required no additional cost or resources (such as performing CPR correctly and implementing best practice in their delivery of nursing and midwifery care). The participants stated that they were empowered, proud and motivated because they saw a tangible difference in their patients' outcomes. As a consequence of applying the knowledge and implementing best practice gained from the education, they witnessed reduced mortality at their respective organisations, such as in the area of maternal and neonatal care.

With regard to the issue of sustaining CPD into the future, the participants raised the need for ongoing support and supervision at ward levels. They felt that the CE sessions provided by GHAWA were essential and 'should continue'. As described earlier, because of the challenges faced by these NMs, their capacity was limited based on how much they could physically achieve in their workday. They suggested that dedicated personnel—identified in collaboration with the hospital management and GHAWA as 'peer group educators and mentors'—could be an important way of enabling staff development so that NMs' capacity building and professional development could become sustainable.

5.2.3 Comparing Both Cohorts' Perspectives of CPD and its Effect on Nursing and Midwifery Practice in Tanzania

The interviews with the WA cohort, followed by the Tanzanian cohort, enabled a rich understanding of these NMs' perceptions and experiences of CPD in Tanzania. Consequently, a comparison of both views was undertaken. This eliminated any bias from a one-sided view, and removed any generalisations about what NMs from developed nations perceive CPD to be in developing nations, versus the real experience of those living in a developing nation, such as Tanzania. Four common themes related to CPD emerged from analysing the interviews with the two cohorts: barriers, enablers, outcomes and sustainability of CPD. While the two cohorts had different roles—as education facilitators and attendees—the findings identified some external factors under the barriers themes that were unique to the WA cohort's experience. Nonetheless, the Tanzanian

cohort shared similar views to those expressed by the WA cohort. This section compares the findings for each theme.

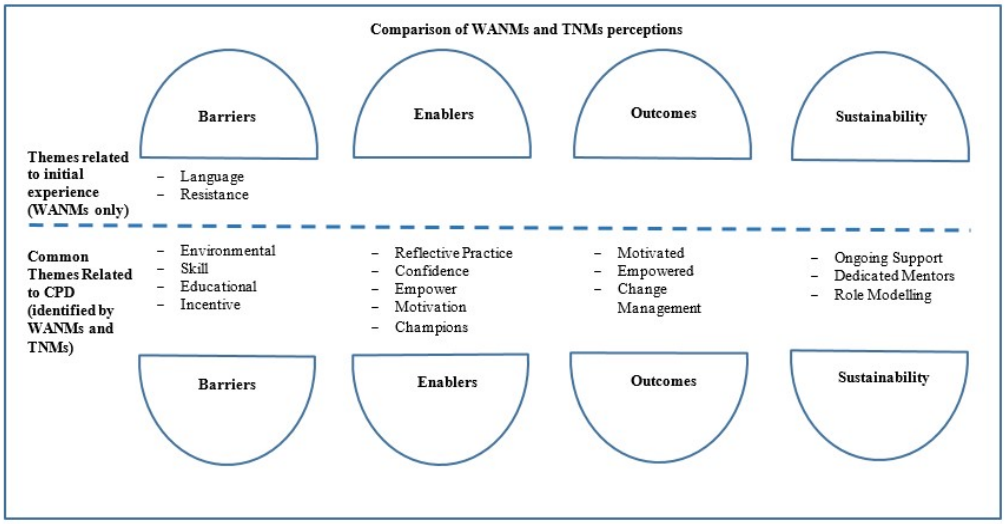

Figure 25: Themes of CPD in Tanzania—WANMs' and TNMs' Perceptions

5.2.3.1 Barriers

Insufficient resources related to staff, basic medical equipment and heavy patient loads were overwhelming issues that emerged from the findings of both cohorts. These were seen as environmental barriers that restricted the TNMs' ability to provide safe and best practice. Dire issues—particularly a shortage of staff and disproportionate staff to patient ratio—were major barriers that restricted the time that TNMs had to attend, prepare and present CE within their organisations. In some smaller hospitals, such as those in rural areas, CPD was not readily available for staff to attend.

Meanwhile, the WANMs voiced a different set of challenges that were unique to them, as educators and foreigners providing education in Dar es Salaam. Language barriers and resistance from some staff were described as the initial barriers. However, through open communication and perseverance, these issues were quickly overcome when relationships were forged with their peers in Tanzania. The other barriers identified were associated with limited skills and understanding about best practice. The TNMs who had a good command of the English language assisted their fellow course participants by translating and clarifying aspects of the education in Kiswahili. However, this occurred mainly in the peripheral settings.

In addition, among a very small number of TNMs, monetary incentive was raised as a factor that could affect the attendance of CPD, with more NMs potentially attending if this was available. Some viewed this as a barrier to CPD, and felt they should be paid to participate in CPD. This is a debatable topic. GHAWA did not provide remunerations, but provided refreshments for people attending CE. To ensure ease, affordability and accessibility for all health professionals, including NMs, this education was provided free of charge at various local organisations. Although no financial incentives were provided for participating, considering the study in its entirety, the outcomes and influence of CPD on staff development and patient outcomes demonstrated that the benefits of CPD outweigh the issue of remuneration. The majority of TNMs did state that they attended CPD because they recognised their need for skill and knowledge improvement.

5.2.3.2 Enablers

The implementation of reflective practice by the WA cohort indicates that the process encouraged TNMs to pause and reflect on their existing situation. This enabled individuals to evaluate and refocus their thinking about their practice, and the TNMs later confirmed that this strategy cultivated critical thinking abilities. Ongoing support is necessary in this area, particularly because it was seen as a new concept to reinforce learning and practice.

Clearly evident throughout the analyses and findings of both cohorts was the vast need and call to continue the delivery of education. As a result of the barriers discussed in the previous theme, NMs who worked at various organisations in Dar es Salaam did not have regular access—and in some cases had limited to no opportunity—to attend CE locally. Consequently, one of the key enablers for accessing CPD was the increased availability of CE made possible by GHAWA. Individuals who were motivated was an important attribute and asset to be ward ‘champions’. These NMs were good role models who demonstrated the ability to influence and empower others through facilitating knowledge and clinical practice enhancement. Changes in practice resulting in positive outcomes were confirmed by the participating NMs in Tanzania.

The findings also indicated that there were good intentions to provide CPD and that organisational education programs were planned at most local hospitals. However, this did not always occur because of their existing limitations. As a way forward, both cohorts

stated that fundamental to enabling CPD locally is a structured staff development initiative delivered by designated local staff, who also have the dedicated time to fulfil such duties. While such an initiative could take some time to achieve, collaboration between local organisations and GHAWA (in the case of this study), as well as ongoing support and supervision of NMs, are significant enablers to continue provision of CE in the short to medium term. This would also facilitate the development of a more confident workforce.

5.2.3.3 Outcomes of CPD

The effects of CPD identified in this study showed that it resulted in a confident, motivated and empowered group of TNMs. By fostering critical thinking, one of the biggest outcomes was the change management that occurred in the NMs' clinical practice and workplace. For instance, they recognised how best to conduct CPR and be competent in their nursing and midwifery practice, including the appropriate use of medical equipment, ensuring hospital fixtures were repaired, and using best practice when giving care. In addition, the NMs witnessed an astounding direct effect and change in outcomes for their patients. The TNMs were proud of their efforts, stating a reduction in mortality incidents of mothers and babies in their respective organisations. This was a major outcome regarding the effect of CPD.

5.2.3.4 Sustainability of CPD

This evaluative study showed that the education programs offered by GHAWA for TNMs were effective. As discussed in the earlier themes, the NMs were generally keen, motivated and empowered, and understood the importance of CPD. The need for ongoing support was raised on numerous occasions as essential to sustaining professional development and to 'give good care' (best practice) into the future. While the intention and momentum exists to continue the delivery of education by local NMs in Tanzania, it was not apparent whether monitoring and maintenance of practice and standards of NMs exists. For the reasons noted in the barriers theme, there was also a lack of designated staff that could provide CE locally—not because the NMs did not want to, but simply because they could not afford the time because of the complex issues faced in the workplace. Thus, CPD in Tanzania is not sustainable in its present form. As such, a robust organisational structure that has dedicated staff (such as 'peer group educators/mentors')

and time allocated to support the ongoing provision of education and manage staff development is fundamental to ensuring the sustainability of CPD within these organisations. This was the crux of building the capacity and capability of the nursing and midwifery workforce in Tanzania, thereby highlighting the potential to sustain CPD.

5.2.4 Section Summary

Section 5.2 has summarised a discussion of the findings from the interviews undertaken in this study. Many of the perceived views identified by the WA cohort regarding CPD in Tanzania were deliberated and confirmed by the Tanzanian cohort. Central to this study, the next section discusses and compares with the literature common topics about workplace constraints, matters related to CPD and the changes that resulted from CPD.

5.3 Comparison of Findings with the Literature

A review of the existing literature found there were similarities and gaps between nursing and CPD in Tanzania. This section compares the study findings with the literature, focusing on specific information relevant to the research topic and how this study fits within the established knowledge. The discussions covered in this section include:

- the *workplace constraints* found to be a major barrier
- the significance of *CPD and CE* in developing nations
- *reflective practice and critical thinking* as enablers from an international context
- *change management* and its sustainability.

5.3.1 Workplace Constraints

Acute and persistent issues related to insufficient medical equipment, unreliable supplies, extreme staff shortages resulting in an inadequate ratio of health workers to patients, its effect on skill mix, inadequate skills and clinical knowledge are apparent in hospitals across Tanzania and Sub-Saharan Africa (Kaaya et al., 2012; Kwesigabo et al., 2012; Shemdoe et al., 2016). Major cutbacks of resources were experienced in Tanzania during the 1990s, and, according to Kwesigabo et al. (2012), this adversely affected health training institutions and skills development for human resources in Tanzania's healthcare system. Consequently, there was a workforce crisis, which caused a critical shortage of staff and workplace challenges across various levels of health service delivery around the

country. Leshabari et al. (2008) stated that health workers in Tanzania, including NMs, often face the limited availability of protective gear and safety equipment that safeguards them from infectious disease. These workplace constraints have also generated discussions regarding the detrimental effect on the recruitment and retention of staff, and the morale of health workers (Leshabari et al., 2008; Shemdoe et al., 2016).

A study of 29 RNs in Tanzania by Haggstrom et al. (2008) indicated that, because of understaffing, work overload and the difficulties faced on a daily basis, Tanzanian nurses were suffering from workplace distress and ethical dilemmas. They identified that, irrespective of whether good care was provided, patients' survival was dependent on what resources were available in the given situation. According to Haggstrom et al. (2008), the prioritisation of care in some instances is based on patients' societal status, where care is provided to the wealthy, rather than the poor, because they can afford to pay for healthcare. They also found that CE was not available to nurses, which meant they could not keep up with contemporary knowledge developments and provide proven methods of care to their patients. These challenges triggered feelings of discomfort and job stress. Similarly, in the current study, the WANMs' interviews revealed findings regarding workplace limitations that led to the TNMs experiencing an internal level of distress. While the scope of this study did not include an examination of workplace distress, the overall findings, including environmental workplace constraints, fit within the established study by Haggstrom et al. (2008).

Kitua, Mashalla, and Shija (2000) argued that these constraints are among the top issues faced by health services in Tanzania. This is even more difficult in rural health sites, including dispensaries and small health centres, where water supplies are unreliable or unavailable, and poor sanitation is regularly encountered (Kahabuka, Moland, Kvale, & Hinderaker, 2012). Consistent with the barriers identified in the current study, one research participant (post-CPD participation) explained their initiation and discussion with their manager about repairing several sinks and taps that had not functioned in their unit for some time. They needed to be repaired so that hand washing and infection prevention and control could be ensured. This finding highlights the difficult situation NMs face in Tanzania. NMs in developed nations take for granted that the basic fixtures, utilities and mechanical services of any healthcare facility should be functional and regularly maintained.

All the workplace constraints combined have major implications for Tanzania's healthcare system, increasing the burden and overwhelming the capacity of the NMs working in these settings. However, not all problems are insurmountable. As demonstrated in the above research finding, the analogy about repairing taps at a unit in one Tanzanian organisation showed that the participant who attended CPD understood the significance of hand hygiene and infection prevention, and was empowered to initiate change in the workplace. The old saying that 'knowledge is power' was true in this regard. The NMs who continually developed through knowledge acquisition from CPD demonstrated the ability to be empowered and achieve positive results. To this end, the next section describes the extent of research regarding CPD in developing nations, such as Tanzania.

5.3.2 CPD and CE

CE is central to enhancing the CPD of NMs (ANMC, 2009; Dickerson, 2010; NMBA, 2010). CE is well recognised as an essential element to developing a skilled workforce, advancing practices and achieving health outcomes (Hosey, Kalula, & Joachim, 2016; International Confederation of Midwives, 2014; International Council of Nurses, 2012; WHO, 2016). As discussed in Chapter 2, CPD is a continual process, where developments are contingent on each individual's area of interest. Knowledge and skills development gained through support and ongoing commitment facilitates the understanding of best practice. This results in the ability to give quality care, and contributes to the wellbeing and health outcomes of patients. As illustrated in Figure 2, the continual process of CPD and education promotes professional development (Aiga & Kuroiwa, 2006; Gallagher, 2007; Manzi et al., 2012).

In the current study, NMs in Tanzania who attended CE provided by GHAWA identified a serious need for CE in their workplace to improve their clinical practice and help save lives. Based on the CPD and education process model (Figure 2), using the knowledge and skills gained through ongoing support and commitment enabled practical changes to be made to their clinical practice. These NMs were able to give quality care and witnessed life-changing outcomes in their patients. Psychologically, this also created a strong sense of empowerment and boosted morale. However, to sustain this, it is vital to gain system-related support from the government and health administrators to ensure the stability of providing CE locally. This can occur through a centralised approach, by coordinating

hospital and region to form a centre of excellence with designated nursing positions responsible for staff development education, including 'train the trainer' concepts. Campbell-Yeo et al. (2014) supported this argument when examining the educational and clinical practice of nurses caring for sick neonates in India, and recommended the establishment of a similar goal. Campbell-Yeo et al. stated this would lead to streamlined management of resources, and, through developing nursing expertise, would improve outcomes.

Another study examined health workers' motivation in rural health facilities by assessing the underlying issues that affected staff's level of motivation in their provision of health services in Zambia (Mutale, Ayles, Bond, Mwanamwenge, & Balabanova, 2013). The research consisted of 96 participants, including nurses (the majority), clinical workers, health technicians and untrained workers who attended to patients daily. The Zambian health context shares the same challenges as Tanzania, including shortage of healthcare human resources, poor pay, stress and work overload. One of the critical findings Mutale et al. (2013) highlighted in their study was that health workers who had attended education or training of some form in the preceding 12 months of working in the facilities showed higher motivation scores than did those workers who did not attend any training. This supported the notion and need for continuous 'systematic refresher training' as a course for skills enhancement and motivation (Mutale et al., 2013, p. 7). A key aspect of health performance is related to staff who are motivated. This is reinforced by the WHO (2016) emphasis on the need to develop capable, motivated health workers.

Given the shortages of NMs in Sub-Saharan Africa and Tanzania, Shortell and Kaluzny (2006) suggested that it is highly desirable to develop ways to improve knowledge and skills without removing staff from the workplace. A qualitative study with midwives in Mozambique further highlighted that all CE provided should be relevant to the local settings and resources (Pettersson, Johansson, Pelembe, Dgedge, & Christensson, 2006), thereby ensuring that the content and context are meaningful and appropriate to the educational needs of the health workers. This is supported by the Tanzania MoHSW (2003) in its policy document, *Strengthening Continuing Education/Continuing Professional Development for Health Workers in Tanzania*. While there are good intentions to strengthen CPD, the practicality and gaps for health workers (including NMs) to access locally available CE remain problematic.

Kaaya et al. (2012) reported that Tanzania lacks a formal system for CPD. Once health professionals are given their licence to practice, individuals are not required to update or improve their skills or knowledge. This adversely affects the professional standards, health workers' motivation, and health outcomes of the population. To improve NMs' performance in providing safe and competent care, in 2014, the TNMC issued national CPD guidelines for NMs in Tanzania. The document promotes CPD as a lifelong learning journey for professional growth and career progression (TNMC, 2014). The National Council stipulated that employers of public and private institutions, including healthcare settings, in Tanzania are obligated to provide, support and sustain the provision of CPD for NMs. This is a positive step in promoting and encouraging CPD across the country; however, more work is still required in this area. In 2014, in its strategic plan, the Tanzania MoHSW acknowledged that the concept of CPD was not adequately emphasised and integrated in the healthcare system. It also stated that a culture of lifelong learning was not instilled in health workers, including its significance into the future for individuals' practice and career development. The document further highlighted that, while some health workers have attended additional CPD training, it is not uncommon to find staff who have not attended CPD for five years or more. There is also little follow-up to establish the issue of performance and the effects of CPD training (MoHSW, 2014).

Previous literature findings and the findings of this study indicate that limited opportunities and barriers for NMs to access CE continue to be an issue in Tanzania (Kaaya et al., 2012; Prytherch, Kakoko, Leshabari, Sauerborn, & Marx, 2012; Tanaka, Horiuchi, Shimpuku, & Leshabari, 2015). This concern is also shared in other parts of Africa, such as Madagascar, Kenya and Lesotho. However, CPD is of growing interest across Sub-Saharan Africa, and various efforts have been undertaken to support CE, including collaborations with benevolent aid agencies around the world.

The WHO (2016) asserted that a well-supported and regulated nursing and midwifery profession can transform health actions and healthcare delivery. NMs play a critical part in strengthening the health system and, within the recently released WHO document, *Global Strategic Directions for Strengthening Nursing and Midwifery 2016–2020*, CPD and collaborative partnerships to maximise NMs' capacities and potentials are considered an integral approach to strengthen the profession. In short, CE enhances the CPD of NMs (International Confederation of Midwives, 2014; International Council of Nurses, 2012;

WHO, 2016). The yielded benefits for staff and ultimately patients are significant, and this notion is widely accepted. However, CPD's sustainability in Tanzania will require significant coordinated efforts by the government, regulatory bodies, hospitals and training institutions to reform the staff development of NMs in Tanzania. As identified in this study, investment in designated staff who are good mentors can enable accessibility to CE in the work environment. Fostering NMs' reflective practice and critical thinking skills will also add value to the overall workforce's capacity and capability, as further discussed in the next section.

CPD sustainability can be enhanced by system-related support, including considerations for a centralised approach to access CPD locally by region and hospital, the prospect for career progression, and equitable remuneration (Campbell-Yeo et al., 2014). However, in the context of this study, the word 'remuneration' must not be confused with 'per diem'. The notions of appropriate remuneration that leads to career progression, versus per diem to attend CPD or education and training of any form, are separate and different. While both are associated with monetary incentives, recent studies have raised questions regarding the sustainability of international development project interventions and the ongoing provision of per diem. Ridde (2010) stated that per diem arose in the 1970s, when the growth of development aid started, and it was introduced mainly out of the motivation to ensure activities would occur. The pervasive use of per diem in certain countries—such as Malawi, Mali, Mozambique, Nigeria, Tanzania and Ethiopia—has become entrenched and expected in these societies, thereby creating a per diem culture that is harmful to healthcare organisations in Africa (Ridde, 2010; Skage, Soreide, & Tostensen, 2015). An obstacle for international development program in recent instances has been how to counter the pitfalls connected with per diems to incentivise participation.

Some of the comments and findings in this study showed that payment to attend CPD could increase the rate of participation. As previously discussed, this raises questions about the quality of people attending CPD sessions and their motivation for participation. A study by Sanner and Saebo (2014) in Malawi regarding the implementation of an information and communication technology project showed that the use of per diem and its expectation had a negative effect on the long-term capacity building and sustainability of project efforts. Not only can this quickly erode access to international donor's funding, but this approach also attracts the wrong people to attend workshops and training sessions

(Sanner & Saebo, 2014). Instead, to strengthen local institutions' capacity, Sanner and Saebo (2014) recommended creating partnerships with ministerial officials, such as the Ministry of Health, to establish a shared pool of resources (including financial resources), and prioritising short-term projects over long-term restructure to achieve set goals. This achieves capacity building and sustainability in the longer term, beyond the lifespan of the international development project.

5.3.3 Reflective Practice and Critical Thinking

The concept that reflective practice improves critical thinking has been around for decades. Aspects of reflective practice foster the idea of rational thinking (Bulman & Schutz, 2013) and learning through reflection (Sherwood & Horton-Deutsch, 2012). The ancient Greek philosopher, Aristotle, initiated this notion of practical wisdom, and, in the 1980s, philosopher Donald Schön influenced the development of reflection in professional education (Sherwood & Horton-Deutsch, 2012). There is a growing body of knowledge about reflective practice, critical thinking in nursing, and the facilitation of students' learning through reflection. While the concept is not new, there is a dearth of published literature about the effect of this pedagogical approach on NMs in developing nations (Kabuga, 1977; Mangena & Chabeli, 2005; Thompson, 2010).

Reflective pedagogy is a learning tool and way of guiding learners' thinking to develop autonomy, critical thinking, practical understanding and open-mindedness (Caldwell & Grobbel, 2013; Sherwood & Horton-Deutsch, 2012). It enables learners to build upon their clinical experiences and develop knowledge, so they can become fully aware of issues in their clinical environment, such as safety (Sherwood & Horton-Deutsch, 2012). A literature review of studies between 2001 and 2012 by Caldwell and Grobbel (2013) indicated that nurses who reflected regularly had a better understanding of their actions, which consequently developed their professional skills and enabled better nursing care. The emphasis leads to health staff thinking more about safe practices, thereby creating a safe environment for their patients and peers. Thus, reflection is an implicit and essential skill in professional nursing practice (Sherwood & Horton-Deutsch, 2012).

It was evident in the current study that the WANMs did not even think about the concept of reflection until their time in Tanzania, where they felt that the TNMs' critical thinking abilities were lacking. This implied that the WANMs used reflection as a normal and

habitual part of their practice. They assumed that what they knew was obvious to other nurses and required no consideration (Price, 2015). Their application of reflective practice, which was then applied as part of the CE process in Tanzania, indicated that the TNMs responded positively with motivation, confidence and empowerment. As a result, it heightened their critical thinking ability. The WANMs also gained insight about how to improve the TNMs' practice and clinical environment, which was later confirmed by the TNMs. This showed that reflection has the potential to augment NMs' practice development. Gustafsson and Fagerberg (2004) supported this view in their qualitative study, where four RNs were interviewed with the aim of determining the nurses' experiences of reflection, and its relation to nursing care and professional development. The results showed that using reflection as a tool stimulated courage and empowered these nurses to meet the needs of their patients. The nurses in the study felt that 'reflection allowed them to develop and mature professionally' (Gustafsson & Fagerberg, 2004, p. 276). Reflective practice provided these nurses the opportunity to learn from their reflection, and further enhanced their capability to teach others (Gustafsson & Fagerberg, 2004).

A Tanzanian study by Haggstrom et al. (2008) also supported the idea of reflection. The study reviewed 29 Tanzanian nurses' written responses to questions. The aim was to gain insight to the nurses' views of workplace distress and ethical dilemmas in Tanzanian healthcare. The results indicated that these nurses felt their work was filled with difficulties, and that they were suffering from work-related stress while trying to maintain good-quality care. The conclusion indicated that better equipment and support for staff were required. It also determined that, to minimise stress overload, it was vital to guide Tanzanian nurses to gain insight and be able to reflect on their situations. This study did not specifically consider reflective practice, yet suggested that reflective practice has a role in supporting nurses to cope with their daily work.

In another study, Bulman, Lathlean, and Gobbi (2012) used an interpretive ethnographic approach to examine the concept of reflection from the perspective of nursing students and teachers in the United Kingdom. The students reported that the process of reflection nurtured a deeper level of thinking, which led to changing and improving their practice. The opportunity to think critically helped develop their self-awareness in recognising their limitations. As their confidence to question their practice grew, they became

comfortable in their role and were better able to face the challenges in their clinical practice (Bulman et al., 2012).

These studies consistently show that reflective practice can improve nurses' critical thinking ability, and one of the ways to achieve professional development is through reflection (Bulman et al., 2012; Caldwell & Grobbel, 2013; Gustafsson & Fagerberg, 2004; Haggstrom et al., 2008; Sherwood & Horton-Deutsch, 2012). Encouraging nurses to reflect on their practice stimulates recognition for a call to action that ultimately promotes better nursing care (Bulman et al., 2012; Gustafsson & Fagerberg, 2004). As a result of this action, a change or transition occurs, as shown in this study. This leads to the subject of change management, as discussed in the following section.

5.3.4 Change Management and Sustainability

Change management in general is a topic widely discussed in the literature (Crossan, 2003; Scott, 1999; Shanley, 2007; Stonehouse, 2012). Change management from a nursing professional context and organisational perspective is often explored separately (Bellman, 2003; Murphy, 2006; Shanley, 2007; Stonehouse, 2012); however, these are interrelated. From a broad holistic sense, the performance of a healthcare organisation, for example, is complex and reliant on multifaceted factors, some of which include the health facilities and healthcare workers' practices and services in the organisation. For the purpose of this study, this section explores organisational learning and the people within the organisation as the driving forces of change through education and training.

Organisational learning is the development of collective education that affects an organisation's operation, performance and outcomes (Ratnapalan & Uleryk, 2014). Kirwan (2013) purported that this is linked to the area of human resource development and adult education. In 1978, Chris Argyris and Donald Schön who began to develop the concepts of learning, described the concept of organisational learning as a knowledge translation phenomena that involves individual and team learning in the workplace, including experts and novices from diverse backgrounds (Gagnon et al., 2015; Ratnapalan & Uleryk, 2014). This social process of knowledge sharing can result in organisational change (Ratnapalan & Uleryk, 2014). From a nursing practice perspective, a case study of eight Canadian nurses by Gagnon et al. (2015) posited that an organisation committed to learning created a culture of learning among nurses at work. In this study, novice nurses

were paired and supported by experienced colleagues in their specific field. Gagnon et al. (2015) explained that this was done to enable knowledge transfer of their work. Routine assessments of the novice nurses' practice were further undertaken by nurse-educators to ensure standards were maintained and to ascertain their integration of knowledge progression and acquisition. Ratnapalan and Uleryk (2014) added that the performance and action of staff in such organisations improves safe patient care.

On reflection, while the NMs in Tanzania did not have nurse-educators to routinely support and maintain their professional development in the workplace, the support of the WANMs offered by GHAWA provided evidence that the TNMs who participated in CE changed and improved their practice. One of the key findings indicated that this change resulted in reduced maternal and neonatal mortality incidents. However, the gap is the question of sustainability and, as demonstrated in the findings, ongoing support with the prospect of 'dedicated group educators/mentors' is proposed. Gagnon et al.'s (2015) example offers a potential strategy to the issue experienced in Tanzania. It seems that the driving force of NMs who are keen to make positive changes in their practice, coupled with organisational support, could lead to sustainable changes in CPD. This strategy would also help maintain sustainable outcomes and performance in the organisation. Frost (2010) advocated that this increases the effectiveness and efficiency of healthcare providers and organisations.

The nursing literature regarding organisational learning supports the importance of CPD and better knowledge management in healthcare (Gagnon et al., 2015; Hovlid, Bukve, Haug, Aslaksen, & von Plesson, 2012). Berta et al. (2015) postulated that this organisational learning framework has the potential to encourage higher-order learning and to sustain modest adaptations to work routines and processes within organisations. Ratnapalan and Uleryk (2014) noted that managing the learning requirements to execute functions and transferring the flow of information will ultimately enhance patient care. Collectively, as an interconnected system, education and learning should occur at all levels in the healthcare system, including the individual, team, inter-professional and organisational levels. The application of this concept in the context of NMs specifically suggests that it can facilitate shared knowledge and experience over time, where changes are more likely to be sustained (Hovlid et al., 2012). This can be further enhanced by motivated nursing educators. The findings in the current study specifically indicated that

the WANMs, as enablers of CPD and adult education, were pragmatic and open in their approach to support their learners. Bahn (2007) noted this to be a desirable attribute, as it enriches the effectiveness of the teaching and learning interaction. Educators with a fundamental understanding of lifelong and adult learning could provide support and help reduce barriers to learners' participation in a challenging environment (Bahn, 2007).

Change is a common feature of any organisation. It requires the open-mindedness and flexibility of individuals at all levels to foster a sense of unity and team learning (Bellman, 2003; Murphy, 2006; Scott, 1999). Trofino (1997) stated that this helps people cope with the change, and shifts the paradigm to avoid reverting to the old practices. After all, change is only positive if it can be maintained. Central to the process of change, the model of organisational change can be traced back to Kurt Lewin's 'force field analysis' (Connolly, 2016). Lewin used the concept of a push between two opposing sets of forces—driving and restraining forces—that directly affect outcomes. The driving force (enablers) is said to promote change, while the restraining force (barriers) attempts to maintain the status quo and is an obstacle to change. Lewin proposed that, whenever the driving forces are stronger than the restraining forces, the existing situation will change (Connolly, 2016). See Figure 26 for a simplified illustration of this model.

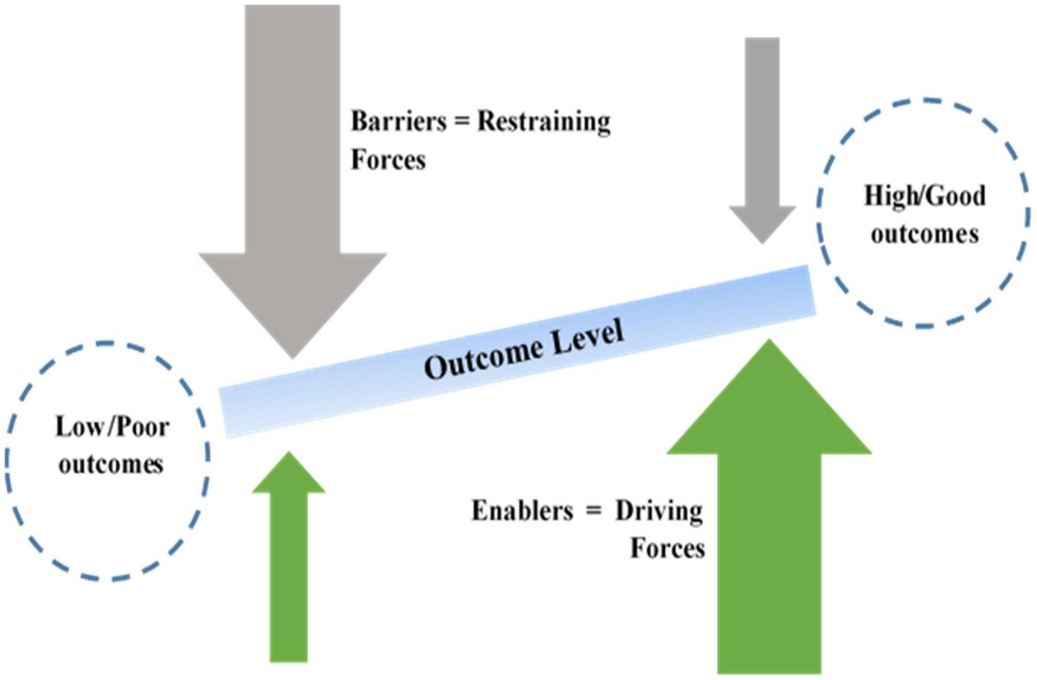

Figure 26: Kurt Lewin's Force Field Analysis (Adapted from Connolly, 2016)

Baulcomb's (2003) study explained that introducing Lewin's force field analysis in a busy haematology unit in the United Kingdom successfully changed a small-scale staff allocation to accommodate an increased number of patients with no additional cost. This was achieved by removing key obstacles within the existing rostering system (barrier), and helping staff increase their clinical skills and understand their role (enabler). This empowered the staff to think, organise and plan for themselves (outcome). The staff also became more focused on their job.

In the case of the current study, the researcher argues that there are merits to applying Lewin's force field analysis concept to help sustain CPD in Tanzania. While this theory was beyond the scope of this study, the findings thus far mirror Lewin's force field analysis, whereby the enablers identified in the study could serve as the driving forces, while the barriers fit within the restraining forces. In this instance, CPD altered the status quo to generate positive outcomes and identify significant results, such as reduced maternal and neonatal mortality. The goal of manifesting sustainability is to help stabilise the equilibrium, which, in this case, is to have ongoing support and develop 'dedicated peer group educators/mentors' to progress CE, thereby creating the opportunity for local sustainable change into the future. Figure 27 illustrates this study, based on Lewin's force field analysis.

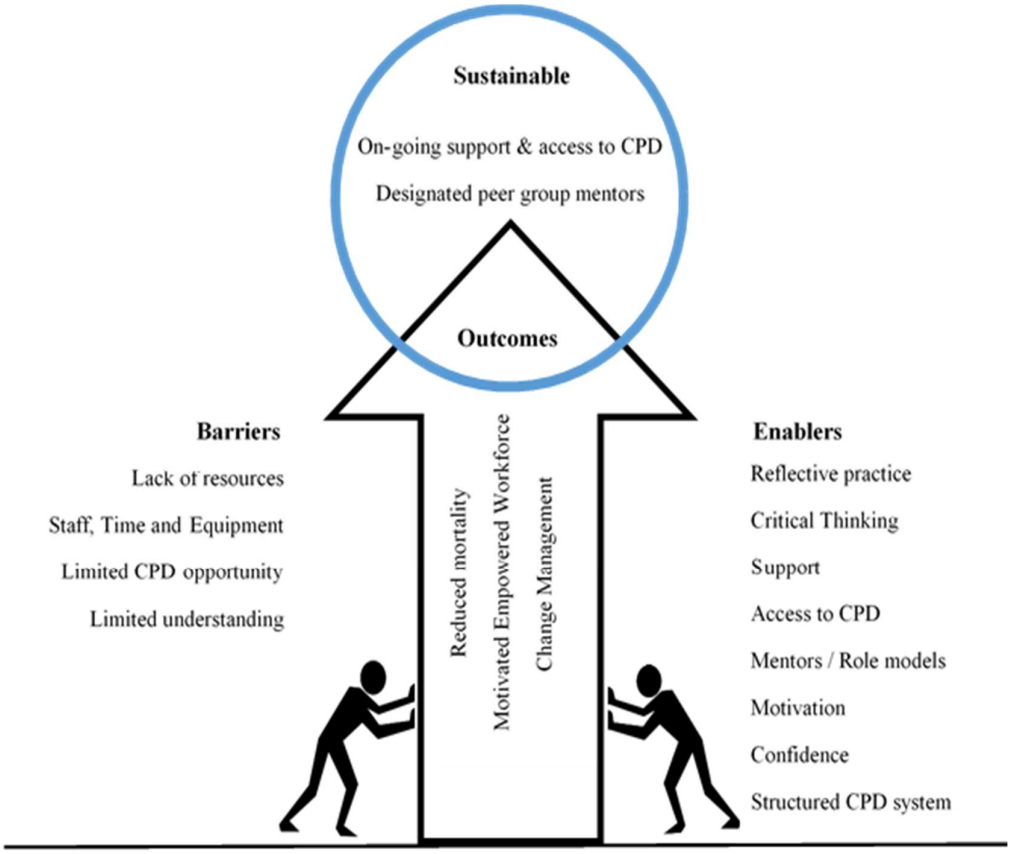

Figure 27: Illustration of Findings for This Study, Adapted from Lewin's Force Field Analysis

5.4 Limitations of this Research

The main limitation of this study was that the NMs came from within one region of Tanzania (Dar es Salaam) and that only those who participated in the GHAWA program at seven public and private organisations located in urban and rural Dar es Salaam were interviewed. There are 30 regions in Tanzania; as such, caution should be taken when generalising the findings to other regions across Tanzania.

Another limitation was that the researcher found that published sources of information and studies related to CPD in developing countries, including Tanzania, were limited. Thus, to be informed by the lessons learnt in this study, it was necessary to rely on comparisons with information from developed nations.

Finally, this study evaluated the effect of CPD for TNMs from the perspective of those NMs in WA and Tanzania who participated in the GHAWA program. However, it did

not link the findings identified (barriers, enablers, outcomes and sustainability) to an established theory. This was not within the scope of the current study. Thus, it is recommended that this topic be examined further, using different types of theorists to understand its causal link to change.

5.5 Summary

This chapter has presented a comparison of the findings from both the WA and Tanzania cohorts. The common areas were then compared with other findings from the literature. The severe shortage of human resources, lack of medical equipment and restricted access to CPD were commonalities identified in the literature that indicated reasons as to how and why hospital staff's ability to provide best practice and quality care in developing countries is hampered. Various studies undertaken in developing countries have emphasised the need for inter-project collaboration among healthcare organisations, the government and international development programs to strengthen the capacity of the workforce and progress sustainable change in the longer term.

This study contributes valuable information to the current body of knowledge about CPD and its priorities to help sustain CE in Tanzania into the future. The findings also offer insights for health service managers, hospital administrators and the MoHSW when developing strategies to enhance CPD and potentially implement a staff development model in Tanzania's healthcare organisations. As a way forward that considers sustainable outcomes for NMs and relevant healthcare systems in Tanzania, the knowledge gained from this study can recommend a staff development CPD model for NMs in Tanzania—one that can support capacity building and sustain the NM workforce to become an effective and efficient component of the Tanzanian healthcare system. Chapter 6 discusses the implications of this study and presents recommendations for supporting CPD, including the future staff development of NMs.