

School of Nursing and Midwifery

Tanzanian Midwives' Perceptions of Their Professional Role

Brooke Eve Jones

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Declaration

To the best of my knowledge and belief, this thesis contains no material previously published by any other person, except where due acknowledgment has been made.

This thesis contains no material that has been accepted for the award of any other degree or diploma in any university.

Signature: *Brooke Eve Jones*

Date: ...8th December 2014.....

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Abstract

The United Nations Millennium Developmental Goals (MDGs) highlight the significant need in developing countries for ‘skilled birth attendants’—namely, midwives—to reduce maternal and neonatal mortality (WHO, 2008a). To ensure that midwives maintain and improve their ability to provide skilled care, it is paramount that they undertake continuing professional development (CPD) (ICM, 2008, 2011c). This however, is not readily available in many developing countries due to a lack of experienced educators (Dennis-Antwi, 2011). As a result, Western midwifery educators are being deployed to provide CPD, including educators from Western Australia working in Tanzania with the Global Health Alliance of Western Australia (GHAWA) (Jones, 2011). Nonetheless, there are vast differences in the maternity contexts of Tanzania and Western Australia, as a developed setting. The purpose of this study was to explore Tanzanian midwives’ perceptions of their professional role in the context of their clinical working environment. Given the uniqueness and importance of the role of the midwife, considerable investigation is required to provide an understanding of midwifery in Tanzania. This new knowledge will allow a greater awareness and appreciation of the issues facing the midwifery profession in Tanzania, and subsequently enable midwifery educators visiting the region to provide culturally appropriate education in maternal and neonatal mortality prevention.

The current study employed a qualitative, descriptive design using focus group interviews as the method of data collection (Beck & Polit, 2010). Relevant ethical approvals from Australia and Tanzania were obtained, and 16 Tanzanian midwives from three government hospitals in Dar es Salaam, Tanzania, participated. Thematic analysis

was conducted using Ritchie and Spencer's (1994) framework analysis. Data saturation was reached within three focus groups.

The findings revealed two major themes relating to the self-identified role of Tanzanian midwives: Saving Lives and Value to Others. In Theme 1: Saving Lives, the Tanzanian midwives identified the overwhelming focus of their role as saving the lives of women and newborns. Within this theme, two subthemes emerged: Prioritising Care and Barriers to Saving Lives. In Prioritising Care, detecting unwell women and newborns, and focusing care accordingly was identified by the midwives as the main component of their ability to save lives. However, there were many barriers faced when trying to save lives, such as insufficient resources, low staffing numbers and a lack of CPD to improve knowledge. As a consequence, Barriers to Saving Lives emerged as the second subtheme under Saving Lives.

In Theme 2: Value to Others, the midwives perceived that they had a low status in the community due to their minimal wage, presumed lack of knowledge and poor attitude. Three subthemes were identified. The subtheme of Personal Community: Family and Friends revealed that, although the midwives believed they were sought for medical help in times of need, they were otherwise not appreciated by those closest to them due to their poor working conditions and low wage. In the subtheme of Professional Community: Patients and Doctors, the midwives believed that, although some women were appreciative of them, pregnant women often disregarded their knowledge and only trusted doctors. The midwives generally had a good working relationship with doctors, although occasionally they were disregarded by doctors for their perceived lack of knowledge. In the final subtheme of The Tanzanian Government, the midwives believed

the government acknowledged the importance of midwives, but did not appreciate them, as evidenced by their poor working conditions and pay. Despite this, the midwives had strong self-belief in the importance of the midwifery profession for saving the lives and improving the wellbeing of women and newborns.

Above all other aspects of care, the Tanzanian midwives perceived their role as being the prevention of maternal and neonatal mortality. This study therefore, recommends that CPD education provided by Western midwifery educators should ensure that saving lives be a major focus, and that the strategies taught must be relevant to the low-resource context of the developing country. To accommodate the needs of the high-risk women being cared for, prevention and management of maternity emergencies should be included, with medical personnel also being involved in these programs.

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List of Abbreviations

ALSO	Advanced Life Support in Obstetrics
AMRN	Africa Midwives Research Network
ARC	African Regulator Collaborative for Nurses and Midwives
CPD	continuing professional development
CMACE	Centre for Maternal and Child Enquiries
COSTECH	Committee for Education, Science, and Technology
GHAWA	Global Health Alliance of Western Australia
HIV	human immunodeficiency virus
ICM	International Confederation of Midwives
ICN	International Council of Nurses
MDG	Millennium Development Goal
MNH	Maternal and Newborn Health
MOHSW	Ministry of Health and Social Welfare
NRMSP	National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania
PMMC	<i>Philosophy and Model of Midwifery Care</i>
PROMPT	Practical Obstetric Multi-Professional Training
TNMC	Tanzania Nursing and Midwifery Council
UK	United Kingdom
UNFPA	United Nations Family Planning Association
UN	United Nations
US	United States
WHO	World Health Organization

Chapter 1: Introduction

The International Confederation of Midwives envisions a world where every childbearing woman has access to a midwife's care for herself and her newborn. ... [midwives are] the most appropriate caregivers for childbearing women and in keeping birth normal, in order to enhance the reproductive health of women, and the health of their newborn and their families. (ICM, 2013b, p. 1)

Care during pregnancy and birth should be the right of every woman. As such, midwives are essential to the wellbeing of all childbearing women and their children (WHO, 2008a). With the internationally recognised role of preventing and detecting complications in childbirth, midwives ensure the safety of those in their care, while creating a valuable experience for the woman and her family (ICM, 2005; WHO, 2013b).

The presence of midwives, is particularly vital in Sub-Saharan Africa (UNICEF, 2010a) due to the high maternal and neonatal mortality rates in the region, and the long history of deficiencies in healthcare resulting from a lack of infrastructure and insufficient political and financial progress (Ekechi, Wolman & de Bernis, 2012). The East African country of Tanzania, in which this study was conducted, is no exception, with 23 women and 228 babies dying every day as a result of birth-related complications (UNFPA, 2011; UNICEF, 2010b). Outcomes such as these have placed Sub-Saharan Africa at the forefront of improvement strategies being promoted by the United Nations (UN) through the establishment of the Millennium Developmental Goals (MDGs), specifically MDGs 4 and 5. MDGs 4 and 5 focus on the need to reduce maternal and under-five mortality rates, particularly in Africa (UNICEF, WHO, The World Bank & UN, 2013; WHO, UNICEF, UNFPA, The World Bank & UNPD, 2014).

In this region, various strategies have been established in an effort to meet these goals (UN, 2010a, 2010b).

To decrease maternal and neonatal (less than four weeks old) mortality rates, the provision of skilled birth attendants (midwives and doctors) is considered an essential factor (Fullerton, Johnson, Thompson & Vivio, 2011; Kamdonyo & Matinhure, 2013; UNFPA, 2013; UNICEF, 2010a). While providing immediate care at this early age, the midwife's initial involvement aims to positively affect both infant (up to one year old) and child (beyond one year) morbidity and mortality (UNFPA et al., 2014). To achieve reduced mortality rates, midwives must have adequate pre-registration education, as well as ongoing professional development and support once qualified (Dennis-Antwi, 2011; Gross, McCarthy & Kelley, 2011a; Lavender et al., 2009). However, access to continuing professional development (CPD) is limited in Sub-Saharan Africa due to a lack of operational funding and the limited availability of suitably skilled educators (Dennis-Antwi, 2011; Lavender et al., 2009; UNFPA et al., 2014).

In Sub-Saharan Africa, the necessity for ongoing midwifery education was first acknowledged by the Africa Midwives Research Network (AMRN) when it was established in 1992 (Forss & Maclean, 2007; Lugina, Mlay, Smith & Lavender, 2002). The AMRN's purpose is to promote and develop evidence-based practice in the 22 African nations (Forss & Maclean, 2007). Alongside the AMRN in 2011, the African Regulator Collaborative for Nurses and Midwives (ARC) was established between key parties in East, Central and Southern Africa, with the aim of improving standards for the professions through providing grants (ARC, 2013; Gross et al., 2011a). At that time, the nations throughout this region were required to state their professional priorities in nursing and midwifery in order to achieve widespread improvement in the standard of care (Gross et al., 2011a). Many of the chief nurses and midwifery officers in the other

nations of the region, including Tanzania, voiced the need for CPD strategies for ongoing midwifery education to be a priority for their profession (Gross et al., 2011a). However, Tanzania was not selected by the ARC for one of their grants, which potentially left the region without the resources to establish CPD (Gross et al., 2011a).

In Western Australia, the CPD goal of the ARC and inability of Tanzania to achieve selection by the AMRN was acknowledged by the state's nursing and midwifery leaders. To address this issue, in 2009, the Global Health Alliance of Western Australia (GHAWA) was established—a non-profit nursing and midwifery-based organisation (Jones, 2011). The aim of the GHAWA is to collaborate with nurses and midwives from developing nations, for instance Tanzania, to work towards achieving MDG 4: Reduce child mortality and MDG 5: Improve maternal health (Jones, 2011). As such, the GHAWA provides CPD to address MDGs 4 and 5 through two-week professional development workshops that are run in Tanzania six times per year by midwifery educators from Western Australia (Jones, 2011; Keyes, Lane, O'Nions & Stanley, 2011). Presently, the GHAWA's professional development programs are still being established for Tanzania.

The key role of Western midwifery educators in the GHAWA program is to donate their time and skills to enhance the professional development of Tanzanian nurses and midwives (Jones, 2011). The GHAWA maternal and neonatal care workshop includes complex maternity care and emergencies, as outlined in Appendix A. The schedules are based on the Practical Obstetric Multi-Professional Training (PROMPT) workshops, which are used worldwide to promote an effective team-based response to obstetric emergencies (Draycott, 2013). Tanzanian midwives from the hospitals who have formed an allegiance with the GHAWA are invited to attend. These include

several government and privately run hospitals in the Dar es Salaam region (Martin, 2012).

Although the aim of these workshops is to provide information and support to Tanzanian nurses and midwives, the Western Australian educators do not receive information on how to deliver culturally appropriate education prior to them travelling to Tanzania. Further, they have limited (if any) immersion in the country's maternity health system prior to or during their short two- to four-week stay. The researcher of this study was one of the first midwifery educators to undertake CPD with the GHAWA in Tanzania. During this time, she and her Australian colleagues expressed difficulty in understanding the philosophy of midwifery practice among Tanzanian midwives. This uncertainty made it challenging to provide sessions relevant to the culture and facilitate positive changes in care delivery.

The researcher compared this experience to her time working as a midwife and midwifery educator in Sierra Leone in 2010. For seven months, she worked alongside local midwives at a new midwifery-led maternity unit in which there were and continue to be approximately 100 births taking place per month. The researcher and her expatriate colleagues expressed similar challenges to those experienced in Tanzania in understanding the cultural context and values of local midwives in order to encourage them to develop their skills and see the potential for change in mortality rates. As the expatriates worked alongside the local midwives on a daily basis, they learnt about their views towards midwifery and aspirations for their profession. Anecdotally, there seemed to be a lack of belief by the Sierra Leonean midwives that improvement in their practices could positively affect mortality rates, and they lacked knowledge regarding midwifery problems and their management. To attend to these concerns, the expatriates adapted the education program to best suit the needs of these midwives, which resulted

in dramatic improvements in the midwives' skills and motivation. These changes had a direct effect on ameliorating the neonatal mortality rate, which decreased from 1:8 to 1:45 babies during the researcher's seven-month stay. Additionally, no maternal deaths of 600 births were encountered during this time.

In comparing the researcher's long stay in Sierra Leone to that of the Western Australian GHAWA educators' short two to four weeks in Tanzania, there was a notable difference in the potential to gain cultural competence—that, is to have, 'the ability to appreciate diversity, including people's values, beliefs and behaviours' (Taylor & Fry, 2010, p. 452). To overcome the effect of this limited cultural exposure in Tanzania, it was evident that additional efforts were required to determine what the midwifery role means for local midwives in order to facilitate the development of culturally relevant education, as this was not occurring. It was within this context that the current study was developed to gain information and address this educational need.

The broad aim of the current study focused on contributing to an understanding of Tanzanian midwives' perceptions of their role. In doing so, this study intended that the information gained would assist in developing CPD programmes that are reflective of the local midwives' values. By providing relevant CPD education, it is anticipated that an increase in the midwives' capability to save women and newborns may result.

Within the context of the current global situation, Chapter 1 provides the background of the study by outlining maternal and child health and midwifery practice. It is important to note that in Sub-Saharan Africa, midwives are commonly referred to as nurse-midwives, due to their integrated education. Within this thesis the term midwives will be used, as it refers to those who are practicing in a midwifery capacity. The concepts of the UN MDGs and Australia's commitments to the MDGs are then introduced as important elements of maternal and child health in Tanzania. Following

this, the purpose and objectives of the study are presented. The chapter concludes by discussing the significance of the study and presenting an outline of the thesis.

1.1 Background of the Study

1.1.1 Maternal and child health.

Maternal health is defined by the World Health Organization (WHO) (2014b) as ‘the health of women during pregnancy, childbirth and the postpartum period’ (p. 1), while child health is defined as the ‘growth and development’ of children (WHO, 2014e). Although closely connected, maternal and child health are addressed by international health agencies as two separate entities (WHO, 2014e, f). The rationale for this separation is that, while the health of a mother is fundamental to the wellbeing of her children, there are different pathological illnesses and reasons for mortality between the two groups (WHO, 2014e, f). Thus, in this chapter, maternal and child health are addressed separately. Further, because the term ‘health’ is mainly reported through mortality rates by means of evidence from the World Health Statistics of the WHO (2012b), evaluation of mortality rates will be considered the most appropriate measure of maternal and child health.

Over the last 23 years, maternal mortality rates have reduced internationally by nearly 45%, with a worldwide decrease in actual deaths from 543,000 to 289,000 women between 1990 and 2013 (WHO et al., 2014). Today, this figure remains unacceptably high, with one woman dying every two minutes somewhere in the world as a result of pregnancy or childbirth complications (WHO, 2012b). It is also reported that every time a woman dies, approximately 20 others suffer childbirth-related injuries, infection or disability (UNICEF, 2010a). Internationally, more than 80% of maternal deaths are caused by haemorrhage, sepsis, unsafe abortion, obstructed labour and

hypertensive diseases of pregnancy, many of which could be prevented with the appropriate management (UNDP, 2012).

The literature indicates that 99% of all maternal deaths occur in developing countries, with one in 30 women dying in Sub-Saharan Africa, in comparison with one in 5,600 deaths in developed regions (UNDP, 2012c). One-third of the world's maternal deaths occur in India and Nigeria, while the majority of the 40 nations with the highest rates of maternal mortality are situated in Sub-Saharan Africa, where 510 women per 100,000 births die each year (WHO et al., 2014). As a result, Sub-Saharan Africa accounts for 62% of all maternal deaths, while Southern Asia accounts for 24%—together comprising 86% of the world's maternal deaths (WHO et al., 2014). Comparisons between these regions with the developed world are illustrated in Table 1.1. Significant reductions in mortality rates, particularly in Southern Asia, are attributed to widespread use of contraception (84% in Southern Asia versus 22% in Sub-Saharan Africa) and improved access to skilled birth attendants (WHO et al., 2014).

Table 1.1

Maternal Mortality Trends

Region	Maternal mortality rate (deaths per 100,000 live births)	
	1990	2013
	<i>N</i>	<i>N</i>
Developed regions	26	16
Sub-Saharan Africa	990	510
Southern Asia	530	190

Note: Adapted from *Trends in Maternal Mortality: 1990–2013* (WHO et al., 2014, p. 25).

In a comparison of developed and developing country outcomes from a global perspective, the mortality of children aged under five years revealed a 47% reduction

from 1990 to 2012, with 90 deaths per 1,000 live births in 1990 declining to 48 deaths per 1,000 live births in 2012. However, this reduction still equates to 18,000 child deaths each day (UNICEF et al., 2013). Sub-Saharan Africa has the world's highest under-five mortality rate, with one in nine children dying (UNICEF et al., 2013). The under-five mortality rate in Sub-Saharan Africa has been increasing by 10% since 1990, which is 16 times higher than the average of developed regions (Shepherd, 2011; UN, 2011c; UNDP, 2012b). Southern Asia's child mortality rates also remain high, at one in 16. The disparity between Sub-Saharan Africa and Southern Asia with the rest of the world has continued to increase, as reported in *Trends and Levels in Child Mortality* by the UN (2013) (illustrated in Table 1.2).

Table 1.2

Child Mortality Trends

Region	Under-five mortality rate (numbers of deaths per 1,000 births)	
	1990	2012
	<i>N</i>	<i>N</i>
Developed regions	15	6
Sub-Saharan Africa	177	98
Southern Asia	126	58

Note: Adapted from *Trends and Levels in Child Mortality* (UNICEF et al., 2013, p. 9).

In 2011, the UN (2011c) reported that the four main causes of child mortality for those under five years of age were: (i) preterm birth complications, (ii) birth asphyxia, (iii) pneumonia and (iv) diarrhoeal disease. To address these challenges, the UN developed a set of goals—the MDGs—to focus international aid where it was needed most.

1.2 The UN MDGs

The MDGs were established in 2000 when 189 nations made eight goals aimed at reducing poverty and its associated deprivations (see Appendix B). Of these, MDGs 4

and 5 were related to maternity care (UNDP, 2012a). MDG 4 has the target of reducing child mortality, while MDG 5 is directed at reducing maternal mortality (WHO, 2008a).

1.2.1 MDG 4: Reduce child mortality.

MDG 4 aims internationally to reduce by two-thirds the under-five mortality rate from 1990 to 2015 (UNICEF et al., 2013). The role of midwives in achieving this aim is essential because they work closely with babies in their first 28 days of life—a time referred to as the ‘neonatal period’ (UNFPA et al., 2014). Recent reports indicate that 44% of child mortality occurs during this period (UNICEF et al., 2013), and neonatal mortality rates are reducing more slowly than the mortality rates of older children. The proportion of neonatal deaths as a percentage of total mortality rates for under-five’s has increased from 36 to 44% since 1990 (UNICEF et al., 2013). The causes of death in the neonatal period are different from mortality among other under-fives (UNICEF et al., 2013). Much of the improvement in neonatal health is dependent on improving the care of women throughout pregnancy and the training of birth attendants in neonatal resuscitation and care—all of which are poorly established in developing regions (Bream, Gennaro, Kafulafula, Mbweza & Hehir, 2005; Grady et al., 2011; UNFPA et al., 2014). These issues differ from the causes of death in older children, such as infectious diseases, which have improved significantly with the implementation of immunisation programmes (UN, 2011c).

1.2.2 MDG 5: Improve maternal health.

This MDG aims at improving maternal health internationally, with the target of reducing the maternal mortality ratio by 75% from 1990 to 2015 (UN, 2013). The WHO defines ‘maternal mortality’ as the ‘death of a woman while pregnant or within 42 days of termination of pregnancy’ (WHO et al., 2014, p.4). Today, the majority of maternal deaths are considered preventable, with the strategies needed to achieve this being quite

diverse (Campbell & Graham, 2006; WHO et al., 2014). The 2003 to 2005 United Kingdom (UK) Confidential Enquiry into Maternal and Child Health is viewed as the gold standard in mortality reporting during childbirth (CMACE, 2011), and reviews maternal deaths to develop recommendations for improved delivery of maternity care (see Appendix C). Although directed at the UK, the strategies are considered employable across other healthcare systems globally. Key recommendations from the Enquiry include improved CPD education in the skills of early recognition and response to the deteriorating patient, basic life support training, and effective communication and referral techniques (CMACE, 2011).

Access to contraception is widely accredited as a turning point in preventing maternal mortality because a woman is, quite simply, unable to die as a result of pregnancy if she is not pregnant (Diamond-Smith & Potts, 2011). However, this accessibility in developing countries remains inconsistent, with only 24% of African women using contraception, compared to 80% of women in the Western Pacific region (WHO, 2012b). The availability of uterotonic agents to prevent and treat postpartum haemorrhage is also considered essential, although is again not readily available in many developing regions (Derman et al., 2006).

One key strategy identified to achieve reduced maternal mortality is increasing the numbers of skilled birth attendants, who are defined as, ‘an accredited health professional—such as a midwife, doctor or nurse, who has been educated and trained to proficiency in the skills needed to manage normal ... childbirth ... and referral of complications in women and newborns’ (WHO, ICM & FIGO, 2004, p. 1). The WHO (2006a, b) reports that a 10% increase in the numbers of skilled birth attendants results in a 5% reduction in maternal mortality. Nevertheless, only 63% of births in developing countries are attended by skilled health workers, compared with 99% in developed

countries (UN, 2011b; WHO, 2008b). In Sub-Saharan Africa, this figure is 46% (UN, 2011b; WHO, 2008a). Therefore, it is significant to acknowledge the direct relationship between maternal mortality and neonatal wellbeing, particularly because motherless children are 10 times more likely to die prematurely (UNDP, 2012c).

1.3 Australia's Commitment to the MDGs

To assist developing nations to achieve the MDGs, the Australian Government has pledged its commitment through their agency, AusAID (2012b). In 2011, AusAID (2012a) provided AUD\$4.3 billion in developmental assistance through various emergency and sustainability-based projects. However, AusAID (2012a) does not have a strong in-country presence, instead providing 75% of its aid support through trusted partners. These associates include UNICEF's Children and AIDS Regional Initiative and the Addis Ababa Hamlin Fistula Hospital.

While Australia's greatest commitment is to its neighbouring Asia-Pacific region, with a 57% expenditure in 2011 to 2012 (AusAID, 2012a), significant contributions have also been made to Sub-Saharan Africa. In the last three years, Australia has contributed AUD\$916.2 million to the region, providing assistance to all Sub-Saharan countries (AusAID, 2012a). The focuses in this region are based on Australia's areas of expertise and experience—namely, maternal and child health, agriculture and food, water and sanitation, and building the region's human resource capability (AusAID, 2012a, 2013b). With attention to MDG 5, in 2011, AusAID contributed AUD\$12.5 million towards maternal health in Sub-Saharan Africa. This support included assisting Tanzania to provide contraception to over 624,000 women, and reviewing and financially assisting maternal and child health programs in Ethiopia and Sudan (AusAID, 2012a). AusAID is also committed to investing in programs that focus on improving the nursing and midwifery workforce capacity and capability

development (Jones, 2011). Encompassed within this commitment is the Australia-Africa Maternal and Child Health Initiative, which supports the training of African midwives (AusAID, 2011).

From a Western Australian perspective, the focus has been on addressing the needs of Sub-Saharan Africa, particularly Tanzania, and the need for improved maternal and child health outcomes in this area (Jones, 2011). In 2009, the Western Australian Minister for Health travelled to Tanzania to discuss the health needs of the nation with the Tanzanian Minister for Health. The visit was undertaken in recognition of the Australian Government's policy of respecting the nation's role as a partner when addressing international inequality, as per the global MDGs (Jones, 2011). As a result of this visit, a process was established to allow the entry of Western Australian nurses and midwives into Tanzania to assist with the development of the region's health service. The collaboration also included Western Australia's five Universities, all of which provide nursing degree programs with three also providing midwifery programs, and the Nursing and Midwifery Office in the Department of Health (Global Health Alliance, 2012). This collaboration was the basis for the establishment of the AusAID-funded GHAWA.

The aim of the GHAWA (2012) is to enhance the capability and capacity of the nursing and midwifery workforce in underserved populations via supporting nursing and midwifery initiatives in developing countries, in accordance with the MDGs. For that reason, GHAWA (2012) operates within the framework of the International Confederation of Midwives (ICM) and International Council of Nurses (ICN). The key Tanzanian education institutions involved with the GHAWA include Hubert Kairuki Memorial University, the Advanced Practice Midwifery School Muhimbili Campus,

and identified hospitals and health clinics in the Dar es Salaam region (see Appendix D).

1.4 Tanzania and Maternal and Child Health

Tanzania is situated on the eastern coastline of Africa in the Sub-Saharan region bordered by the Indian Ocean, Mozambique, Malawi, Zambia, the Democratic Republic of Congo, Burundi, Rwanda and Kenya, as illustrated in Figure 1.1 (Central Intelligence Agency, 2014; Transport Intelligence, 2012). Tanzania became independent from British rule in 1961, and united with Zanzibar in 1964 to form the United Republic of Tanzania, of which President Jakaya Mrisho Kikwete has been head of state since 2005 (Central Intelligence Agency, 2014). The country's capital is Dodoma, yet the city of Dar es Salaam has the densest population of 3.2 million people and is Tanzania's commercial capital and a major seaport (Central Intelligence Agency, 2014). Approximately 74% of the country's population live outside the cities in rural areas. Additionally, Tanzania accommodates the greatest number of refugees of all African countries, with over half a million displaced people (Central Intelligence Agency, 2014).

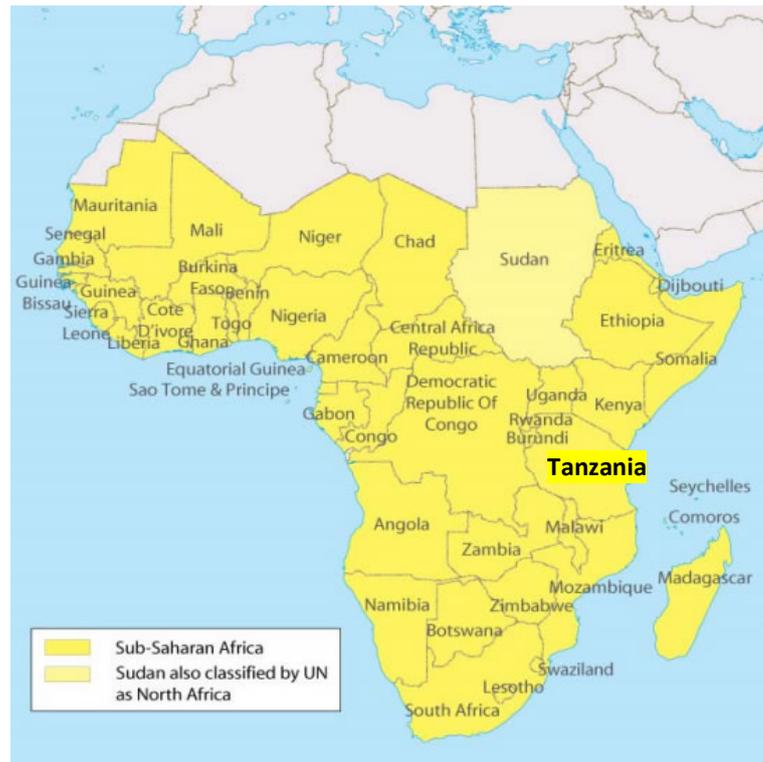


Figure 1.1. Location of Tanzania in Sub-Saharan Africa.

Note: Adapted from *Sub-Saharan Africa Logistics* (Transport Intelligence, 2012).

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Religious representation in Tanzania is 35% Muslim, 30% Christian and 35% with indigenous beliefs (Central Intelligence Agency, 2014). The population of 47,783,000 people use many local languages, while Swahili is the official national language and English is officially used in administration, commerce and higher education (WHO, 2014c). However, only 69% of the population are deemed literate. The gross income per capita is INT\$1,560, compared to INT\$43,300 per capita in Australia, with Tanzania being the ninety-third country of 191 in gross domestic product ranking, compared to Australia at number 12 (WHO, 2014a, 2014c; World Bank, 2013).

To provide a snapshot of the differences between Tanzania as a developing nation in need of healthcare assistance, to that of a developed nation endeavouring to

provide such help, this study makes contrasts by using Australia as an example of a developed country providing midwifery CPD education in Tanzania. These facts are also illustrated in Table 1.3. Presently, Tanzania has more than double the population of Australia, with 47.7 million people. The life expectancy in Tanzania is 59 years for males and 63 years for females, compared to 81 years for males and 85 years for females in Australia. Tanzania is significantly affected by diseases, such as human immunodeficiency virus (HIV) and tuberculosis, which are nearly 20 times more prevalent in this region than in Australia (WHO, 2014a, 2014c).

In relation to MDGs 4 and 5, the under-five mortality rate in Tanzania is 54 per 1,000 births, whereas in Australia it is five per 1,000 births. The maternal mortality in Tanzania is 68 times that of Australian women, with a maternal mortality ratio of 410 (WHO, 2014a, 2014c). These facts suggest that Tanzanian women have a 1:23 risk of death during childbirth in their lifetime. On average, 38 women and 170 babies in Tanzania die each day as a result of birth-related complications (UNFPA, 2011).

The fertility rate for Tanzanian women is 5.3 children versus 1.9 for Australian women, with approximately 34% of women using contraception, compared to 80% in Australia (WHO, 2014a, 2014c). Despite the WHO (2014a, c) recommendation that women with normal pregnancy should have a minimum of four antenatal visits during pregnancy, this is only achieved for 43% of Tanzanian women, compared to 90% of women in Australia. Only 49% of births are attended by a skilled birth attendant in Tanzania, compared with 99% of births in Australia occurring in the presence of midwives and medical practitioners (WHO, 2014a, c). This equals two midwives per 1,000 births in Tanzania (UNFPA, 2011). The 51% of Tanzanian women who do not have access to a skilled birth attendant are typically cared for by female relatives or traditional birth attendants, who are defined as 'traditional, independent (of the health

system), non-formally trained and community-based providers of care during pregnancy, childbirth and the postnatal period' (WHO et al., 2004, p. 8). In Tanzania, there are 2.4 nurses and midwives per 10,000 people, equalling just over 11,000 nurses and midwives for the total population. This number is significantly less than the 257,200 registered nurses and midwives in Australia for half the population size (ABS, 2013; WHO, 2014a; WHO 2014c).

Table 1.3

Comparison between Australia and Tanzania

	Australia	Tanzania
Demographic information	<i>N</i>	<i>N</i>
Population (2012)	23,050,000	47,783,000
Life expectancy—males	81	59
Life expectancy—females	85	63
HIV prevalence (per 100,000 population)	99	3,082
Tuberculosis prevalence (per 100,000 population)	8.8	176
Total health expenditure per capita (Intl \$, 2011)	4,068	109
Maternal and child health		
Maternal mortality ratio (per 100,000 live births)	6	410
Under-five mortality rate (per 1,000 live births)	5	54
Fertility rate (per woman)	1.9	5.3
Contraception use (%)	80	34
At least four antenatal visits (%)	90	43
Births attended by skilled attendants (%)	99	49

Note: Adapted from 'Australia: Health Profile' and 'United Republic of Tanzania: Health Profile' (WHO, 2014d, pp. 1–2).

The information in Table 1.3 provides insight to maternal and child health in Tanzania and highlights the urgent need for strategies to improve the health outcomes of these two vulnerable groups. One proposed strategy is to enhance the capabilities of local midwives through CPD, as they are direct caregivers to both women and children. To accomplish this and ensure the education provided is culturally relevant, a greater

understanding of Tanzanian midwives' perceptions of their professional role in their work environment is required to ensure that improvement strategies are appropriate to their needs.

1.5 Purpose

Considerable attention is required to enable an understanding of midwifery in Tanzania due to the uniqueness and importance of these midwives' role. This study will enable a greater awareness and appreciation of the issues facing the midwifery profession in this country, and subsequently enable midwifery educators visiting the region to provide culturally appropriate education in maternal and neonatal mortality prevention. Therefore, the purpose of this study was to explore and describe Tanzanian midwives' perceptions of their professional role in the context of their clinical experience.

1.6 Objectives

The research objectives guiding this study were to:

1. examine the self-identified elements of the role of Tanzanian midwives working in their local context, in alignment with the *International Code of Ethics for Midwives* (ICM, 2008)
2. describe the perceived cultural factors that contribute to how Tanzanian midwives establish their professional role
3. provide recommendations for CPD midwifery programs in Tanzania, as well as those teaching with the GHAWA.

1.7 Significance

The UN MDGs highlight the need for significant improvements in the delivery of maternity care, particularly in the high-mortality setting of Sub-Saharan Africa. As a consequence, there has been increasing focus on midwives in this region to improve

their skills through the provision of CPD to maintain and advance professional competence. However, the scarcity of midwifery educators to provide CPD in the area has resulted in increasing numbers of Western midwifery educators working in Sub-Saharan Africa to deliver this service to Tanzanian midwives.

It is envisioned that, by providing insight to the self-perceived midwifery role in Tanzania, the findings of this study will enable improved professional development programs to meet the needs of local midwives. With the delivery of more effective education as a result of modelling the education to be of optimal cultural relevance, there is greater potential for engaging local midwives in professional development, and developing strategies to improve outcomes for the community. These strategies can then be implemented with the aim of improving midwifery practice, which may positively affect maternal and neonatal outcomes in alignment with MDGs 4 and 5. While clearly beneficial to Western midwifery educators entering this challenging and unfamiliar international environment, the findings may also be relevant and useful for other international health professionals educating in Sub-Saharan locations. These educators may gain an appreciation of the need for cultural competence due to the vast differences in cultures and working conditions between countries.

The results of this research may also contribute to the international midwifery body of knowledge. Not only provoking discussion into culturally appropriate education in the midwifery profession, the current study may also question whether it is justified that Sub-Saharan midwives in low-resource settings be expected to practice in accordance with the same scope of practice as those in high-resource countries.

1.8 Summary

Chapter 1 has outlined the background, objectives, purpose and significance of this study. The literature from the Sub-Sahara African region was presented to

demonstrate the contextual situation of maternal and child health in Tanzania. Vast differences were shown between the contexts of midwifery in Tanzania compared to Western countries. These differences demonstrate the need for Western midwifery educators in the Tanzanian context to gain an optimal understanding of midwives' perceived role in their clinical work environment to provide culturally appropriate education. This knowledge includes the midwives' views of how women in their care and the wider community perceive their role. With this insight, it is anticipated that Western midwifery educators will be able to demonstrate cultural competence through the delivery of appropriate CPD education for Tanzanian midwives.

1.9 Outline of the Thesis

Chapter 2 will expand on the background information presented in Chapter 1 and the literature relevant to the study. The role of a midwife will be explored, first from an international perspective, then relative to the Tanzanian context. Current knowledge of the cultural factors affecting midwifery in Tanzania will then be detailed. The need for CPD education in Tanzania will be addressed, thus evaluating the need for cultural competence in midwifery education.

The methodological considerations pertinent to this study are described in Chapter 3, and are divided into two sections. The first section includes the research design, sample, setting, procedure, ethical considerations and data collection methods. The second section discusses the qualitative and quantitative approaches used in the current study. Chapter 4 presents the findings and describes the self-perceived role of Tanzanian midwives, as well as the cultural factors affecting their role. Finally, Chapter 5 discusses the implications of the findings and presents recommendations for future research, as well as the concluding remarks.

1.10 Glossary of Terms

Child mortality: The death of an infant (greater than seven days old) or child of less than five years of age (UNICEF et al., 2013).

Cultural competence: The capability to appreciate people's diverse behaviours and values in order to effectively work in cross-cultural situations (Taylor & Fry, 2010).

Eclampsia: A life-threatening pregnancy disease usually characterised by tonic-clonic seizures. This usually occurs in women who have had pre-eclampsia (Pairman et al., 2010).

Maternal mortality: The death of a woman while pregnant or within 42 days of the pregnancy ending (WHO et al., 2014).

Perinatal mortality: The death of a foetus or newborn of up to seven days of age (WHO, 2006c).

Pre-eclampsia: A pregnancy disease characterised by high blood pressure and protein in the urine (Pairman, Pincombe, Thorogood & Tracy, 2010).

Postpartum haemorrhage: Blood loss of greater than 500 mL following birth (Pairman et al., 2010).

Chapter 2: Literature Review

2.1 Introduction

Chapter 2 expands on the information and literature pertinent to the study in order to provide insight into the midwifery profession from an international perspective, including the cultural factors affecting Tanzanian midwives. First, a global understanding of the midwifery role will be established. This will be followed by incorporation of the WHO's MDGs that are relevant to midwifery practice and the standards set by the ICM. A comparison of the midwifery role between developed and developing countries will duly be discussed. Focusing attention on the midwifery role in Tanzania, the chapter will then depict the local context in which these midwives work, including the Tanzanian ethical and legal standards, contextual challenges and community perceptions of the profession. Finally, recognition of the need for CPD in Tanzania will be addressed, along with the necessity for Western midwifery educators to be culturally competent in providing CPD education.

2.2 Role of the Midwife

To develop an understanding of a midwife's role, it is important to acknowledge where the word 'midwife' originated: 'The term midwife is derived from Middle English: mid = "with" and Old English: wif = "woman"' (Midwives Australia, 2014, p. 1). Through this title, midwives are recognised as professionals who provide care to childbearing women and newborns (ICM, 2011e). Global bodies, including the ICM and the WHO, as the UN international health body, have established expectations of the midwifery profession that are considered transferrable to any setting in developed and developing countries (ICM, 2005, 2008, 2011e; UNFPA et al., 2014). For this reason, the MDGs and key ICM documents are used in this study to clarify the role of the midwife internationally.

Through the WHO's eight MDGs (see Appendix B), the WHO acknowledges inadequacies in maternal and child health that are of particular relevance to the midwifery profession (UNFPA et al., 2014). The two MDGs that relate directly to childbirth are MDG 4: Reduce child mortality and MDG 5: Improve maternal health (UNICEF et al., 2013; WHO et al., 2014). These are of particular significance in developing country settings, such as Tanzania in the Sub-Saharan Africa region, due to the high mortality rates.

To achieve MDG 4: Reduce child mortality, there is a great demand in developing regions for skilled midwives to meet the growing birth rates and assist in reducing mortality of children under the age of five (UNFPA et al., 2014; WHO, 2008a). Midwives have a crucial role in preventing neonatal mortality, particularly in newborn survival at birth, through effective resuscitation techniques, improving breastfeeding rates to prevent malnutrition and diarrhoeal disease, and better care of preterm infants to prevent death from conditions associated with prematurity (Bream et al., 2005; ICM, 2011b; UN, 2011c). Midwives are similarly involved with primary healthcare where education can prevent and treat diseases such as malaria and HIV, both of which can result in maternal and perinatal death. For instance, the UN estimates that malaria alone causes 16% of deaths in children under the age of five in Sub-Saharan Africa (UN, 2011c). At the time of this thesis submission, the Ebola outbreak in the region has further affected the healthcare system, with a likely effect on maternal and child health (WHO, 2014d).

In order to address MDG 5: Improve maternal health, the WHO identified that midwives are a vital component, describing their role as aiming to prevent complications in pregnancy where possible, providing early detection of any complications and referring women as required, and providing emergency care if

medical help is unavailable (UNFPA et al., 2014). Both the WHO (2008a) and ICM (2013a) suggest that the overwhelming majority of maternal deaths would be prevented if there were adequate numbers of qualified and sufficiently resourced midwives. Additionally, in order to provide global coverage for maternity care, it is estimated that 350,000 extra midwives are needed (ICM, 2014a). Adequate presence of trained midwives has significantly contributed to a reduction in mortality rates in many countries. Thailand, Malaysia and Sri Lanka have credited their reduction in maternal mortality by more than 50% to universal access to midwifery care and investment in midwifery training (Graham & Rosmans, 2006). The WHO (2008a) further acknowledged that, while midwives are needed, they must also have access to obstetric support and adequate medicine and equipment to prevent and treat complications. A sustained approach towards recruitment and training is also needed to ensure adequate numbers of midwives with the correct skills and competencies (WHO, 2007).

The ICM (2014b) is the international professional association for midwives and midwifery. It is affiliated with midwifery associations from 102 countries, representing 300,000 midwives. The ICM has a strong involvement with many African nations, including Tanzania, and held its 2011 Triennial Congress in Durban, South Africa (ICM, 2011d). As a directive body, the ICM provides documents to guide midwives in understanding their role, which are intended to be applicable to any context. The four documents used as a framework for this study are the *International Definition of the Midwife* (ICM, 2011e), *Code of Ethics* (ICM, 2008), *Bill of Rights for Women and Midwives* (ICM, 2011a) and *The Philosophy and Model of Midwifery Care* (ICM, 2005), and will now be briefly discussed.

The *International Definition of the Midwife* (ICM, 2011e) provides an outline of the midwife's scope of practice, irrespective of the setting. It highlights that the

midwife's role is to collaborate with women to provide education and care across the pregnancy continuum, including conducting the birth and caring for the newborn. While promoting normal birth, midwives are also responsible for preventing, detecting and referring complications, as well as providing emergency care if needed (ICM, 2011e).

The ICM (2008) *Code of Ethics* (CoE) provides a moral guide for midwives to enable them to practice with integrity, respect, trust and dignity in their relationships with others. According to the CoE, the midwife's duty during the pregnancy continuum is to empower women to take responsibility for their health, while providing holistic care that caters to the physical, emotional and cultural needs of the woman and her family (ICM, 2008). The CoE also states that the midwifery role incorporates educating and advocating for the woman and protecting the family unit from harm (ICM, 2008). According to the CoE, midwives are required to take an active role in eradicating dangerous practices through using evidence-based care, and, in doing so, actively seek learning opportunities to enhance their professional scope (ICM, 2008).

The *Bill of Rights for Women and Midwives* (ICM, 2011a) outlines the basic human rights to which women and midwives should be entitled, and provides direction to governments concerning what support is expected from them. Regarding women's rights, the Bill emphasises that every woman has the right to access a midwife's care, be provided with current information, and be an active participant in decision making during childbirth (ICM, 2011a). The Bill also advocates for midwifery being recognised as an individual profession, and that midwives should have access to education opportunities and a safe working environment (ICM, 2011a).

The final document, the ICM (2005) *Philosophy and Model of Midwifery Care* (PMMC) elucidates the foundations on which a midwife's care is based. According to the PMMC, midwives believe that birth is a 'normal physiological process', and that the

midwife should support non-intervention when caring for uncomplicated pregnancies (ICM, 2005). Further, the PMMC affirms that midwives are the most appropriate caregivers to women throughout the normal pregnancy continuum, in turn establishing a 'midwifery' model of care framework (ICM, 2005). A midwifery model of care encompasses the provision of individualised care to the woman and her family, thus practising within a women-centred philosophy (ICM, 2005). This philosophy focuses on the holistic wellbeing of women, rather than only on physical health, and is traditionally reflected in the role of all midwives (ICM, 2005).

2.3 The Midwifery Role in Developed Countries

The midwifery role in developed countries correlates typically with the ICM philosophy in placing a strong emphasis on holistic care and the emotional wellbeing of the childbearing woman (Homer et al., 2007; ICM, 2005; Jones, Creedy & Gamble, 2012; Lundgren, 2005; Parry, 2008). Evidence of this women-centred focus is demonstrated in studies from developed regions. In Sweden, women who had birthed two years prior were asked about their birth experience, with data collected from 10 women through individual tape-recorded interviews (Lundgren, 2005). Strongly emerging from the interviews was that the women regarded birth as an 'unavoidable situation' (Lundgren, 2005, p. 348) that was demanding and could easily result in feelings of helplessness and loss of control. The women considered it paramount that the midwife's role should involve mentally and emotionally supporting and empowering the women so that they could cope with the birth experience (Lundgren, 2005). Similar findings emerged from the Netherlands, where 14 women were interviewed regarding their birth experience. Midwife support and empowerment were regarded as fundamental to the birthing experience (Johnson, Callister, Freeborn, Beckstrand & Huender, 2007).

This understanding of the midwifery role as a support person establishes midwives as caregivers during normal birth, which was further emphasised in Canadian and Australian studies. In Canada, women were interviewed regarding their choice to access a midwife for their care. The eight women had sourced a midwife as their primary caregiver because they saw this as their best opportunity to achieve a safe, normal birth, with one participant stating that birth was a ‘natural process, and the midwife helped me create that as much as possible’ (Parry, 2008, p. 796). In Australia, midwives and women were asked about their perspective of the midwifery role (Homer et al., 2007). Using a qualitative approach, 32 midwives were randomly selected by regulatory authorities from around Australia to undertake a telephone interview, with the preference of four midwife participants from each state or territory. The 28 women were recruited through their membership in maternity service lobby organisations via postal questionnaire (Homer et al., 2007). The findings indicated that both the midwives and women specified the midwifery role as one that provides women-centred care, reassurance and advocacy for a woman’s right to choice in childbirth. Although the women regarded the midwife’s clinical skills as important, their overall perception of the midwifery role was in meeting their emotional needs. Interestingly, the midwives in this study presented a broader perception of their professional role, including the need to ensure a safe birth and manage emergencies. Nevertheless, like the women, the midwives focused strongly on the holistic ‘caring’ elements of the midwifery role (Homer et al., 2007).

A quantitative study also undertaken in Australia evaluated 815 midwives’ attitudes towards providing care to distressed labouring women (Jones et al., 2012). The midwives completed a postal survey that used a subscale as the feedback method, with seven responses that ranged from ‘strongly disagree’ to ‘strongly agree’. The study

identified that 55% of Australian midwives reported having adequate time to evaluate women's emotional health status, and 75% believed they had enough time to deal with any emotional problems that arose (Jones et al., 2012). These findings, along with those of the qualitative studies explained previously, emphasise that in Western settings, the midwife's role is not only focused on the physical health of women and newborns, but also on women's psychosocial wellbeing.

In developed settings, pregnant women are generally cared for in either midwifery- or medically-based models of care, which means the main caregivers are either midwives or obstetricians (Sandall, 2012; Sandall, Soltani, Gates, Shennan & Devane, 2013; Soltani & Sandall, 2012; Taylor, 2005). However, the philosophies of these two models are seemingly opposed. Midwifery-based care focuses on childbirth as a normal event where complications can be managed if they occur (Soltani & Sandall, 2012), while medically-based care typically focuses on the unwell 'patient', where problems are expected to occur and intervention rates are higher (Taylor, 2005). These differences in philosophy were explored by Taylor (2005), who interviewed Australian midwives and doctors regarding their roles and opinions of each other. The midwives revealed conflict between them and the obstetricians, as evident in the following quotation: 'they're doctors and they can't ... separate the pregnant woman from the "sick person"' (Taylor, 2005, p. 3). The medical professionals were openly opposed to the midwives' 'normal birth' philosophy, with one stating that a 'down-side is that they [midwives] are very anti-interventionist ... it can get them into trouble' (Taylor, 2005, p. 5). Although these two models of care contrast, globally, the professions are encouraged to collaborate. This expectation is evident in the advocating by the WHO and ICM for midwifery-led care for low-risk women, with the involvement of

obstetricians in the care of those who are considered high-risk with maternal or neonatal complications (ICM, 2008; WHO et al., 2014).

2.4 The Midwifery Role in Developing Countries

While much is known about the values and experiences of midwives in developed settings, there is a significant dearth of information regarding the self-perceived role of midwives in developing countries. Sub-Saharan Africa is no exception to the limited insight available regarding the role of the midwife in developing countries. As a result, holistic exploration into the local midwifery context is required to gain understanding of the midwives' role. The United Republic of Tanzania, in which this study was conducted, is presented as an example of a developing country in Sub-Saharan Africa.

2.4.1 Midwifery in Tanzania.

In order to understand the contrast between the role of the midwife in a developed country such as Australia and the role of the midwife in a developing country such as Tanzania, it is first necessary to explore the origins of midwifery in Tanzania, as well as its current educational and ethical frameworks. During the pre-colonisation era, childbirth care for women in Tanzania was provided by female family members or traditional birth attendants. These family members and birth attendants received hands-on training in skills passed down through generations, with no official education system (Moyo & Mhamela, 2011). In the 1880s, Germany gained control of Tanzania, during which time qualified nurses were introduced, with the first nurse arriving from Germany in 1888 (Moyo & Mhamela, 2011). From 1919, Britain occupied Tanzania after defeating Germany at the end of World War I, and also brought nurses and midwives to the country. At that point, there was a direction from the British Colonial Government to establish nursing and midwifery education in Tanzania. The Tanzania Nursing and

Midwifery Council (TNMC) was subsequently established in 1952 (Moyo & Mhamela, 2011). Since Tanzania gained independence in 1961, nursing and midwifery have continued to be identified as the same profession through its registration systems, with the vast majority of midwives subsequently being qualified as nurse-midwives (UNFPA, 2011). The timeline of events leading to nursing and midwifery regulation in Tanzania today is illustrated in Figure 2.1.

Nurses and midwives in Tanzania are regulated by the Tanzanian Government and TNMC, in accordance with the following documents:

- *Nursing and Midwifery Act (2010)* (The United Republic of Tanzania, 2010b)
- *Nursing and Midwifery (Practice) Regulations (2010)* (The United Republic of Tanzania, 2010a)
- *Code of Professional Conduct for Nurses and Midwives in Tanzania (2007)* (TNMC, 2007a)
- *Standard of Proficiency for Midwifery Practice in Tanzania (2007)* (TNMC, 2007b).

The origins of these four documents, which are illustrated in Figure 2.1, will now be discussed.

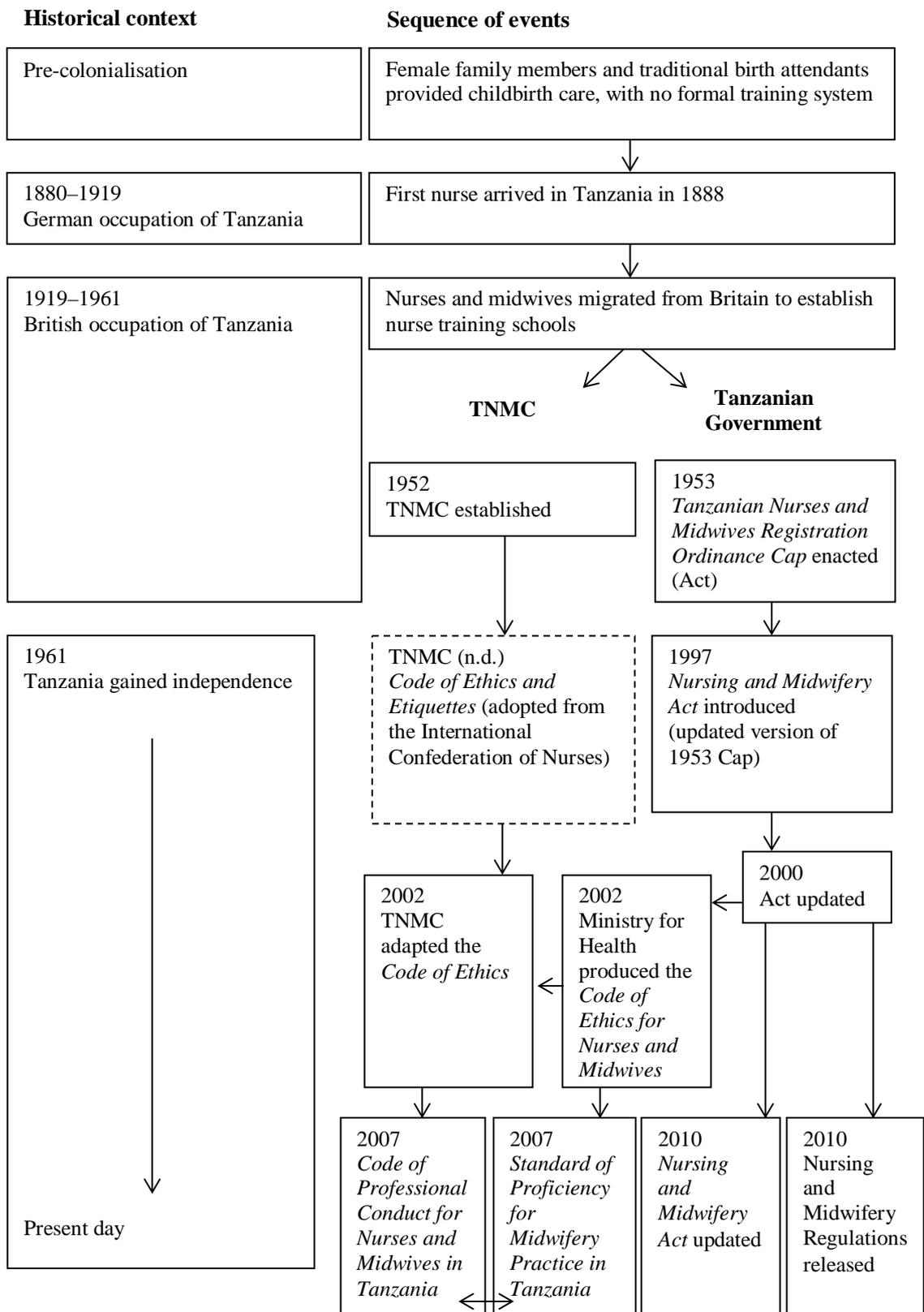


Figure 2.1. Timeline of events leading to nursing and midwifery regulation in Tanzania today.

2.4.1.1 Tanzanian Nursing and Midwifery Act (2010).

The *Tanzanian Nursing and Midwifery Act (2010)* outlines the requirements for the registration and endorsement of nurses and midwives, and regulates these professions for the purpose of maintaining standards of competence and conduct. This includes directives for the establishment and management of the TNMC, as well as orders for the registration and disciplinary management of nurses and midwives (The United Republic of Tanzania, 2010b).

Although focused predominantly on the requirements for registration, the Act also provides guidance on how nurses and midwives should practice. The Act states that nurses and midwives not practising in accordance with national standards may be investigated under ‘professional misconduct’ directives (The United Republic of Tanzania, 2010b). This includes ‘abusing a client verbally, physically, sexually or emotionally ... abandoning a client who is in need of attentions ... [and] failing to maintain the standards of practice and the code of ethics of the profession’ (The United Republic of Tanzania, 2010b, p. 46).

2.4.1.2 Tanzanian Nursing and Midwifery (Practice) Regulations (2010).

The *Tanzanian Nursing and Midwifery (Practice) Regulations (2010)* were developed in conjunction with the *Nursing and Midwifery Act (2010)* to provide an overall guide for the governance of nursing and midwifery (The United Republic of Tanzania, 2010a, 2010b). The regulations include scant information regarding the role of nurses and midwives; however, they do mandate that Tanzanian nurses and midwives must maintain the necessary skills and knowledge base to demonstrate competent practice (The United Republic of Tanzania, 2010a). However, this has not been readily available prior to the involvement of Western educators (Jones, 2011). The regulations also mandate that nurses and midwives must not neglect, abuse or harm a patient, and

must keep legible and precise records to demonstrate accountability for their practice. Additional regulations include safeguarding patient information and dignity, and working with others to promote the wellbeing of those in their care and the community (The United Republic of Tanzania, 2010a).

The TNMC, which was established in 1953 during the British occupancy of Tanzania, is the national nursing and midwifery registering authority (Moyo & Mhamela, 2011). The role of the TNMC is to ensure the integrity of the professions and wellbeing of the community (The United Republic of Tanzania, 2010b). The TNMC was established under Part IV of the *Tanzanian Nursing and Midwifery Act (2010)*, which states that the Council must ‘establish, keep and maintain a register and a roll of qualified nurses and midwives’ and may ‘strike off ... any registered or enrolled person who fails to comply within the provisions of this Act’ (The United Republic of Tanzania, 2010b, p. 40, 43). In 2007, the TNMC released two documents—the *Code of Professional Conduct for Nurses and Midwives in Tanzania (2007a)* and the *Standard of Proficiency for Midwifery Practice in Tanzania (2007b)*—both of which are concerned with the professional and ethical conduct of midwives, thus providing guidance for appropriate practice.

2.4.1.3 Code of Professional Conduct for Nurses and Midwives in Tanzania (2007).

The *Code of Professional Conduct for Nurses and Midwives in Tanzania (2007a)* outlines the professional expectations of nurses and midwives. The Code requires nurses and midwives be accountable for their practice, protect patients from harm, and maintain professional competence and reputation (TNMC, 2007a). Nurses and midwives must also ensure that they practice without ‘undue delay, risk or unnecessary expense to the employer, client/patient’ (TNMC, 2007a, p. 5) and be fair in

the distribution of resources. The Act recognises that the professions are constantly evolving and, as a result, nurses and midwives must be aware of and integrate new practices based on research, and, throughout their careers, further develop knowledge and skills (TNMC, 2007a).

2.4.1.4 Standard of Proficiency for Midwifery Practice in Tanzania (2007).

The *Standard of Proficiency for Midwifery Practice in Tanzania (2007b)* is the only midwifery-specific regulatory document that reflects the *International Code of Ethics for Midwives* and was developed to improve the quality of midwifery education and practice (TNMC, 2007b). The Standard states that midwives should provide ‘client-centred’ care, provide a therapeutic environment for women, ensure the provision of psychological support to women, have an adequate scope of knowledge to undertake midwifery tasks, and demonstrate evidence-based care (TNMC, 2007b). Specific skill requirements are also addressed, including the obligation of midwives to have competent skills in neonatal resuscitation and management of sepsis, eclampsia, maternal haemorrhage and shock (TNMC, 2007b).

These four documents were created with the intention of guiding Tanzanian midwives in how they practice. Another important aspect to understand is the midwifery education system in Tanzania because this initial training provides a basis for how midwives are prepared for their role and scope of practice (Nursing Training Section, 2003). This is discussed in the following segment.

2.5 The Education System for Nurses and Midwives in Tanzania

Although nursing education in Tanzania is well established, the education framework for midwifery as a separate profession remains in its infancy. According to the UN Family Planning Association (UNFPA) (2011), there are 84 accredited nursing education programs in Tanzania. While the possibility of independent midwifery

courses is being explored in Tanzania, midwifery is currently reliant on being incorporated into nursing training programs. Midwifery is generally one of the seven subjects covered in the two-year nursing diploma (Nursing Training Section, 2003). Students learn about midwifery at the same time as learning about all areas of nursing, including surgical, mental health and community studies (Nursing Training Section, 2003). Subsequently, those practising in a midwifery role refer to themselves as nurse-midwives (Mselle, Moland, Mvungi, Evjen-Olsen & Kohi, 2013; Prytherch, Kakoko, Leshabari, Sauerborn & Marx, 2012).

During the two-year nursing diploma, to align with the Tanzanian national requirement to gain registration, students must complete 432 hours of clinical midwifery experience, compared with the much larger amount of 1,371 hours of clinical nursing experience (Nursing Training Section, 2003). While hours of practice are not specified in the *Australian Midwifery Accreditation Standards* (Australian Nursing and Midwifery Council, 2009a), the time spent in midwifery practice is considerably more than in Tanzania. This includes equal amounts of theory and clinical time for both undergraduate midwifery students and postgraduate students who are already registered as nurses (Australian Nursing and Midwifery Council, 2009a). In conjunction with reduced clinical hours and course durations, there is a lack of appropriately qualified educators to teach midwifery in Tanzania (UNFPA, 2011).

The UNFPA (2011) has highlighted this shortage of appropriately qualified midwifery educators in Tanzania, which is also a widespread problem throughout Sub-Saharan Africa (Fullerton et al., 2011). This stems from the lack of skilled preceptors in the clinical environment, as evidenced in a study conducted in the Sub-Saharan African region by Dennis-Antwi (2011), which explored the current trend of preceptorship in the midwifery profession. Ethiopia, Ghana, Uganda and Zambia were selected for the

study due to their involvement with the ICM and UN Population Fund, which aims to improve the education and practice of midwives (Dennis-Antwi, 2011). The methods used included focus groups and individual interviews with 100 participants, ranging from new midwives to midwifery tutors and retired midwives. Observation of the preceptoring environment, skills laboratories and review of national training needs reports were also used. Dennis-Antwi (2011) found that there were no standardised policies for preceptorship in the hospitals, and that the staffing numbers were too low to provide appropriate supervision of students (Dennis-Antwi, 2011). As a result, not only were the skills of practising midwives affected, but their ability to become skilled preceptors themselves was also reduced (Dennis-Antwi, 2011).

The skill level of midwives in Sub-Saharan Africa was explored by Lugina, Mlay and Smith (2004). The study investigated the mobilisation and birth positions for women in labour at four hospitals within and around the Dar es Salaam region (Lugina et al., 2004). The 1,151 women were individually interviewed after giving birth, and four focus groups were undertaken with 12 midwives per group. Four doctors and three traditional birth attendants were also individually interviewed. The study found that, due to inadequate midwifery knowledge, suboptimal care was given to women (Lugina et al., 2004). The findings revealed that only 2.9% of women mobilised in the labour ward, and that supine birth positioning was routinely used at the four hospitals. Further, the women in most instances were not informed by the midwives that there were other options available to them (Lugina et al., 2004). Despite the strong evidence against these practices and in support of mobilisation and upright positioning during labour, the midwives did not demonstrate awareness of this in their care (Lugina et al., 2004).

Supporting Lugina et al.'s (2004) research was an audit using case narratives undertaken by Kidanto et al. (2009a) to investigate the causative factors of perinatal

mortality at a tertiary maternity hospital in Dar es Salaam. The case narratives, which were independently reviewed by two external and one internal obstetrician, found that inadequate foetal assessment during labour—a primary responsibility of midwives—was directly associated with 40% of the perinatal deaths (Kidanto et al., 2009a). This lack of midwifery assessment was the leading cause of perinatal mortality in the hospital.

The recommendations from both studies indicate the need for improved midwifery education in Tanzania to ensure that midwives' knowledge and skills are of sufficient depth and breadth to provide safe and effective care (Kidanto et al., 2009a; Lugina et al., 2004). In addition to inadequate education, midwives in Tanzania are further hindered from providing appropriate care to women and babies as a result of scarce resources being available in the hospitals. This can be explained by reviewing the maternity setting in Tanzania.

2.6 The Maternity Setting in Tanzania

Tanzanian midwives most commonly work in government hospitals. Thus, awareness of this environment is essential to develop an understanding of the midwives' experiences. The key factors influencing maternity care in Tanzania include non-conducive hospital environments caused by inadequate government expenditure, the resulting lack of resources and staffing, poor referral systems and high infection rates. Similarly affecting Tanzania's maternity system is poor regulation of midwifery practice and the general health of Tanzanian women. These issues are now discussed in depth.

2.6.1 Non-conducive hospital environments.

2.6.1.1 Inadequate government expenditure.

Inadequate government expenditure for healthcare has been widely documented throughout the Sub-Saharan region (Ekechi et al., 2012; Gerein, Green & Pearson,

2006; Kawuwa, Mairiga & Usman, 2006; Nyamtema, Urassa, Massawe, Lindmark & Van Roosmalen, 2008a; UNDP, 2012c; WHO, 2008a). In Tanzania, the government only spends approximately INT\$109 per capita annually on healthcare, compared to INT\$4,068 per capita in Australia (WHO, 2014a, c). This figure is 7% of the Tanzanian Government's total expenditure as a percentage of gross domestic product, which is lower than Australia at 9.1% (WHO, 2013a). The limited funding leaves maternity units struggling to provide adequate care, particularly due to the resulting shortages of staffing and resources (Kidanto et al., 2009a; Kruk, Mbaruku, Rockers & Galea, 2008; Kwesigabo et al., 2012; Nyamtema et al., 2008a).

In 2003, Tanzania's government declared that maternal and child health services would be free in government facilities (United Republic of Tanzania Ministry of Health, 2003). However, a study in 2008 by Kruk et al. (2008) showed that three-quarters of Tanzanian women still pay for maternity care, including being charged for the supplies used during the birth, medications and diagnostic tests. A causative factor of this practice is the poor distribution and management of essential supplies for maternity units (Kruk et al., 2008). Further, the population of Dar es Salaam is increasing annually, while the capacity of health facilities has remained the same (Kidanto et al., 2009a). Funding is not only meagre, but is also often unreliable and delayed, which impedes maternity units' ability to improve their services (Kruk et al., 2008). Discrepancies occur between required care and the resources available, including having only one theatre for caesarean sections in some major hospitals (Kidanto et al., 2009a). There is also a lack of 24-hour obstetric emergency care due to low staffing levels (Kidanto et al., 2009a).

2.6.1.2 Understaffing.

Midwives frequently work understaffed because of limited funding to employ sufficient staff numbers (Kwesigabo et al., 2012). This issue has been further compounded by the ongoing migration of skilled midwives to developed countries (Dennis-Antwi, 2011; Ekechi et al., 2012). According to the recommendation from the Tanzanian Ministry of Health and Social Welfare (MOHSW) (2009) document, only 35% of Tanzania's required workforce is available as a result of an employment freeze. This freeze by the Tanzanian Government occurred from 1993 to 2005 (MOHSW, 2009), at which time, one-third of the healthcare workforce was retrenched (Kwesigabo et al., 2012). By 2006, the freeze, combined with Tanzania's growing population, had caused an estimated 65% shortage in government health workers. In response, in 2008, the MOHSW declared a workforce crisis, initiating a plan to create a five-fold increase in healthcare workers from 2007 to 2017 (Kwesigabo et al., 2012). However, despite this plan, the number of healthcare workers remains low, particularly because training facilities are unable to achieve the required increase of 145,000 qualified workers in the allotted timeframe (Kwesigabo et al., 2012; UNFPA, 2011). The outcome of this dilemma has resulted in Tanzanian midwives dealing with a high number of labouring women to monitor at once, making it difficult to assess how each labour is progressing (Lavender et al., 2011; Nyamtema et al., 2008b).

2.6.1.3 Lack of resources.

Lack of resources was also reported as a factor affecting maternity care. A multi-method study from rural Tanzania on the quality of antenatal care in the region identified a deficit of essential equipment at healthcare facilities, which was attributed to inadequate care provision (Nyamtema, Jong, Urassa, Hagen & van Roosmalen, 2012). Labour care is likewise affected by inadequate resources. An audit by Nyamtema

et al. (2010) in Tanzania found that maternal mortality occurs as a direct result of limited resources. Of the 363 severe morbidities reviewed, 20% were found to be due to staff shortages, insufficient equipment and consumables (Nyamtema et al., 2010).

2.6.1.4 Poor operational systems.

While the effect of limited resources and insufficient staffing are easily recognisable in the Tanzanian healthcare system, there are other constraints affecting patient care. Midwives must function within poor operational systems, which inhibits early and appropriate referral of unwell women and newborns to higher acuity hospitals (Ekechi et al., 2012; Kidanto et al., 2009a). A demonstration of this issue was apparent when three-quarters of the women and newborns referred to a tertiary facility in Dar es Salaam experienced excessive delays in their transfer, despite these cases being classed as emergencies (Kidanto et al., 2009a). This occurred because ambulance drivers were waiting until more than two patients needed transfers in an effort to save on fuel costs (Kidanto et al., 2009a). Accordingly, the women and newborns arrived at the tertiary facility too late, which directly affected the 92:1,000 perinatal mortality rate (Kidanto et al., 2009a). Other delays in the hospital system have conjointly been reported, including eclamptic patients waiting over two hours to be seen by the medical team on admission, and junior staff failing to consult experienced doctors when needed (Kidanto et al., 2009a).

2.6.1.5 High rates of infection.

Additional challenges in the Tanzanian hospital setting include the high rates of infection and the associated morbidities and mortality. In order to reduce the rates of often-preventable infection, significant government and organisational commitment are required (Allegranzi et al., 2011; Gosling, Mbatia, Savage, Mulligan & Reyburn, 2003; Maher, Smeeth & Sekajugo, 2010). A high incidence of infection places great pressure

on the health system in any country, but more so in developing countries. This was evident in a systematic review of 220 studies that highlighted that intensive care admissions from infection are three times more prevalent in developing countries than in developed countries (Allegranzi et al., 2011). In everyday practice, midwives in Tanzania are facing increasing numbers of patients with pre-existing diseases, and poor levels of infection control due to limitations in professional education and resources (Allegranzi et al., 2011; Gosling et al., 2003; Jaakkola & Nsubuga, 2005; Maher et al., 2010; UNFPA, 2011). Moreover, hospital-based infection control protocols are not well established, which further inhibits the midwives' ability to prevent infections (Allegranzi & Pittet, 2009).

2.6.2 Regulation of midwifery practice.

Along with the immediate challenges of the clinical environment, midwifery practice in Tanzania is affected by insufficient regulatory and improvement strategies. There is a general lack of accountability and implementation of legislation in the Tanzanian health system, which directly affects childbirth outcomes (Kidanto, Mogren, Massawe, Lindmark & Nystrom, 2009b; Nyamtema et al., 2008b). An example of this problem was highlighted in an audit in a tertiary labour ward in Dar es Salaam on partogram use—the documentation used to monitor labour progress and maternal and foetal wellbeing (Nyamtema et al., 2008b). Of the 367 partograms reviewed, over half had no record of labour duration and 91% had insufficient foetal heart rate documentation. This result was strongly related to poor neonatal outcomes (Nyamtema et al., 2008b). Compounding these shortfalls was the poor standard of documentation in patient notes, which was likewise found to occur frequently in other Tanzanian studies (Kidanto et al., 2009a; Kidanto et al., 2009b).

It is well noted that undertaking research to establish evidence-based practice is essential in improving health outcomes and providing guidance for midwifery practice, yet funding constraints and organisational resistance suggest that completing research in Tanzania can be very challenging (Bhutta, Darmstadt, Hasan & Haws, 2005; Lugina et al., 2004; Nyamtema, Urassa, Pembe, Kisanga & van Roosmalen, 2010; van Teijlingen, Simhada & Ireland, 2010). An option is to acclimatise evidence-based practice from Western settings to low-resource countries such as Tanzania (Mudokwenyu-Rawdon & Nikarawu, 2001; Pettersson, 2007). However, this is often difficult to achieve in the Sub-Saharan region, as explained by Senior Maternal Health Advisors from the UNFPA:

reasons are ... reluctance from senior clinicians ... to acknowledge the benefits of innovations and change protocols, insufficient investment in training institutions for health, or simply administrative barriers ... lack of access to journals, to the Internet, to modern manuals and protocols, and to international conferences (Fauveau & de Bernis, 2006, p. 180).

2.6.3 Women's health in Tanzania.

2.6.3.1 Women's socioeconomic status.

Alongside non-conducive hospital environments and lack of regulation of the midwifery practice, the socioeconomic status of women in developing countries contributes to the difficulties experienced by midwives trying to improve women's health outcomes (Pettersson, 2007). This difficulty is supported in the literature, which indicates that women are more likely to die in childbirth if they are poor, are vulnerable, have many children and have received little formal education (Ndikom, 2010; Pettersson, 2007; UN, 2011a)—all of which are factors that affect the majority of Tanzanian women (WHO, 2014c). Further, the limited income and low status of many

women in the Tanzanian community suggests that they cannot afford any medicines should they become necessary during pregnancy (Brouwer, Cameron, Ewen, Laing, Neins & Van de Poel, 2010). Added to this situation is the lack of antenatal clinic attendance by Tanzanian women, which is reported to be attributed to a lack of accessibility and a high cost caused by low government expenditure (Galea, Kruk & Prescott, 2007; Nyamtema et al., 2012).

2.6.3.2 Suboptimal care in community pregnancy centres.

Care at Tanzanian community pregnancy centres has also been reported as suboptimal. In an observational study of 32 doctors and nurse-midwives during routine antenatal visits, 42% of women were not informed of pregnancy danger signs by the healthcare providers (Pembe et al., 2010). As a result, women were less aware of pregnancy danger signs and often attended hospital too late when acutely unwell (Kawuwa et al., 2006; Pembe et al., 2010). This lack of insight among childbearing women was evident in a second study from rural Tanzania, which interviewed 1,118 women who had birthed (Pembe et al., 2009). Of these women, 98% had attended at least one antenatal appointment; however, their awareness of pregnancy danger signs was very low. Only 26% of women knew at least one danger sign during pregnancy, 23% during birth and 40% postnatally (Pembe et al., 2009). Further, studies from Kenya, Tanzania and Malawi have all highlighted the need to provide improved education to women on the importance of postnatal care to prevent and detect complications (Mrisho et al., 2009; Rotich, 2011; Sakala & Kazembe, 2011).

2.6.3.3 Family planning in Tanzania.

Another issue of concern for women's health is that of family planning in Tanzania. Family planning is not well established or used as a result of inadequate education to women, scarcity of free contraception distribution, and community non-

acceptance. Hence, Tanzanian midwives deal with much higher fertility rates than do midwives in more developed settings, as illustrated in Table 1.3 (from Chapter 1) (WHO, 2014c). With high birth numbers and the limitations of the Tanzanian clinical environment, midwives are confronted with high mortality rates, often with minimal organisational support (Lindmark & Roosmalen, 2008; Pettersson, 2007; WHO, 2014c).

Overall, the evidence indicates that there are significant challenges hindering the provision of maternity care in Tanzania, including non-conducive work environments and the high mortality rates of women and newborns. However, to date, few studies have explored the effect of these issues on the self-perceived role of local midwives and how they feel about their midwifery practices. This insight is invaluable when initiating improvement strategies to ensure that these midwives' professional continuing development learning needs have been identified and met.

2.7 Tanzanian Midwives' Perceptions of Their Role

There is a dearth of research investigating midwives' perceptions of their role, not only in Tanzania, but also across the wider Sub-Saharan region. Nonetheless, the small number of qualitative studies conducted has revealed some factors described by midwives as affecting their practice, as discussed in the following sections (Maputle & Hiss, 2010; Modiba, 2008; Prytherch et al., 2012).

2.7.1 Factors influencing midwifery practice.

Previous studies have found that the factors influencing midwives' practice include patient decision making, inadequate staffing and insufficient ongoing education. These factors were seen to challenge the midwives' professional role and inhibited their ability to deliver adequate care (Maputle & Hiss, 2010; Modiba, 2008; Prytherch et al., 2012).

2.7.1.1 Patient decision making.

Using unstructured interviews, Maputle and Hiss (2010) examined the experiences of 12 midwives working in a public hospital in South Africa. This was the only identified study that explored how midwives perceived their relationships with those in their care. The major theme that emerged was that the participants' believed the women did not want to be involved in decision making about their care, despite the midwives perceiving that they provided them with adequate information to do so. There were further disclosures of the difficulty of working with uneducated women, as their knowledge of the birthing process and subsequent mutual participation in care was minimal (Maputle & Hiss, 2010).

2.7.1.2 Staffing and education.

Inadequate staffing and a lack of ongoing education were commonly found to influence midwives and their practice. Qualitative studies using individual interviews were conducted in the Sub-Saharan region to explore the experiences of midwives in the hospital setting. In Maputle and Hiss's (2010) study, midwives were questioned about their experience caring for women in labour in South Africa. The findings revealed that a shortage of staff prevented midwives from spending adequate time with each woman (Maputle & Hiss, 2010). This was supported by another study conducted in South Africa, in which seven doctors and nine midwives were interviewed regarding their experiences caring for women with perinatal loss (Modiba, 2008). The doctors and midwives disclosed that they were overwhelmed with staffing problems and overcrowding, which inhibited their ability to provide quality care (Modiba, 2008).

A study from rural Tanzania further emphasised the challenges faced by midwives due to understaffing (Prytherch et al., 2012). By interviewing 25 nurse-midwives about the influences on their job satisfaction, Prytherch et al. (2012) found

that the wards were frequently understaffed and workloads were subsequently high, resulting in the midwives being demotivated in the workplace. The findings highlighted the effect of inadequate staffing on the midwives, which caused them to be unable and perhaps unwilling to attempt to implement optimal care.

Together with the requirement of improved staffing numbers, the midwives from Prytherch et al.'s (2012) and Modiba's (2008) studies expressed the need for ongoing education to improve the care they provide. The midwives revealed the need for refresher courses to improve their skill level, as well as adequate supervision from senior staff in order to maintain the quality of their practice (Modiba, 2008; Prytherch et al., 2012). Although these studies did provide some insight to the situation midwives face, they did not expand on the midwives' experiences in great depth; hence, understandings of their role working in such conditions are minimal.

2.7.2 Women's perspectives of the midwife's role.

Despite the limited research on midwives' perceptions of their role, there have been several studies undertaken in Sub-Saharan Africa exploring maternity care from the women's perspective. Lack of resources similarly emerged as a prominent concern to both pregnant and recently birthed women. In Tanzania, as well as other parts of Sub-Saharan Africa, women disclosed being forced to pay for their care and having to purchase items needed while in hospital due to insufficient supplies being available (Mbekenga, Christensson, Lugina & Olsson, 2011; Ndikom, 2010; Pettersson, Christensson, de Freitas & Johansson, 2004). Further, the women believed the amount of time spent with them by midwives during labour was insufficient, as they were often left unattended (Eustace & Lugina, 2007; Maputle & Nolte, 2008; Mselle, Kohi, Mvungi, Evjen-Olsen & Moland, 2011). This behaviour was attributed to the high patient–midwife ratio in the setting (Eustace & Lugina, 2007; Maputle & Nolte, 2008;

Mselle et al., 2011). Throughout the Sub-Saharan region, women also reported being provided with inadequate education from the midwives about their condition and potential complications that could occur (Bangser et al., 2011; Maputle & Nolte, 2008; Mathole et al., 2011; Sakala & Kazembe, 2011). This is in contrast to the study by Maputle and Hiss (2010) discussed in Section 2.7.1.1, which revealed that midwives' felt the women were uneducated and disinterested in participating in decision making about their care.

The issues surrounding lack of resources affecting care were also supported by Lavender et al.'s (2011) study in Kenya, in which 51 midwifery students were interviewed through focus groups about the monitoring of women during labour. The findings revealed that the students thought there were high midwife–patient ratios, a lack of adequate supervision and a lack of in-service education, all of which affected their ability to provide sufficient care and ensure evidence-based practice (Lavender et al., 2011). These views were found to reflect those of the women in relation to inadequate staffing and education as examples of the lack of resources.

The limitations in resources and ongoing education not only affect the quality of care that the midwives provide, but also affect the midwives' relationships with those in their care. The literature frequently identifies that, due to working with inadequate resources, midwives are frequently perceived as having a negative attitude to their care, as acknowledged by the women for whom they care (Eustace & Lugina, 2007; Maputle & Nolte, 2008; Mselle et al., 2011; Shimpuku, Palit, Norr & Hill, 2013). This 'negative attitude' has been identified as the midwives neglecting the women, as well as verbally and physically abusing them (Eustace & Lugina, 2007; Maputle & Nolte, 2008; Mselle et al., 2011; Shimpuku et al., 2013). There were anecdotal accounts of women being threatened and slapped by midwives during labour, and of midwives telling family

members to care for the labouring woman themselves (Mselle et al., 2011; Shimpuku et al., 2013). These events were amplified by midwifery students who identified that inadequately trained and overworked midwives would falsify patient documentation to keep observations within the 'normal range' (Lavender et al., 2011).

Interestingly, the negative attitude displayed by midwives was also found in several studies where inadequate resources were not recognised as an issue. In qualitative studies from Zimbabwe, Uganda and Tanzania that interviewed women about their experiences in labour, the women stated that they were not respected by midwives, and were forced by the midwives to provide them with gifts for their care (Bangser et al., 2011; Mathole et al., 2004). The participants reported that midwives did not allow them to express pain in labour, did not inform them of the reason for assessments being undertaken, and sometimes slapped them during labour. Conversely, the midwives reportedly blamed the women if there was a negative outcome in their pregnancy (Bangser et al., 2011).

The perception of midwives as being abusive and rude by the women in their care was established as the main theme in a systematic review of 27 qualitative studies in Sub-Saharan Africa exploring the experiences of women in labour (Brighton, D'Arcy, Kirtley & Kennedy, 2013). The review identified that these behaviours by the midwives were the leading barrier to women seeking maternity care (Brighton et al., 2013). The women's attitudes were also shared by 76 South African midwifery students in a qualitative study conducted by Chokwe and Wright (2011). The students, who were asked about their impressions of midwives' behaviours, perceived them as rude towards patients and generally uncaring. Moreover, they did not appear to promote comfort to labouring women, and were seen by the students to undertake unsafe practices,

including ‘pushing’ on the abdomen of a birthing woman and giving women analgesia against their will (Chokwe & Wright, 2011).

In light of these discernments, it is evident that further education for qualified midwives in Sub-Saharan Africa is required, not only to enable midwives to identify their professional role, but also to enable safe clinical care (Mrisho et al., 2009).

2.8 CPD Education for Developing Countries

CPD education traditionally describes the undertaking of learning experiences to maintain and improve professional competence once qualified (Thomas, 2012). CPD education is widely acknowledged as a fundamental component of quality midwifery care. However, the lack of educators and resources in developing countries means that this education is often unavailable (Ekechi et al., 2012). In Tanzania, the need for an increase in CPD has been identified by the Ministry of Health and Welfare. This educational need was indicated in the *National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths (2008)* (NRMSP), which addresses the necessity for capacity development—specifically in terms of increasing the skills and knowledge of current healthcare workers, including midwives, to enable quality care (MOHSW, 2009).

Globally, there is great emphasis on the requirement and benefits of CPD for midwifery practice. The ICM Global Standards for Midwifery Education identify the importance of CPD in maintaining professional competence (ICM, 2013c), and CPD is mandatory in many countries, including Australia and the UK (Thomas, 2012). For example, in Australia, midwives must complete 20 hours of CPD annually to meet national requirements for registration (Nursing and Midwifery Board of Australia, 2010). In the UK, midwives must undertake 35 hours of CPD every three years to maintain registration (Nursing and Midwifery Council, 2010).

The provision of CPD is deemed a fundamental element of improving patient outcomes, with recognition that, in countries where at least 80% of births have a skilled obstetric care provider present, risk of complications resulting in death are less than 200 deaths per 100,000 births (Donkor, 2008). While this cannot be solely attributed to CPD education, the statistics do suggest that promoting the development of skilled midwives correlates with improved outcomes (Donkor, 2008). Internationally, midwives have reported increased self-confidence and enhanced relationships at work due to ongoing CPD programs (Fahey & Monaghan, 2005; Gray, Rowe & Barnes, 2013; Katsikitis et al., 2013). An Australian study conducted by Katsikitis et al. (2013) found that 92% of the 289 nurses and midwives surveyed believed that CPD improved their knowledge and clinical skill capacity, and hence was beneficial to their practice and their patients. This finding was supported by Gray et al.'s (2013) qualitative study, in which 20 midwives were interviewed about their attitude towards CPD. The participants stated that their main drive in obtaining CPD was the belief that it enabled them to provide the best care to women through maintaining and advancing their skills (Gray et al., 2013).

Combined with the emphasis on CPD for midwives, inter-professional CPD with doctors and midwives is also being increasingly encouraged due to the frequent interaction between these professions in the hospital setting (Draycott, Winter, Crofts & Barnfield, 2008a; Draycott et al., 2008b). The PROMPT workshop, developed in the UK, is one example that has been adopted by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (Draycott et al., 2008a). This program emphasises the importance of teamwork in order to maximise team capability of managing obstetric emergencies. Inter-professional CPD education through PROMPT has demonstrated improved childbirth outcomes. In Bristol, UK, the course was associated with better management and neonatal outcomes in cases of shoulder dystocia

(Draycott et al., 2008a). This included a reduction of neonatal injury from 9.3 to 2.3% (Draycott et al., 2008b). In the United States (US), a similar program called Advanced Life Support in Obstetrics (ALSO) was established in 1991, and has been adopted in several countries, including Australia (ALSO, 2013). In Western Australia, PROMPT has been adapted to the local setting and is called 'In Time' (Women and Newborn Health Service, 2014).

While the provision of CPD is heavily supported and evolving in most developed settings, in developing countries, it often remains a challenge to achieve due to financial restraints (MOHSW, 2009). In 2008, the Tanzanian MOHSW (2009) estimated that, to provide the necessary CPD to maternal and child healthcare workers, particularly in emergency management, the required expenditure would be US\$7 million over seven years. Given that such funding was unachievable with current government healthcare spending in Tanzania, the Ministry of Health identified the need for partnerships with international organisations to provide CPD (MOHSW, 2009). In response to this identified need, GHAWA, the WA initiative described in Chapter 1, provides midwifery educators from Western Australia to deliver CPD to Tanzanian midwives—a scenario that often occurs in the Sub-Saharan region from other developed countries (Jones, 2011). However, the Western midwifery educators supplying such courses should be aware of the local cultural context and adapt their teaching accordingly (Opollo, Bond, Gray & Lail-Davis, 2012).

2.9 Cultural Competence for Western Midwifery Educators in Sub-Saharan Africa

Due to the shortage of midwifery educators in Sub-Saharan Africa, midwives from developed Western countries are increasingly undertaking teaching roles in the region through various aid organisations, such as the GHAWA (Global Health Alliance,

2012; Kamdonyo & Matinhure, 2013; Lavender et al., 2011). However, in order to effectively deliver education in a setting that is foreign to many Western midwives, attention must be given to ensuring these midwives are prepared to provide education that is culturally appropriate and sensitive (Enskär, Johansson, Ljusegren & Widäng, 2011; Hawala-Druy & Hill, 2012; Marcinkiw, 2003).

Cultural competence can be defined as the ability to collaborate effectively with a culturally diverse community through in-depth understanding of their cultural beliefs and circumstances (Capell, Dean & Veenstra, 2008; Marcinkiw, 2003). Such competence can be acquired through immersion in the culture and receiving education regarding the beliefs and practices of the local people (Enskär et al., 2011; Hawala-Druy & Hill, 2012; Marcinkiw, 2003). Developing cultural competence ensures that midwifery educators in countries that are different to where they reside can appreciate and incorporate the needs and values of their student group, and acknowledge that the philosophy of midwifery varies in different parts of the world (Enskär et al., 2011; Foster, 2009). Once cultural competence has been established by the external party, the local people are able to feel respected, have their opinions valued and strive to achieve mutually agreed goals (Foster, 2009).

The importance of cultural competence was reflected in a qualitative study by Enskär et al. (2011) that interviewed 26 lecturers who had delivered education in other countries, including Sub-Saharan Africa. The educators revealed that they needed to be able to adapt to the local culture and clinical situations because different teaching styles and curricula had to be established to suit the student group (Enskär et al., 2011). This is particularly relevant to the Sub-Saharan African setting, where not only the culture is different, but also the midwifery clinical environment differs greatly to the Western world as a result of the significant resource limitations (Ekechi et al., 2012).

Achieving cultural competence is a challenge that requires optimum understanding of the local context in which Tanzanian midwives practice, to ensure the education is relevant and as effective as possible. To achieve cultural competence, Western midwifery educators entering the developing country must be aware of the local midwifery role and the midwives' perceptions of the working environment (Foster, 2009).

2.10 Summary

This chapter has established an understanding of the midwifery role. Through the ICM and WHO, midwives were identified as professionals who provide holistic care to the childbearing woman and her family. This incorporates the promotion of normal birth, as well as preventing, treating and referring any complications that arise. In their role of protecting women and children from harm, midwives are strongly aligned with MDG 4: Reduce child mortality and MDG 5: Improve maternal health. However, particularly in developed settings, midwives are also considered to have a strong role in emotionally supporting, empowering and advocating for women.

In reviewing the literature from Tanzania, it became evident that the experiences of Tanzanian midwives were vastly different to those of midwives in developed settings. While ethical frameworks are established, midwifery education in Tanzania remains undeveloped. Low staffing numbers, high demand and inadequate supplies in hospital settings are leading factors resulting in a non-conducive environment. This affects not only the midwives' ability to deliver optimal care, but also their relationships with the childbearing women.

Through qualitative studies exploring both midwives' and women's perceptions of the midwifery role in Tanzania, it became apparent that improved access to CPD education is required for Tanzanian midwives. As this is currently unachievable at a

local level, Western midwifery educators are entering Tanzania to provide this education. However, to optimise the success of the education they provide, these Western educators must be assisted to competently provide culturally appropriate CPD education. As minimal information regarding the self-perceived role of a midwife in Tanzania has been previously attained, this information is needed to address this gap in understanding. Therefore, the purpose of the current study was to explore and describe Tanzanian midwives' perceptions of their professional role in the context of their clinical experience in order to enable Western educators to provide education appropriate to their needs. The next chapter will detail the methodology used to meet the objectives of this study.

Chapter 3: Research Method

3.1 Introduction

This chapter describes in detail the methodology used in this study to achieve the research objectives. First, the positive and naturalistic paradigms for research will be explained, as will the reasoning for the chosen qualitative, descriptive design employed (Johnson & Welch, 2011). The sample, setting and data collection method will then be described, as will the method of data analysis. Finally, the strategies used to ensure that the study was ethically founded will be addressed.

3.2 Paradigms of Research

There are two paradigms of research—positive and naturalistic (Johnson & Welch, 2011). The positive paradigm is based on the belief that objectivity is the foundation of truth (Beck & Polit, 2010; Johnson & Welch, 2011). This paradigm is associated with quantitative research, where objective means of data collection are used, often to investigate cause and effect relationships (Beck & Polit, 2010). The positive paradigm has been essential in the development of evidence-based management of physical health problems, including pregnancy complications (Beck & Polit, 2010). However, the rigidity of the positive paradigm has resulted in criticism of its ability to gain understanding of the complex concept of human behaviour, which cannot be objectively measured (Johnson & Welch, 2011). As a result, the naturalistic paradigm was developed (Johnson & Welch, 2011).

The naturalistic paradigm is considered a subjective means of understanding social phenomena (Creswell, 2013; Johnson & Welch, 2011). Theories are generated rather than tested, often to gain insight to the human experience (Johnson & Welch, 2011). In this paradigm, qualitative methods are used to collect data that are often the points of view of the participants, and then analysed to generate theories from the

complex information collected (Beck & Polit, 2010). For this reason, the naturalistic paradigm was determined to be the most appropriate paradigm for gaining insight to the perceptions of Tanzanian midwives' role in their clinical working context.

3.3 Choosing a Qualitative Design

Within the naturalistic paradigm, several designs can be used by the researcher. Five recognised qualitative designs are narrative research, phenomenology, grounded theory, case study and ethnography (Creswell, 2013). Narrative research focuses on individuals' stories to understand how they interpret events in their lives. The narrative approach is differentiated from other designs through its use of 'broad contours of a narrative; stories are not fractured or dissected' (Beck & Polit, 2010, p. 272). The phenomenology design assumes that there is an essential invariant structure—also called an 'essence'—to how individuals perceive their experiences (Beck & Polit, 2010; Creswell, 2013). In-depth conversations are the main method of data collection in phenomenological studies (Beck & Polit, 2010). The grounded theory design is concerned with understanding people's actions by exploring the causative factor to the behaviour and, in turn, the individual's response (Creswell, 2013). The case study design is suited to studies where the researcher intends to understand issues that are significant to the history and development of the people being studied. Multiple sources of data collection are normally used (Creswell, 2013). Ethnography design is concerned with defining a culture, and typically incorporates fieldwork and observation (Beck & Polit, 2010).

The current researcher reviewed these designs and their strengths, alongside the purpose of the present study, which was to explore and describe Tanzanian midwives' perceptions of their professional role in the context of their clinical experience.

Narrative research design focuses on detailed stories from participants, rather than

responses to specific topics, such as the professional role of Tanzanian midwives (Beck & Polit, 2010). Phenomenology design is dependent on in-depth individual interviews about a personal lived experience, while, in the present study, focus groups were regarded the most appropriate data collection method to facilitate group interaction and discussion about Tanzanian midwives' professional role (Creswell, 2013; Streubert & Carpenter, 2011). Grounded theory design is concerned with how people act and the causes for their actions, while the present study was focused on the perception of a professional role (Beck & Polit, 2010). Case study design is reliant on multiple methods of data collection, and ethnography design is focused on cultural, rather than professional, perceptions (Creswell, 2013). Thus, it was determined that none of these widely recognised designs were specifically suited to address the purpose and objectives of the current study. The rationale for this decision included that the study was concentrated on understanding a professional group, and required in-depth understanding of the contextual situation through one data collection method. As a result, alternative designs were explored.

A qualitative, descriptive design was then considered because it is included in the naturalist paradigm (Beck & Polit, 2010). This design is intended to describe a phenomenon of interest, where the researcher can selectively choose the methods of data collection and analysis (Beck & Polit, 2010). The qualitative, descriptive design was considered most applicable to the present study because a rich description of the midwifery role in the Tanzanian context could be attained (Sandelowski, 2000). The explorative nature of the design also enables researchers to explore the broad nature of the phenomenon, rather than only describing the situation (Beck & Polit, 2010; Sandelowski, 2000).

It was also apparent through the literature that this design is being used globally for studies where the five well-recognised designs may not be well suited. For example, Reed (2012) used a qualitative descriptive design to explore Australian midwives' experiences of counselling distressed postnatal women (Reed, 2012). A Swedish study used the same design to gain insight into women's experiences with homebirth (Sjöblom, Nordström & Edberg, 2006). Graner et al.'s (2010) study also used a descriptive design to reveal the experiences of healthcare providers offering maternity care in rural Vietnam (Graner, Mogren, Duong, Krantz & Klingberg-Allvin, 2010). Through evaluating the qualitative, descriptive design using both methodology texts and previous studies, it was evident to the researcher that the design was the most appropriate for fully achieving the study's purpose and objectives.

3.4 Sample and Setting

The objectives of the study were to:

1. examine the self-identified elements of the role of Tanzanian midwives working in their local context, in alignment with the *International Code of Ethics for Midwives* (ICM, 2008)
2. describe the perceived cultural factors that contribute to how Tanzanian midwives establish their professional role
3. provide recommendations for CPD education midwifery programs in Tanzania, as well as those teaching with the GHAWA.

3.4.1 Sample.

To achieve these objectives, the sample consisted of midwives from three hospitals in Dar es Salaam, Tanzania, and was divided into three focus groups on a hospital basis—Hospitals A, B and C. These groups were referred to as focus group from Hospital A (FGHA), B (FGHB) and C (FGHC). Participants included in the study

had to be registered, practising midwives who had graduated from a nursing and midwifery school in Tanzania and were currently employed as a midwife in one of the Tanzanian hospitals chosen for the study. Participants from the three different hospitals were recruited for the study to gain a broad spectrum of understanding of midwifery self-perception in Tanzania. Participants were full-time, part-time or casually employed, and included both novice midwives and experienced midwives with more than 20 years of experience. Although Swahili is the national language in Tanzania, all staff in the three hospitals were expected by their organisation to complete clinical documentation in English. This ensured that they could understand the English written word. They were also conversant in spoken English.

3.4.2 Setting.

The settings involved Hospitals A, B and C and were chosen based on their involvement with educational programs provided by the GHAWA. Official information on these hospitals was limited due to unreliable record keeping; consequently, their descriptions in this thesis are predominantly based on observational findings and verbal information provided by the GHAWA administrator. A more detailed description of the three hospitals is considered valuable to allow appreciation of the Tanzanian hospital settings in contrast to Western hospital contexts.

3.4.2.1 Hospital A.

At the time of the research, Hospital A was a large, multi-storey district hospital with an operating suite that was funded and overseen by the Tanzanian Government and provided care to patients of all ages with surgical and medical problems. It also comprised a maternity unit that was in a single-storey building, roughly 200 square metres in size, and approximately 100 metres from the main hospital. Water and

electricity supplies were unreliable due to poor infrastructure and inconsistent supply from the main sources.

The size of the maternity unit was six by 10 metres, containing 16 labour ward beds that were about half a metre apart. Curtains were not provided between the beds, and there were between 30 to 50 births each day. There was only one combined antenatal and postnatal ward containing 20 beds situated side by side in an open ward, with very little space between. On an average day, this room accommodated up to 50 women with their babies: two to three women and their babies sitting on each bed, while pregnant women sat on the floor. Once again, there were no curtains or dividers between beds, except at the entrance, where there were two maternal assessment bays with a divider separating them from the open ward. Attached to this ward was an eight-cot neonatal unit, which was three by three metres in size, with each cot accommodating two babies.

3.4.2.2 Hospital B.

Hospital B was another large government-run district hospital that similarly catered for patients with surgical and medical health problems. With an overall hospital capacity of 360 beds, there was a two-storey maternity block that contained obstetrics, gynaecology and neonatal wards. The small but very busy labour ward was a six by six metre single room with six beds that catered for 50 to 100 births per day. Comparable to Hospital A, there were no curtains between the beds and the water and electricity supplies were inconsistent. Women remained in an antenatal ward when they were in labour, and only transferred to the labour ward when birth was imminent. The eight by 10 metre antenatal ward accommodated approximately 20 women in an open-plan room, with usually one woman per bed, unless the ward was particularly busy, in which case the women shared a bed. The layout for the two postnatal wards was similar to

Hospital A, with three women and their babies to every bed. Women whose babies had died shared beds with those who had live babies. The maternity unit also had a newly renovated neonatal unit attached with 20 to 30 cots in a single room that was the same size as the other wards mentioned. Babies occasionally needed to share cots; however, generally, there was one baby per cot.

3.4.2.3 Hospital C.

Hospital C was the tertiary referral hospital in Dar es Salaam, and the largest of the three hospitals. Patients with complex medical and surgical issues were transferred here from other hospitals throughout Tanzania. Between 1,000 and 1,200 inpatients and a similar number of outpatients were cared for each day. There was a four-storey maternity block for the purpose of obstetric and neonatal care, including the region's only eclampsia ward, containing eight beds. The labour ward had 10 labour beds to accommodate 40 to 50 births each day. Akin to the other hospitals, the labour ward and all other wards were open-planned large rooms; however, the labour ward in Hospital C had curtains between each bed. The five antenatal and postnatal wards were not as crowded as Hospitals A and B, with few women having to share a bed. The neonatal unit was divided into five rooms, and babies were allocated based on their weight and condition, with a '500 to 1,000 g' room, a '1,000 to 1,500 g' room, a '1,500 to 2,000 g' room, a room for babies with 'congenital abnormalities' and a room for babies with 'infectious diseases'. The neonatal unit had 60 cots, but accommodated, on average, 150 babies, with as many as four babies per cot. Hospital C was the only hospital to include private sector beds, with a private four-bedded labour ward, as well as a postnatal and caesarean ward. It was a teaching hospital with a university campus on site. The university was the main nursing and midwifery education facility in Tanzania, as well

as offering courses in medicine and other allied health disciplines. The TNMC was located in a building attached to the nursing school.

3.4.3 Recruitment of midwives.

The recruited midwives for this study all took part in the Maternal and Newborn Health (MNH) workshops because the hospitals at which they worked were affiliated with the GHAWA. These workshops, which were attended over a period of two weeks, focused on emergency and preventative care across the childbearing continuum. Each workshop accommodated 16 midwives from Hospitals, A, B and C.

Over a three-month period from September to November 2012, a total of three MNH workshops were to be conducted. The researcher's intention was to use a purposive sampling approach to recruit midwives from these, as two workshops would take place during her four-week stay in Tanzania. However, due to unexpected organisational changes in Tanzania, midwives from Hospitals A and B completed the workshop prior to the researcher's arrival (see Table 3.1). This resulted in only midwives from Hospital C participating in the final workshop during the researcher's stay in Tanzania. However, as Hospital C was a large institution, this still enabled 16 midwives to attend the workshop.

Table 3.1

Data Collection Timeline

Event	Dates
GHAWA MNH workshop with midwives from Hospitals A and B	1 to 12 October 2012
Researcher arrived in Tanzania	15 October 2012
Focus group conducted with midwife participants from Hospital A	25 October 2012
GHAWA MNH workshop with midwives from Hospital C	22 October to 2 November 2012
Focus group conducted with midwife participants from Hospital C	31 October 2012
Focus group conducted with midwife participants from Hospital B	7 November 2012
Researcher left Tanzania to return to Australia	12 November 2012

Due to these organisational changes, the sampling method had to be modified to enable an adequate sample size and representation of the midwifery population. Two separate sampling approaches were subsequently used with the participating groups, which were termed as previously mentioned—Focus group from Hospital A (FGHA), B (FGHB) and C (FGHC).

3.4.4 Focus groups from Hospitals A and B.

When the researcher arrived in Tanzania, she met with the GHAWA midwifery educators who were conducting the MNH workshops. The educators informed the researcher that they could take her to Hospitals A and B to meet the midwives who had completed the workshop to see if they would agree to participate in the study. Prior to entering the maternity ward, verbal approval was obtained from the Director of Nursing and Midwifery Manager at the hospitals to approach their midwives, after they had been provided with an information sheet about the study by the researcher. Information sheets were always offered in either Swahili or English (see Appendices E and F). Before being distributed, the translations were completed by the interpreter and checked by the Committee for Education, Science, and Technology (COSTECH), which is the ethics committee for health research in Tanzania. Contact with the midwives was undertaken in person and informally, as rapport had been established between the educators and midwives involved in the workshops. The educators visited the hospitals with the researcher, and located the midwives who had completed the workshop who were working that day.

The researcher found that the number of midwives on duty that day who had taken part in the workshop and wished to participate in the study was insufficient to form separate focus groups. Thus, through a snowball sampling technique (Beck & Polit, 2010), the researcher asked these midwives if they had any colleagues who they

thought may want to be involved in the study. The midwives who had completed the workshop then accompanied the researcher to approach informally their colleagues in person and on the ward that same day, to enable the researcher to distribute the study information sheet. These colleagues had not been given permission to attend the workshop due to insufficient staffing, hence a combination of midwives who had and had not completed the workshop were recruited from both hospitals. This sampling approach was effective, with five midwives recruited from Hospital A and six from Hospital B, thereby comprising two of the three focus groups. It was not a prerequisite that participants had to attend the workshop in order to be recruited for the study, as this sampling method was too limited. Both focus groups were composed of three midwives who had taken part in the workshop and two to three of those who did not.

3.4.5 Focus group from Hospital C.

Midwives from Hospital C had participated in the GHAWA workshop during the researcher's stay in Tanzania. The midwives were addressed regarding the study during the first week of the two-week workshop, and provided with an information sheet explaining the study. Five midwives requested to participate in the focus group.

3.4.6 Focus group environment.

The environments chosen for the focus groups in the three hospitals were private, as quiet as possible, and located in the hospital grounds in order to maintain familiarity. This is supported by Freeman (2006) who suggested that, when establishing an environment, it should be non-threatening, inductive and naturalistic. Thus, in Hospitals A and B, the interviews took place in meeting rooms close to the maternity wards, as selected by the participants. Given that the participants from Hospital C were taking part in the GHAWA MNH workshop, which was held in a university classroom on the hospital campus, this location was used.

3.5 Data Collection

Prior to commencing the study, approval was sought and attained by the GHAWA director and the appropriate ethical bodies in Western Australia and Tanzania. The researcher then approached the GHAWA midwifery educators who were conducting the workshops in order to inform them about the study. This was done when the researcher arrived in Tanzania on 15 October 2012. At the same time, an interpreter was employed to assist with both the recruitment of participants and the focus group interviews. Approval was also obtained from the Directors of Nursing and the Midwifery Managers in Hospitals A and B, as well as the Midwifery School Director at the university situated on the Hospital C campus. An information sheet about the study was provided, followed by verbal approval being received. The three focus groups took place over three consecutive weeks (see Table 3.2).

Table 3.2

Focus Group Timeline

	Monday	Tuesday	Wednesday
Week 1	22/10/12 Hospital A: information about study provided	23/10/12 Hospital A midwives agreed to participate	24/10/12 Hospital A focus group took place
Week 2	29/10/12 Hospital C: information about study provided	30/10/12 Hospital C midwives agreed to participate	31/10/12 Hospital C focus group took place
Week 3	5/11/12 Hospital B: information about study provided	6/11/12 Hospital B midwives agreed to participate	7/11/12 Hospital B focus group took place

3.5.1 Hospital A focus group.

The first focus group consisted of participants from Hospital A. The midwives were informed about the study on Monday 22 October, when information sheets were provided in hardcopy in both English and Swahili (see Appendices E and F). Two days later, the researcher met with the interested midwives to answer any questions, using the interpreter as needed, before seeking verbal confirmation if they wished to participate. Following this, a time was arranged that was convenient to all participants to hold the focus group (see Table 3.2).

3.5.2 Hospital C focus group.

The focus group with participants from Hospital C was undertaken following completion of the GHAWA workshop they were attending. The same procedure as Hospital A was conducted, with regard to using an interpreter and providing bilingual information sheets. The midwives were informed about the study on Monday 29 October, and asked to respond to the invitation the following day. In consultation with those who consented to participate in the study, the focus group was arranged and undertaken (see Table 3.2).

3.5.3 Hospital B focus group.

During the third week, the focus group with participants from Hospital B took place. The midwives were approached regarding the study on Monday 5 November, using the same principles as the Hospital A focus group. Those wishing to participate gave verbal consent on Tuesday, and the focus group was arranged and completed the following day. All midwives who were approached at the three hospitals agreed to participate in the study (see Table 3.2).

3.5.4 Focus group procedure.

At the commencement of each focus group, the researcher once again introduced herself and the interpreter. The participants were verbally reminded of the aim of the study and their rights before and during the focus group interview, including the fact that they could withdraw at any time without implications for their involvement in the GHAWA education programs. The participants then completed a written consent form, which was available in both English and Swahili (see Appendices G and H). As with the information sheet, the consent form was translated by the interpreter and checked by the COSTECH in Tanzania. Ten participants opted to complete the Swahili consent form and six completed the English one. They were also reminded that the focus group interviews would be recorded on a voice recorder, and were given nametags along with the researcher and interpreter. Using nametags enabled a more personalised and comfortable setting for the participants (Stewart, Shamdasani & Rook, 2007).

To begin the focus group, a written demographic questionnaire was circulated and completed by the participants in order to provide the researcher with relevant information about the participants (Stewart et al., 2007). This included the participants' gender, age, religion, tribe, relationship status, educational qualifications, length of time qualified as a midwife and location of current employment, as well as whether they had dependents. These questionnaires were offered in both Swahili and English (see Appendices I and J).

Once the demographic information had been collected, the focus group interviews commenced using open-ended questions, which were verbally translated by the interpreter (see Appendices K and L). Using open-ended questions is considered valuable because they do not assume the participants' responses, and provide the richest possible data (Beck & Polit, 2010). The questions were asked by the researcher and

each participant was invited to respond. All questions were offered in English and Swahili by having the interpreter present, and concluded once all questions had been answered and the participants expressed they had nothing further to add (Freeman, 2006). To assist in creating a relaxed environment, refreshments were provided during the focus group interviews.

The main areas covered in the focus group questions were the participants' perceptions of the important aspects of midwifery care, their relationships with those in their care and the cultural factors affecting their practice. The open-ended questions were based on addressing the purpose of the study and a review of the relevant literature. Although the study was focused on the 'role' of the Tanzanian midwife, the word 'role' was not used specifically in the questions in order to avoid the midwives focusing on tasks, rather than on the overall purpose of their profession. This exclusion was based on the researcher's previous experience in Tanzania, where midwifery practice appeared to be task-orientated rather than based on its philosophical underpinnings.

Each interview lasted for approximately one hour, which is supported by Berg and Lune (2011), Freeman (2006) and Rabiee (2004) to be an appropriate duration for a focus group interview. This period ensured that the participants remained engaged, while allowing for maximum insight into the topic (Freeman, 2006; Rabiee, 2004). Although focus group interviews can extend for two hours (Freeman, 2006; Rabiee, 2004), this was unrealistic for this study because some participants were required to return to the ward.

The total number of focus groups planned for the current study was dependent on reaching the point of data saturation to ensure that maximum understanding of the phenomenon had been attained (LoBiondo-Wood & Haber, 2006; McLafferty, 2004;

Rabiee, 2004). Data saturation was achieved and confirmed in these three focus groups. If this had not been the case, an additional group would have been organised. The final sample size was 16 midwives, five each from Hospital A and Hospital C, and six from Hospital B. The small size of five to six participants in each focus group was based on the recommendations by Berg and Lune (2011), Freeman (2006), McLafferty (2004), Rabiee (2004) and Stewart et al (2007), all of whom have suggested that focus group sizes of four to 12 participants are ideal.

The focus group members knew each other prior to the focus group interview, which was considered beneficial because it was seen to help them relate to each other's comments and feel more confident in challenging other views in the group (Rabiee, 2004; Stewart et al., 2007). No awkwardness was noted during the interviews and the participants voiced strong opinions, when speaking in both English and Swahili.

3.5.5 Reasons for employing focus group interviews.

Focus group interviews can best be defined as directed or undirected group discussions that address a topic considered relevant or of interest to the group (Berg & Lune, 2011). The researcher leads the interview with a group of participants, each responding to the questions that the researcher asks, and discussing their answers with the other participants throughout the interview (Berg & Lune, 2011). The aim of interviewing methods is to achieve an in-depth exploration of a particular topic through examining the participants' personal experiences and perceptions by using the group interaction to effectively produce a breadth of responses (Berg & Lune, 2011). This form of collecting data is regularly used in qualitative research, and its benefits are widely documented (Berg & Lune, 2011; Freeman, 2006; McLafferty, 2004; Rabiee, 2004; Stewart et al., 2007). The advantages of a focus group environment include the following:

- the beliefs presented by living respondents in the present time bring with them pronounced credibility of the data
- the group interviews provide a broader scope of insight than do individual interviews because responses may prompt further discussion between participants (Stewart et al., 2007).

In addition, when using focus groups, a more equal interaction between the researcher and participants may occur. This enables flexibility to expand on topics that arise, which the interviewer may not have anticipated to be relevant to the discussion (Berg & Lune, 2011). Participants are able to clarify their points of view effectively through considering their responses to the questions against the responses of other participants (Freeman, 2006; Stewart et al., 2007). The technique also ensures that participants are less likely to be misinterpreted or to misunderstand questions, which may be the case with written questionnaires. This is of particular benefit in a country such as Tanzania, where English is not the primary language (Beck & Polit, 2010). As a result, any similarities or differences between responses can be clarified through the interactions in the focus group (Freeman, 2006). Additionally, participants who initially feel they have little to contribute can be encouraged to determine how they feel about the topic in response to the viewpoints of the other participants (Freeman, 2006). The researcher is able to relay his or her interpretation of the participants' responses to ensure they have understood the opinions correctly (Stewart et al., 2007).

A further reason for choosing focus group interviews for this study was that they are best suited to a selection of participants who have similar demographics (Rabiee, 2004). It was anticipated that this would be applicable to the participants in this study because they were expected to share the same gender, ethnicity and profession, as well as having similar working conditions, wages and assumed socioeconomic status. The

similarities between the participants would allow them to feel more comfortable with one another and make them more likely to contribute and engage in the discussion. Subsequently, the focus groups would be able to run more smoothly and encourage involvement from all members. This could provide an accurate reflection of the larger population (Barbour, 2007; Rabiee, 2004; Stewart et al., 2007). Incentives, including small gifts or food and drink, can be used to attract a more even sample group (Barbour, 2007), which the researcher opted to do for this study by providing refreshments.

Focus groups are an efficient source of data collection when there are time restraints on accessing participants (Berg & Lune, 2011). They enable the collection of a large quantity of data from a group of people in a relatively short period (Berg & Lune, 2011; Stewart et al., 2007). As a result, this interviewing method was also chosen for the present study due to the restricted time that the researcher had with the participants as a result of being in Tanzania for only a four-week period.

The researcher or moderator in a focus group has a vital role in ensuring that a sufficient quantity of rich data is obtained (Rabiee, 2004). The role is to ensure that the focus group follows a procedural guide and remains on topic, while encouraging participants to express their views and feelings in order to obtain optimal information (Berg & Lune, 2011; Rabiee, 2004). However, there is some risk in this role of assuming that sufficient data have been collected at the time of the interview because one may later discover, when examining the transcribed data, that certain areas should have been expanded (Stewart et al., 2007). The researcher must likewise ensure that their own biases do not influence how they encourage participants to respond to questions, including not providing cues (Stewart et al., 2007). For this reason, the background of the researcher will now be discussed.

3.5.6 The researcher.

As an instrument of the data collection process, the researcher reflected on her previous experiences in order to identify any potential biases that may have affected her role in the focus groups and data analysis. As an Australian-trained midwife who had worked in Australia, Sierra Leone and Tanzania, she reflected on her previous observations of the midwifery role in these settings.

In Australia, the researcher perceived midwives to be women-focused, with the quality of the birth experience founded on the holistic wellbeing of the mother and the ability to bond with her newborn. In Sierra Leone, where the researcher worked alongside local Sierra Leonean midwives for seven months, the midwives were significantly challenged by a lack of referral opportunities and critical care resources. However, building relationships with the local midwives revealed their strong sense of commitment to women and newborns. Women were not always spoken to with the same 'respect' as the researcher viewed in Australia; however, it was evident that the midwives were committed to keeping women and newborns alive, and were saddened by their deaths.

In Tanzania, the year prior to data collection, the researcher spent two weeks in the labour ward of one of the three studied hospitals. She found that this period was too limited to enable her to engage thoroughly with the midwives and understand their perceptions of the midwifery role. However, the researcher initially assumed that the midwives did not care about the women and newborns because resuscitation attempts were minimal, as was the time spent with each woman.

Given her experiences, the researcher was cautious of the appropriateness of her being an instrument of the data collection. However, there was no one else available to guide the focus groups, and the researcher decided that the knowledge that could be

gained from the midwives would be invaluable to the education provided to them. The researcher used her experiences to build rapport with the midwives prior to the focus group discussion. She regarded the process of determining her pre-existing biases as paramount to separating her own views from the present study. As a result, she was able to enter the data collection and analysis periods with her own views aside. The researcher also elected to engage an interpreter in order to assist with both the recruitment of participants and the focus group interviews.

3.5.7 Using an interpreter.

The researcher involved in this study spoke only English, while the official language in Tanzania is Swahili (Central Intelligence Agency, 2014). Although all the participants demonstrated that they spoke English fluently, the researcher elected to have an English/Swahili interpreter present for the focus group interviews. This was because, when participants are able to speak in their first language, more open and spontaneous discussion can often be achieved (Barbour, 2007). This strategy was supported in a study conducted by Umaña-Taylor and Bámaca (2004), who interviewed South American women and found that, despite speaking English, the participants often reverted to their native language when exploring emotive concepts; hence, richer data can be attained when an interpreter is present. The presence of an interpreter can also allow for equal participation among those in the focus group who do not feel as confident speaking English (Barbour, 2007).

However, using an interpreter can also entail many challenges (Williamson et al., 2011). First, some words and terms are not translatable in certain languages (Barbour, 2007). For example, a study in which 35 Tanzanian healthcare workers were interviewed found that the Swahili interpretation of the word ‘motivation’ related heavily to receiving a monetary reward (Prytherch et al., 2012). Thus, for the current

study, meetings were held between the researcher and interpreter prior to data collection to ensure that all terms in the questions were translated into Swahili with the same meaning. This was achieved by the researcher checking the definitions of the translated Swahili words to ensure they matched the English interpretation.

Having an interpreter present during an interview can also significantly affect the validity of the collected data because the meaning of what is said by the researcher or participants may be lost due to the complex interpreting process (Shimpuku & Norr, 2012; Williamson et al., 2011). Thus, care must be taken when selecting an interpreter to ensure they are culturally and academically suitable (Jones & Boyle, 2011; Shimpuku & Norr, 2012). For this study, an interpreter was chosen based on availability and appropriateness. The interpreter, who was Tanzanian and lived in Dar es Salaam, was the administrator for the GHAWA. His role for the GHAWA was to liaise with local organisations to ensure effective coordination of the GHAWA strategies, including the MNH workshops, which the researcher used as her basis for participant recruitment. He was fluent in English and Swahili and undertaking a Master's Degree at a reputable university, thereby possessing a thorough awareness of the research process. It must be noted that the interpreter was not involved in the delivery of the workshops and had no contact with the participants prior to the focus groups. As emphasised by Jones and Boyle (2011), this was important in order 'to understand the relationship of potential translators with the target community and the community's possible concerns' (p. 114).

Given that all participants were women, a female interpreter was initially considered. However, the interpreter used in the current study was familiar with each hospital and the participants from each focus group had met him before. While males are employed as nurse-midwives in the hospitals, the participants were still asked prior to being interviewed whether they were comfortable with a male interpreter, to which

they stated they were. The researcher had extensive discussion with the interpreter regarding the expectation of his role and the aim of the study prior to the focus groups in order to ensure that the role would remain unbiased and have minimal effect on the collected data (Williamson et al., 2011).

3.6 Data Analysis

The demographic data were manually analysed due to the sample size of 16 participants. The qualitative data collected from the interviews were analysed using Ritchie and Spencer's (1994) framework analysis method, which is described as 'quite similar to grounded theory; however, framework analysis differs in that it is better adapted to research that has specific questions [and] a limited time frame' (Srivastava & Thomson, 2009, p. 73), which was applicable to the present study. First, the audiotaped interviews were transcribed by a transcriber, and the interpreter assisted with transcribing Swahili recordings to English transcripts. The transcripts were then checked by the researcher to ensure accuracy and enable her to become more familiar with the data through repetitive exposure (Tuckett, 2005). Prior to this process commencing, the participants' details were coded to maintain anonymity and confidentiality.

Using Ritchie and Spencer's (1994) framework analysis method, the researcher manually reviewed each transcript repeatedly, line by line, developing initial coding of the data through tagging and making remarks based on units of meaning in the transcripts (Ritchie & Spencer, 1994; Srivastava & Thomson, 2009). The tagged 'coded' data were then evaluated for trends within each group and compared, resulting in early theme development (Moretti et al., 2011; Ritchie & Spencer, 1994; Tuckett, 2005). The identified themes became more integrated as datasets were analysed, incorporating quotations and theoretical notes from each interview (Tuckett, 2005).

These datasets were then re-evaluated several times using analysis and reduction to develop more logically established themes (Tuckett, 2005). Two additional reviewers proceeded to simultaneously and independently review the transcripts and then the coded data in order to achieve interrater reliability of the findings through detection of any observer errors (Beck & Polit, 2010). Further measures were taken to ensure the overall trustworthiness of the data, as explained in detail in Section 3.7.

3.7 Trustworthiness

The purpose of trustworthiness in research is to ensure that the experiences of the study's participants are accurately represented (Beck & Polit, 2010). Given the naturalistic nature of qualitative research, four criteria must be addressed in order to achieve rigour through face validity of the data: credibility, transferability, confirmability and objectivity. These will now be defined and explained.

3.7.1 Credibility.

Credibility in research is the ability to trust in the truth of the collected data (Beck & Polit, 2010). Credibility of the data in the study was achieved through using engagement with participants (Beck & Polit, 2010). This was done by arranging the timing of the focus groups to suit each participant, having no fixed time restriction for the focus groups, and making available the researcher's contact details in case the participants wished to expand on their responses (Beck & Polit, 2010). At the time of the focus group interview, the researcher reiterated what was said by the participants after each question to guarantee that her interpretation of their opinions and beliefs was correct.

It was ensured that all questions focused on the Tanzanian midwives' views of their role to ensure that the objectives of the study were achieved. The participants were provided with written information (see Appendices E and F) about the study and the

researcher to ensure they felt confident in the collection, interpretation and management of the data (Beck & Polit, 2010). The transcriptions were then reviewed by the researcher's supervisors, who were experienced qualitative researchers, in order to develop theme so that accuracy and professionalism were ensured through consistency of the developing themes. It was intended that, if any discrepancies arose in the themes, all researchers involved would revisit the data. The researcher further detailed her own professional and personal perspective of the collected data in a journal in order to identify any biases in the study (Beck & Polit, 2010).

3.7.2 Transferability.

Transferability refers to the degree to which research findings can be transferred to other groups or settings (Beck & Polit, 2010). This was achieved through the detailed richly described data of the settings and the sampling methods (Beck & Polit, 2010; LoBiondo-Wood & Haber, 2006). The researcher was able to gauge whether the research findings could be transferred and have meaning to similar context/settings (Beck & Polit, 2010). Including participants from various maternity areas and hospitals allowed for holistic perspectives of the topic.

3.7.3 Confirmability.

Confirmability refers to the data being neutral (Beck & Polit, 2010). During the study, confirmability was attained by a clear audit trail linking evidence from the data through the thought processes that led to the findings, as well as enabling easy access to the dated progress of the research (Beck & Polit, 2010). Collected documents in the audit trail included transcripts from interviews, documentation of phenomena as they developed, and peer debriefing sessions that occurred monthly with independent researchers (Beck & Polit, 2010).

3.7.4 Objectivity.

Objectivity is the prevention of bias in research findings (Beck & Polit, 2010). This was accomplished by the researcher documenting in a journal her own professional and personal opinions and responses to the research throughout the duration of the study. This identified any attitudes and beliefs of the researcher during her study, and subsequently enabled optimum avoidance of views on the process of the research that could affect the data collection, analysis and findings (Beck & Polit, 2010). As an example, the following is an excerpt of an entry, which was made on 24/10/14 at 5:30pm:

As I entered the ward to meet the participants, I could see a midwife slapping a labouring woman's leg whilst shouting at her. Then, during the interview, the midwives' stated they were respected by the women. The interaction I had just witnessed did not seem like it would build a respectful professional relationship, but this is from my Western context. I have to be extremely mindful that how midwives' interact with women here may be accepted very differently to what it would in Australia.

3.8 Ethical Considerations

Prior to the study being undertaken, permission was sought and attained by the Human Research Ethics Committee at Curtin University in Western Australia, and the COSTECH in Tanzania (Appendices M and N). Following approval for the study from the two committees, local approval was obtained from the relevant Directors of Nursing and Midwifery Managers at Hospitals A and B, and the Director of Education at the university situated at Hospital C.

All individuals wishing to participate in the study were informed in both English and Swahili about the purpose, nature and benefits of the study. They were further told

that their involvement in the study was voluntary and that they could withdraw at any time without penalty. These facts were also provided in English and Swahili on the information sheet. Written consent was obtained prior to the study being conducted, following which a copy of their signed consent form was attained. The participants were informed that all data collected would remain confidential, including their identity and the tape recording of their responses.

3.9 Data Storage, Access and Disposal

The data collected were de-identified to protect the participants' privacy and confidentiality. The researcher constructed a master list that assigned an alphabetical code to each focus group (A, B or C) and a numerical code to each participant (1 to 15), thereby ensuring no names were recorded. The master list was stored securely in a locked filing cabinet, accessible only to the researcher. The data and completed consent forms were kept separately so that numerical codes could not be matched to participants' personal information. Interview transcripts were identified using only this numerical code. Any audible names or identifying information included in the interviews were removed during transcription.

The data collected throughout the course of this study were stored in accordance with guidelines under Section 2 of the *Australian Code for the Responsible Conduct of Research* (Council, 2007). Cassette audiotapes and devices containing digital recordings of interviews were stored in a separate locked cabinet. All electronic data were password protected and only accessible to the researcher. Study documents and audio-recordings will remain in secure storage for a period of seven years from the date of last publication of this research, after which time, the recordings will be erased and paper documents shredded. The transcriptions will be kept for a five-year period, after which time, they will be destroyed, as per the *Australian Code for the Responsible Conduct of*

Research requirements (Council, 2007). The contributions and cooperation of the subjects and hospitals involved in this study will be acknowledged in a manner that ensures confidentiality. Anonymity will be ensured when citing findings in all publications and presentations.

3.10 Summary

This chapter has described the methodological considerations pertinent to this study. These were divided into the research design and considerations, sample, setting, procedure, data collection methods and ethical considerations. The qualitative approach has been explained, as have the reasons why and how the method was used in the present study. The findings from this study are presented in Chapter 4.

Chapter 4: Findings

4.1 Introduction

This chapter presents the research objectives and subsequent findings. A demographic description of the participants is provided, followed by their responses to the focus group interview questions. Since the purpose of this study was to capture in rich detail the points of view of the participants, examples of the participants' responses are presented verbatim, with no alterations made by the researcher.

The focus group questions were designed to address the overall purpose of this study, which was to explore and describe Tanzanian midwives' perceptions of their professional role in the context of their clinical experience. The objectives of the study were to:

1. examine the self-identified elements of the role of Tanzanian midwives working in their local context, in alignment with the *International Code of Ethics for Midwives* (ICM, 2008)
2. describe the perceived cultural factors that contribute to how Tanzanian midwives establish their professional role
3. provide recommendations for the provision of optimal CPD education for midwives in Tanzania.

The focus group questions that were designed to address the objectives were pre-determined, and are outlined in Appendices K and L. Three focus groups were conducted for this study, and referred to as Focus Group from Hospital A (FGHA), Focus Group from Hospital B (FGHB) and Focus Group from Hospital C (FGHC). Taking part in each focus group interview were five participants from Hospital A (FGHA.1 to FGHA.5), six participants from Hospital B (FGHB.6 to FGHB.11) and five

participants from Hospital C (FGHC.12 to FGHC.16). Quotations from the participants are presented in italicised text to enable clear illustration of their viewpoints.

4.2 Profile of Midwives

The 16 participants were all female, aged between 30 and 59 years, with a mean age of 38.8 years. Fifteen were married, and all had children. Their religious backgrounds were Christian, Muslim and Roman Catholic, as shown in Table 4.1.

Table 4.1

Personal Demographic Characteristics

	<i>N</i>	<i>%</i>
<i>Religion</i>		
Christian	9	56
Muslim	4	25
Roman Catholic	3	19
<i>Relationship status</i>		
Married	15	94
Widowed	1	6
<i>Children</i>		
Nil	0	0
One	4	25
Two	4	25
Three	6	38
Four	1	6
Five	1	6

Other demographic items involved the length of time qualified, place of employment, clinical setting and length of employment in current hospital. The participants had trained in 11 of the 84 nursing colleges in Tanzania where midwifery was a component of the degree (UNFPA, 2010). Therefore, all referred to themselves as nurse-midwives. The professional demographic data can be seen in Table 4.2.

Table 4.2

Professional Demographic Characteristics

	<i>N</i>	%
<i>Length of time qualified</i>		
0–5 years	7	44
6–10 years	4	25
11–15 years	1	6
16–20 years	2	12
21–25 years	1	6
40 years	1	6
<i>Length of time at current hospital</i>		
0–5 years	10	62
6–10 years	3	19
11–15 years	0	0
16–20 years	2	12
21–25 years	1	6
<i>Maternity specialty area</i>		
Labour suite	4	25
Antenatal	2	12
Neonatal unit	4	25
Obstetric theatre	1	6
Gynaecology	1	6
Private caesarean ward (fee paying)	1	6
Eclampsia ward	3	19

4.3 Qualitative Findings**4.3.1 Emerging themes.**

Two themes emerged from the qualitative data and, as the thematic analysis process continued, other patterns developed that were subsequently delineated into five subthemes as follows:

- Theme 1: Saving Lives
 - Subtheme 1: Prioritising Care
 - Subtheme 2: Barriers to Saving Lives
- Theme 2: Value to Others
 - Subtheme 1: Personal Community—Family and Neighbours
 - Subtheme 2: Professional Community—Patients and Doctors
 - Subtheme 3: The Tanzanian Government

4.3.2 Theme 1: Saving Lives.

Table 4.3 provides an overview of Theme 1 and its subthemes.

Table 4.3

Overview of Theme 1 and Subthemes

Theme 1: Saving Lives	
This theme presents the participants' perceptions of their role in saving the lives of mothers and babies in childbirth, and the factors that impede their ability to do so. Two subthemes emerged from this theme.	
Subtheme 1: Prioritising Care	Subtheme 2: Barriers to Saving Lives
The importance of prioritising care emerged as the participants described the fundamental aspects of midwifery practice that contribute to the prevention of maternal and neonatal mortality.	This subtheme provides an insight to the limitations in the delivery of effective care, as identified by the participants, such as shortage of resources, inadequate staffing levels and lack of ongoing education.

Emerging from each focus group interview was the overwhelming belief that midwifery is a vital profession, with repeated mention of how significant the midwife's role is in 'saving the lives' of Tanzanian mothers and their babies. All participants verbalised that this role is vital in preventing maternal and neonatal mortality, with comments such as, '*midwifery is so important to save the life of the mother and the baby*' (FGHC.12), and that midwives are needed '*in order to have well mothers and children*' (FGHC.15). This was further emphasised as, '*You are taking care of the mother, and you save the life of the mother and, at the end of the day, the mother and baby are well*' (FGHC.12).

The strong opinion regarding mortality prevention emphasised a powerful sense of professional significance and pride among the participants, as one person stated, '*we are very important people in our country*' (FGHB.6). There was also reference to themselves as a '*saviour to the people who need help*' (FGHB.6), which is achieved by '*making them [women and newborns] healthy when they are sick*' (FGHB.6). This made them feel '*important*' (FGHC.15), as they identified the women and newborns

they cared for as often being very sick or at-risk ‘patients’ who could be saved by their skills.

Many of the participants focused on the significance of providing midwifery care to women throughout pregnancy, including during the postnatal period. This was seen as essential to the wellbeing of mothers and children in order to facilitate a safe pregnancy and birth, as indicated by the statement, *‘a midwife is needed. Midwifery is important to care for a pregnant woman, to be with a woman, during pregnancy, during delivery, after delivery, in the first 28 days’* (FGHC.15).

While all participants identified the need for midwifery care to enable a safe birthing process for Tanzanian women, the importance of the role in educating expectant mothers about health promotion and prevention of complications was also emphasised, with one participant stating:

Midwifery is important because we teach women how to keep themselves well during pregnancy and after pregnancy and during time for breastfeeding the baby, and how to use medicine when they go to clinic to prevent infections and diseases. (FGHB.8)

This view was further supported in the participants’ acknowledgement that the profession is not only essential to the health of those immediately in their care, but also to the wider Tanzanian community. One participant stated, *‘midwifery is important to our country’* (FHGC.16), while another stated that their care enables those who are ill to *‘get well, go back to their job to continue with the building of the nation’* (FGHB.6). All recognised the role of the mother as vital to the wellbeing of her family and, in turn, to the wider community, with one participant stating, *‘if you save the mother, it means that you have saved the community’* (FGHC.12).

The profession was not only viewed as important to saving lives, but the midwives also expressed enjoying their role: *'I am very happy to be a midwife'* (FGHB.11) and *'I am proud to be a midwife'* (FGHB.6). These feelings were a result of their ability to provide care to women and newborns in a way that enabled a safe birth: *'receiving antenatal mothers, you care for her, deliver a live baby, you are very happy'* (FGHA.2). Another stated, *'I am proud because the mother, when she gets her baby, she is feeling very happy'* (FGHB.11).

The participants emphasised the significance they placed on ensuring the women for whom they cared were both physically and emotionally well: *'I am happy when I give service to pregnant woman and she leaves happy, or when a woman comes with a problem and I help her until she is okay and safe to go home'* (FGHB.8). This often related to them ensuring the women were fit during childbirth, and birthed a healthy baby. Feelings of pride and happiness were revealed by statements such as, *'when the mother comes with labour pain, I help that mother to leave here, the hospital, with their baby, live baby and healthy baby. And the mother, they are happy. I am very happy'* (FGHB.10). Another stated, *'I enjoy most when I conduct delivery and end up with a result without complications. Baby is alive, mother is alive. Both is happy and doing well. That is when I enjoy it most'* (FGHC.13). The establishment of this desire to contribute to the physical and emotional wellbeing of women and their babies was seen as *'a calling. You can feel it first from the inside'* (FGHC.13). One participant explained that her 'calling' came from visiting her family in hospitals as a child and *'seeing some of the mothers who are sick and so forth'* (FGHC13). This was also stated by another participant:

When I was going to hospital, it was the way they [midwives] are giving care to the patients. The way the patients were sick and the way until they are discharged, I see them saving the lives of people. (FGHA.4)

The participants also discussed their experiences of dealing with very unwell women and newborns, and the difficulties faced in seeking to prevent mortality in their work environments. All emphasised that the most satisfying experience of the midwifery role was when they were able to preserve the life of the woman and baby, with *'both of them leaving the hospital with safe condition'* (FGHB.7). Although there were descriptions of frequently dealing with birth complications, the fulfilment of the role was expressed when there were no complications: *'baby is alive, mother is alive, both is happy and doing well'* (FGHC.13).

A strong sense of connection with the women and families for whom they cared in relation to mortality was also demonstrated, with one participant defining maternal mortality as *'losing a sister'* (FGHA.3) and another stating, *'I feel like I have lost my young, my children, I feel very bad'* (FGHA.2). When asked about dealing with neonatal mortality, they stated that they *'did not feel well'* (FGHA.4), particularly when having to explain to a mother that her baby has died. One participant stated, *'when you need to counsel the woman about her baby dying, it is very hard'* (FGHA.5).

The participants were then asked about their knowledge of the ICM CoE. None expressed awareness of this international CoE, and those who could relate to an ethical code were only aware of the national TNMC's CoE. This national CoE is included in their curriculum, and was described as *'a special document that shows us how to behave'* (FGHB.9). However, the participants acknowledged that, post-registration, there was no ongoing reference to the CoE, and their awareness of the content was minimal. Only two explained their perceived purpose of the CoE: *'It protects me and*

protects our patients, how to give good care for the patient without causing psychological and physiological effect' (FGHB.11) and *'to maintain privacy and confidentiality of patients'* (FGHC.12).

In summary, saving the lives of women and newborns was seen by all involved as the strongest driver in the delivery of midwifery care. The prevention of maternal and neonatal mortality generated feelings of pride, happiness and connection with the women they assisted during birth. However, there was no awareness of the ICM CoE, and knowledge of any national ethical principles was minimal. Emerging as significant factors in their practice in order to save lives were the following two subthemes: *Prioritising Care and Barriers to Saving Lives.*

4.3.2.1 Subtheme: Prioritising Care.

Prioritising care was seen as crucial in preventing maternal and neonatal mortality in the participants' description of their 'typical day' at work. All stressed the significance of first identifying the sickest women or newborns in their unit, followed by addressing their needs. One participant stated, *'if there is anyone serious, I care for her first. Before I do anything, I look for serious patients'* (FGHA.2). This was supported by another participant who explained, *'we give care according to the condition of the patient'* (FGHA.4).

Two processes were described to be fundamental to effective midwifery practice in order to prioritise care: receiving handover and completing initial assessments on their patients. All agreed that receiving handover through written and verbal reports at the change of shifts was essential in determining which women and newborns were unwell. This was seen as the first point of communication, with one participant stating, *'The most important thing is to receive report. It allows you to know who the most serious patients are and to prioritise where to start'* (FGHB.6). These feelings were

further supported by another participant: *'It is very important to be aware of your patient, know your patient well, by name, by diagnosis and by examination. You can't care for the patient who you don't know. That is the point of the report'* (FGHC.14).

Together with the significance of receiving the handover report, the participants disclosed the importance of their ability to assess women and newborns to further detect those who were more seriously unwell: *'Assessment, prevention and implementation are very important'* (FGHA.4). It was further explained that, once the report has been received, they personally check each patient to ensure that the most seriously ill patients have been identified accurately. After this, they prioritise their care. As one participant stated, *'[assessment allows midwives] to see things. You see which patients need more care'* (FGHA.5). By using handover and their own assessment of the women and newborns in their care, they are able to implement care based on patient acuity: *'after assessing, maybe you find that this baby is serious and you start with them'* (FGHA.4). It was reasoned that these two processes provided the midwives with the greatest ability to get to know each patient and prioritise their care according to who was most unwell.

In summary, prioritising care through the midwifery-based skills of receiving handover and completing patient assessments was considered vital to provide the effective care needed to save lives. However, these processes were exacerbated due to the barriers participants experienced in their daily practice, which emerged as the second subtheme of Theme 1.

4.3.2.2 Subtheme: Barriers to Saving Lives.

Barriers to saving lives were described by participants as the limited resources to enable the delivery of safe and effective care, and thus prevent mortality. A range of issues was revealed as contributing to this, including a shortage of appropriate

resources, inadequate staffing levels and the lack of continuing professional development education for the midwives to ensure maintenance of clinical competence.

Despite dealing with high mortality rates, the participants confirmed awareness that death should not be a common occurrence during childbirth. They stated that *'pregnancy is not a disease. It is normal process'* (FGHC.13) and *'maternal mortality, its causes are well known and it is preventable. Those who come for delivery should have safe delivery'* (FGHC.14).

The belief in the normal birthing process greatly affected the participants, with them voicing frustration and sadness at not having adequate resources to provide appropriate midwifery care and save more lives. One participant stated, *'If I could do this and this, this woman wouldn't have died'* (FGHC.13) and another stated, *'the woman should not have died and it is so painful because it is not like someone who had suffered from medical disease'* (FGHC.12). There were accounts of how they felt when dealing with the relatives of a patient who had died due to lack of resources: *'it is bad and uncomfortable—sometimes you learn to be answerable for something that is not you [your fault]. It is because of lack of facilities'* (FGHC.13). Feelings of discontentment were indicated: *'What is hard is the working environment. According to the job we are doing. We find that the supply, the resources are not enough'* (FGHA.4). Others stated, *'Working in labour ward, there is no intravenous fluid, or maybe there is no oxytocin, and you know that after getting that drip and the oxytocin that you can save that mother who has got the postpartum haemorrhage'* (FGHA.4), and *'Last week, it was difficult for us, we had many mothers and many babies who were sick, no drugs, no water, so working environment is very difficult'* (FGHA.4). Another participant stated:

You want to do simple things like suction the baby, but you find out that other wards do not have even the suction machines. Maybe they have in labour ward, maybe also theatre, but not all the wards. Sometimes you can conduct delivery in another ward, then you start running with baby to suction machine in other ward, which is a waste of time and sometimes a baby pass away because of such a simple thing. It feels very bad. (FGHC.13)

Although the Tanzanian Government pledged that all healthcare was free to women and children under five, adequate resources have not been provided to hospitals to achieve this. As a result, this hinders the ability to save the lives of women and their babies, as explained by one participant: *'the government says that services and equipment are free. Yes, it's true, but the supplies are not enough to suffice the numbers of children and expectant mothers'* (FGHA.4).

Similar to the inadequacy of equipment and resources being required to provide care, the participants also stressed the overwhelming need for an increase in staffing levels to *'fulfil the gaps that can cause the care to be not well done'* (FGHC.15). There were descriptions of an ongoing *'increase'* in patient numbers and the need for more midwives to allow for *'a smooth run in taking care of the patients'* (FGHC.14).

While identifying the necessity for improved resources, there was further disclosure of a great need for ongoing professional education in order to expand the midwives' scope of knowledge in their specialty. The participants expressed joy in possessing the knowledge and skills to help women and newborns, with comments such as, *'to know and understand the work, I am very happy'* (FGHB.10) and *'it makes me happy to have learnt many things. For example, to know signs and symptoms of anaemia and how to care for an eclamptic patient'* (FGHB.6). However, it was recognised that their scope of practice required continual workplace education *'in order*

to improve our knowledge to make us more competent' (FGHC.15). The participants expressed that, if continuing education was provided, their care would improve.

Following completion of the GHAWA workshop, one participant stated:

If our government provides knowledge and skills for nurses, day to day, not only maybe every two years with a seminar like this, would be very helpful. Some midwives, they don't even know how to resuscitate the baby, how to save a baby, including me. This is something I have added from the seminar. (FGHC.12)

In summary, Theme 1 detailed the participants' role in saving lives by preventing maternal and neonatal mortality, as well as the importance of prioritising care (Subtheme 1) and the barriers to achieving this (Subtheme 2). Delving further into the data, the issue of the role being valued by others emerged as Theme 2.

4.3.3 Theme 2: Value to Others.

Table 4.4 provides an overview of Theme 2 and its subthemes.

Table 4.4

Overview of Theme 2 and Subthemes

Theme 2: Value to Others		
This theme describes how the participants felt their role was of value to their family and neighbours, the community, those in their care, and the other professionals with whom they worked. It further presents the participants' perceptions of how their profession was valued in the community and by the Tanzanian Government for whom they worked.		
Subtheme 1: Family, Neighbours and the Community	Subtheme 2: Patients and Doctors	Subtheme 3: The Tanzanian Government
This subtheme establishes how the participants believed they were viewed as midwives by those they personally encountered.	This subtheme explains how the participants felt they were perceived as midwives by the doctors they worked with and women they cared for.	This subtheme identifies how the participants felt they were valued by the government for which they worked.

Theme 2 revealed how the participants believed others in their personal lives—such as community, family, neighbours, patients, doctors with whom they worked and the Tanzanian Government (as their employer)—valued their role as midwives. This

was reflected in comments such as, *'when someone is sick, they come to me and call, "can you help us?"', so we have big value in the community'* (FGHB.11)

Views arose regarding how the participants felt about their position in the community. The majority of responses suggested that, although they were seen as someone who could be turned to for midwifery and general health assistance in times of need, they indicated that they were not always valued as professionals. For example, *'I am a very important person to them when they need me [when unwell], then they seek assistance. But when they don't need me, I am rejected'* (FGHC.14). The discussion of others' perceptions focused initially on the participants' interactions with their community, family and neighbours. The participants described how these personal interactions affected their feelings of professional value.

4.3.3.1 Subtheme: Family, Neighbours and the Community.

In their personal lives, there were conflicting responses of how the midwives were regarded by their friends and neighbours. These views ranged from feeling respected and trusted for their contribution to helping others, to being undervalued and seen as having low status. The participants indicated that they thought the positive views towards them were a result of their ability to assist when health problems arose among family, friends and the community.

Details were expressed of how they felt their family respected them because of their role. This included descriptions of their relatives being *'happy'* (FGHA.4) to have a midwife in the family. They were seen as someone who could be turned to for any health problem, as well as midwifery advice, and they were subsequently trusted to help the family in times of need. As one participant stated:

My family they are very happy, because I am a midwife. They trust I will help them if any problem arises in the family. When they are pregnant, they come and

ask about when they will give birth, before they give birth they come and ask me. And if anyone in the family is sick, they ask me before they go to the hospital.

(FGHA.2)

At times, they expressed how their role went beyond their scope of practice and extended to their neighbours, who would ask for help when health concerns arose. This request was a responsibility that the participants felt confident to undertake, and, as noted by one participant, *'If someone is sick, they worry, they get frightened, maybe they are sick and needing treatment, I care for her'* (FGHA.3). Another stated, *'The community, they value the helper. So we can help them by giving instruction, explanation and education as well, as a counsellor, as a teacher, everything'* (FGHB.11).

In contrast with the recognised importance of their role by some family, friends and members of the community, there were revelations of how their profession was sometimes perceived by others as being one of low status, with low income and no prospects. As one participant noted, *'[relatives] look at me in a very sorrowful way because they think I'm lost because the profession is not payable, the profession is not respected'* (FGHC.14). Similarly, another stated that midwifery is seen by those around her as *'a hard job, so others they look at us and feel sorry for us because they wonder how we are keeping up with a difficult job like this one'* (FGHA.3).

The participants' also stated that the community had negative views towards the role, and considered it a *'filthy'* (FGHC.14) profession, with practitioners having limited knowledge. There were opinions that they were not respected by their neighbours because they worked in *'a very dirty environment, looking after patients who are vomiting, those with diarrhoea, and those who are incontinent'* (FGHC.15). Another participant stated:

They don't trust us, they think that doctors are the one that are going to help them. But when they come here they can find out I can give good care, maybe more than doctor. So for me it works like that. (FGHC.13)

Most participants revealed that there was strong community opinion that midwives lacked a caring attitude and did not respect their patients. They consequently struggled to gain respect as a profession due to the 'negative attitude' (FGHC.13) towards them, even though they tried to 'provide care 100%' (FGHC.12). This frustration was described by one participant:

When you are in the community, maybe at a funeral, wedding, you can hear people talking bad things towards nurses. Others they say we have bad language to the patients, others they say we are not helping the patients, that we are not willing. I feel bad because according to what I do here. I am caring for patients, but I don't know (FGHB.10).

Discussion progressed from descriptions of family, friends and the community, to the midwives' interactions with those in the professional setting. Specifically, this incorporated how the participants felt perceived by the women in their care, and the doctors with whom they worked.

4.3.3.2 Subtheme: Professional Environment—Patients and Doctors.

As in their personal lives, the participants expressed contrasting opinions of how they were viewed by the individuals they encountered in their professional lives. In general, they believed they were valued and trusted. However, they were also occasionally unappreciated due to patients and doctors viewing midwifery as a low-status profession in Tanzania.

The participants stated that there were positive ways in which the women for whom they cared perceived their role. All described receiving a strong sense of

gratitude from most women, as feeling relied on and appreciated for their care. Several stated that the women saw them as a ‘*second god*’ (FGHA.3) because they had complete faith in their care and did not hold them responsible for negative outcomes. One participant stated:

maybe the baby is very sick and the mother comes and asks you ‘what do you think, I’ll get my baby or I lose my baby?’ It is a difficult question for you to answer. They do not blame you, most of them, they accept. (FGHB.11)

The participants reported that some women saw them as poorly skilled and incompetent in their practice. This was particularly evident for those working at Hospital C, which was situated in a significantly more affluent area of Dar es Salaam than Hospitals A and B. These participants expressed that their professional abilities were not valued until they proved their competence by delivering efficient care without negative outcomes to the patient. They indicated that this was due to them being ‘*poorly paid*’ and their education not being appreciated: ‘*They think we don’t have the knowledge*’ (FGHC.12). One participant pointed out that, when she told the women how long she had studied at university, ‘*they responded, “four years doing what—just a midwife?”*’ (FGHC.14). Some participants stated that they were seen as merely following ‘*doctor’s orders*’, rather than independently coordinating care: ‘*They think we are just helping them by being directed by the doctors, and not from our brain and our schooling*’ (FGHC.12). As a result, the participants expressed frustration because their care had previously saved the lives of women and babies. This was compounded by the fact that, even if a doctor was not involved with the birth, the women would only show gratitude to the doctors, with “*no words of thanks to [the midwives]*” (FGHC.14).

Others described how the women for whom they cared were not trusting of the midwives until they proved they were able to provide kind and competent care. This

was explained by one participant who stated that some women were surprised at their skill level and would say, *'oh, you are working in a good way. I respect you'* (FGHC.15). However, the participants reported this only occurred once midwifery care had been provided, rather than women trusting the participant's manner and skills beforehand. Another commented that if she made one error when giving care, the woman would *'remain with that one bad thing, and forget 100 good things which you have done for her'* (FGHC.13). These feelings were supported by another participant, who discussed an occasion where her abilities as a midwife were questioned:

I was in the labour ward when a woman came in labour. She was treated as a private patient. The professor was called, examined the patient as usual, and then he went away. The patient asked me who is going to help her in labour? I said, 'it is me, I am going to assist you'. 'Ha, nurse, my midwife, you are going to help me in labour, during my process of delivery? No, no, no.' I said, 'yes, I am competent. We are quite competent, that's why the professor went away'. At the end of the day, I was the one who conducted the delivery to that mother. At the end she said, 'Oh, thank you, I am sorry that I did not know that you know much, you are so good'. (FGHC .14)

Regular encounters with pregnant women and the wider community for whom they cared led to the participants stating that the general public do not realise how much university-based training midwives have completed and the high level of responsibility they hold in their professional duties. Relative to these views, they expressed a great need for improved awareness of their role in order for the midwifery profession to be respected and trusted. This sentiment was voiced as a need for improved *'health education to the community'* (FGHC.14) and to build on the midwifery image in Tanzania as an essential profession in achieving safe birth. Statements made by the

participants included, *'midwives can conduct a delivery safely'* (FGHC.13) and *'it is important to provide service to pregnant women so that, when they deliver, they can go home safely'* (FGHB.7).

The participants stated that a key factor in how they were perceived by pregnant women was often related to the midwives' attitude when caring for these women. One participant stated, *'it depends on my attitude'* (FGHA.1) and another explained, *'it depends on how you treat them. If you treat the woman well, she will respect you'* (FGHA.3). In contrast, another participant expressed difficulty in communicating with those for whom she cares within the community because *'[the women] say that we are bad people due to our attitude. We do it to help them to get their babies, but they take it differently, they are negative'* (FGHB.9).

Another factor considered to be compounding this problem of negativity was the fallout from the Tanzanian Government's unmet pledge that healthcare would be free to women and children. This negatively affected the participants' relationships with the women for whom they cared. Inadequate resources were provided to the hospitals, and midwives subsequently had to ask women to purchase their own supplies. Although most women trusted the midwives when told that free resources were unavailable, some believed the midwives were hoarding the supplies, as divulged by one participant:

The problem is that when the client comes from home, she knows I will get everything from the hospital, and if they come and there is no treatment, when we tell them to buy, they feel very bad. They say why, why to buy it when the government says it's free? They feel that the nurses don't give it to them. If we tell them we do not have it, they do not trust us. (FGHA.2)

The working relationship with the doctors was also discussed, with participants stating they generally had a *'good relationship'* (FGHB.11) and were comfortable

voicing their opinions to doctors regarding care delivery. However, some stated that their professional opinions were not valued by the doctors, indicating that doctors were often condescending to midwives for being '*just a nurse*' (FGHC.13). All participants appeared assertive in their relationship with the doctors, with one respondent disclosing how she would respond if her judgement was ever questioned by the doctors: '*They look at us as if we don't know, and I tell them I know because I am a midwife, a professional. I know how to manage my patient as a midwife*' (FGHC.14).

From this point, the participants proceeded to discuss how they perceived the Tanzanian Government's view of midwives, given that they all worked at government-run hospitals.

4.3.3.3 Subtheme: The Tanzanian Government.

There was strong agreement that those in the Tanzanian Government did not value or appreciate the efforts of midwives, and had no regard for the non-conducive working conditions in the hospitals. There were descriptions of how the government did not see the importance of midwives for maintaining the health of women and newborns. Although the participants did not specify their exact working hours, they stated that they worked '*long hours*' with only two staff for '*maybe 30 to 40 patients*' (FGHB.6). As a result of such situations, the participants considered that the government did not care about these issues and chose to ignore them. One participant stated:

[The government] are not seeing the importance of us. They just maybe treat us as normal people, but we are carrying a big load in our country. By treating patient to get well and they go back home to build the nation, but the government, they don't think about that. They treat us very badly. (FGHB.11)

Low wages was identified as an issue that further exacerbated the situation. The participants stated that midwives earn low wages in comparison with other government

professions, along with differing pay rates between midwives when, clinically, their practice is the same. Working in ‘*dangerous*’ (FGHA.1) environments was also of concern, due to caring for people with contagious diseases and having poor safety standards in place. As one participant stated:

patients in our hospital should be on the beds with enough sheets. Then the midwife caring for the woman will be much more comfortable. Taking care of the woman lying on the floor, it is very difficult to care for that woman. And then myself, nurses, we are suffering from back ache because of the positioning—most of the time we get down for that woman who is lying on the floor.

(FGHC.13)

Additionally, their salary was revealed as not reflecting the risks of their job, nor was there adequate compensation provided if they became injured or unwell at work. When questioned about yearly salary increases, one participant explained that increment rises are ‘*very little—you may find only 2,000 TSH [AUD\$1.30] per year it is increasing*’ (FGHB.10). Others expressed that their wages were barely enough to accommodate their families’ basic needs, and they were desperate for a reasonable increase in their wages, ‘*so we can at least be comfortable*’ (FGHC.14).

Difficulties were disclosed with regard to the expectation of the government for midwives to always be well mannered in their care without considering the poor conditions in which they worked. The participants revealed that the ability to always be polite towards patients was not easy with their very high workload and associated exhaustion. One expressed that the government ‘*do not think on our side*’ (FGHC.13) regarding the difficulty of maintaining good manners when working in such a demanding environment, and allowing one midwife to care for ‘*eight patients*’ (FGHC.14) each day. Another participant stated:

The government tells midwives that they are not caring, but with the high workload, all I am able to do is touch and leave and touch, touch, touch and at the end of the day, you can't remember the work you have done—what was good and bad. You just stand in the middle of the ward and you look at who needs attention first—otherwise, I don't know where to start, I don't know where to finish. You find yourself in a dilemma. Once you are tired, you won't give care to your patients, but this is not recognised by the government. (FGHC.14)

Although the participants believed they were not acknowledged professionally and did not have their needs accommodated by the Tanzanian Government, they did believe the government still considered midwifery a vital profession for the nation, as reflected in the following statement:

The government, they don't recognise us, but they know our importance. They insist to the community that you go and deliver in hospital because you will find the midwives there. They have the knowledge and skills to deliver you safely, and you will leave there with the baby and the mother safe. Even the community, although sometimes they have negative attitude, they know it is better that they come to us. Because they know we have the capacity to do the better thing for their safety, keep women and babies alive. We are very important. (FGHB.6)

In summary, the participants generally perceived that midwifery was valued by the community as a life-saving profession. However, their skills were sometimes devalued by family, friends, neighbours, community, patients and doctors due to the midwives' apparent lack of education and low socioeconomic status. As their employer, the Tanzanian Government was considered unappreciative of the work conditions and associated difficulties faced in providing effective and compassionate midwifery care.

4.4 Summary

The qualitative findings of this study detail a strong midwifery identity among the participants. The participants indicated perceptions that their profession was one that could save the lives of women and newborns during childbirth, including feelings of both pride and responsibility. Connection existed with the women for whom they cared, and the midwives' desire to help these women was subsequently strong. There was the belief by the participants that, in order to "*build the nation*" (FGHB.6), women and newborns must be kept alive and well.

In the interest of saving lives, the key requirements were expressed as prioritising care based on the information provided, and undertaking physical assessment, along with being able to provide care in conducive environments. The participants described the hospitals as frequently being understaffed and under-resourced, which restricted their ability to provide adequate care. This generated frustration at being unable to provide adequate care due to circumstances beyond their control. Further, they recognised that their midwifery practice needed to be improved, and that ongoing education was required to achieve this.

Although the participants regarded the importance of the midwifery role for the wellbeing of society very highly, they felt that their value was not always appreciated by those around them. Despite the fact they had support and appreciation from many family members, friends and neighbours for the healthcare they provided, this was not the case in some circumstances. There were incidences when they felt looked down on by neighbours for their poor income and the 'dirty' nature of their work, and that they were not caring for their patients. These same views extended to the hospital environment. The participants revealed that, while most women appreciated the care they provided, some disregarded their knowledge base in comparison with doctors.

Additionally, certain members of the medical team tended to regard them as recipients of orders, rather than as members of the decision-making process.

These expressed concerns were compounded by the participants feeling undervalued and underappreciated by their employer, the Tanzanian Government. The overwhelming opinion expressed that this lack of appreciation was evident in their low incomes and the consistent lack of essential equipment and medication. Further, the Tanzanian Government's promise of free healthcare to women and children had not been adequately introduced. Subsequently, the participants explained that midwives were forced to be the gatekeepers to resources and were forced to ask women to buy their own supplies. This made them feel accountable to issues beyond their control.

The next chapter explores the possible rationales for the findings of this study by making comparisons with the relevant literature. The study conclusions will be presented, together with this study's implications and recommendations to enable the culturally appropriate provision of education for midwives in Tanzania.

Chapter 5: Discussion, Implications and Recommendations

5.1 Introduction

This final chapter provides a brief overview of the background, methods and findings prior to the main focus of the discussion, where the findings are situated within the existing literature. In addition, this chapter discusses the study findings and considers their implications, which are embedded in the discussion. The limitations and recommendations for further research are then detailed.

5.2 Overview of the Background and Methodology

The improvement of maternal and child health in developing regions has been acknowledged as a key priority for healthcare over the last two decades due to the establishment of the UN (2013) MDGs 4 and 5. Midwives have a vital role in accomplishing these MDGs through providing care to women and babies across the pregnancy continuum (UNFPA, ICM & WHO, 2014). To achieve the best possible care, CPD is an essential component of maintaining and evolving a midwife's competency (Dennis-Antwi, 2011; Gross et al., 2011a; ICM, 2008; Lavender et al., 2009). However, in Sub-Saharan Africa, there are significant barriers to providing appropriate CPD for midwives, which has led to foreign aid organisations negotiating the involvement of midwifery educators from Western countries to implement education and training in developing countries (Global Health Alliance, 2012).

International midwifery guidelines and philosophies are derived from developed country settings, where the midwifery role is well established and viewed holistically, advocating for normal birth and women-centred care (ICM, 2005, 2008). Nevertheless, this environment is in stark contrast to the situation faced by midwives who practice in developing countries. In such settings, it is imperative that insight to the midwifery profession is gained from local midwives to ensure that any quality improvement in

maternity care suggested through CPD is culturally relevant to the needs and values of the midwives being taught (Wood & Aktins, 2006). Following a comprehensive appraisal of previous studies, it became apparent to the current researcher that there was minimal published knowledge of the perceived role of midwives in Sub-Saharan Africa, and the factors affecting them. An understanding of these issues was felt to be crucial because the developing country environment is an enigmatic system of formal and informal associational ties based on midwives' professional characteristics, roles, norms and ongoing socialisation processes in that environment.

The current study was conducted to address this dearth of knowledge, specifically in the Sub-Saharan African nation of Tanzania, where Australian midwives are providing CPD through the GHAWA organisation. The study's purpose was to explore and describe Tanzanian midwives' perceptions of their professional role in the context of their clinical experience. It is intended that this study's findings will assist in developing CPD programmes, specifically offered by the GHAWA, to ensure that they are more appropriately aligned with the local midwives' values and working environment.

The specific objectives of this research were to explore midwifery practice in Tanzania by:

1. examining the self-identified elements of the role of Tanzanian midwives working in their local context, in alignment with the *International Code of Ethics for Midwives* (ICM, 2008)
2. describing the perceived cultural factors that contribute to how Tanzanian midwives establish their professional role
3. providing recommendations for the provision of optimal continuing CPD education for midwives in Tanzania.

To gain insight to this phenomenon, a qualitative, descriptive design was used with a sample of 16 Tanzanian midwives from three hospitals in Dar es Salaam, Tanzania. In Chapter 4 of this thesis, extracts were presented from descriptions by the midwives to illustrate the self-identified fundamental themes of midwifery practice and the perceived cultural factors that contribute to how they establish their professional role. In undertaking this research, the researcher was mindful of the fact that each Tanzanian midwife brought her own personal and professional characteristics to the study. It was further acknowledged that this is not for an outsider to judge and that the insider's perspective must be accepted as authentic.

5.3 Summary of the Findings

The knowledge gleaned from the study made it apparent that the midwife participants identified their role as predominantly saving the lives of women and newborns. This element of midwifery care was not only the overwhelming focus of their role, but was also how they attained fulfilment in their profession. Therefore, 'Saving Lives' emerged as Theme 1 in the findings. Within this theme, there were two subthemes. In the subtheme 'Prioritising Care', the midwives identified that detecting unwell women and newborns and focusing their care accordingly was the main competent of their ability to save lives. They prioritised their care through receiving clinical handover and performing patient assessments to detect those who were most unwell. However, the midwives faced many barriers in order to save lives, such as insufficient resources, low staffing numbers, and a lack of CPD to improve their knowledge. Therefore, 'Barriers to Saving Lives' emerged as the second subtheme.

Theme 2: 'Value to Others' revealed that the midwives perceived that their image in the community was low due to their minimal wage, presumed lack of knowledge and poor attitude. Within this theme, there were three subthemes. The

subtheme of 'Personal Community: Family and Friends' revealed that, although the midwives believed they were sought after for medical help in times of need, they were otherwise disregarded by those closest to them due to their poor working conditions and low wage. In the subtheme of 'Professional Community: Patients and Doctors', the midwives disclosed that, although some women were appreciative to them, pregnant women often disregarded the midwives' knowledge and only acknowledged the doctors. The midwives generally had a good working relationship with the doctors, although occasionally they were disregarded by their medical colleagues for their perceived lack of knowledge and skills. The final subtheme of 'The Tanzanian Government' revealed that the midwives believed that the government needed them, but did not appreciate them, as evidenced by their poor working conditions and pay. Despite this, the midwife participants' self-belief in the importance of the midwifery profession for saving the lives and improving the wellbeing of women and newborns remained strong.

This study's findings highlight the close integration between the way in which these midwives viewed themselves and the cultural factors that affected their professional role. It was thus considered most appropriate to integrate the discussion related to the first two study objectives and use this to address the third study objective to provide recommendations for the continuing provision of education.

5.4 Discussion

Through evaluating the findings and comparing them with literature relevant to the topic, eight key concepts emerged: the role of the Tanzanian midwife, prioritising the midwifery workload, workplace constraints, CPD education, cultural competence for Western educators, women-centred care, CoE and the status of midwifery. These are now discussed in detail.

5.5 The Role of the Tanzanian Midwife

The overwhelming role of the Tanzanian midwives was saving the lives of women and newborns. This focus of midwifery is undoubtedly shared by all midwives globally. With the establishment of the UN (2013) MDGs in 2000, an international focus on maternal and child health outcomes was established. The ICM (2013a), as the global midwifery professional association, identified that midwives are fundamental to achieving the MDGs. The goal of saving lives remains the paramount concern, even in countries with considerably lower maternal and neonatal mortality rates than Tanzania (CMACE, 2011; Draycott, 2013).

Due to the need to monitor health outcomes, auditing systems are in place in many settings to identify and address the causes of adverse outcomes, and enquiries into deaths are conducted (CMACE, 2011). Locations where maternal mortality enquiries are well established include the UK and Australia. The CMACE in the UK is globally regarded as the gold standard because no other country is as thorough in its recording of maternal death investigation (CMACE, 2011). In comparison with the standardised UK enquiry system, similar but less comprehensive investigations are undertaken in other developed countries, including Australia, the Netherlands and the US (Lewis & de Swiet, 2007).

In Australia, each maternal death is reported to the Australian Safety and Quality in Healthcare Commission. However, it is then investigated by local state and territory maternal mortality committees that are not nationally standardised (Royal Australasian College of Surgeons, 2010). The Netherlands has collated national data, although the reporting systems have been criticised for not consistently stating whether a woman was pregnant when she died from non-pregnancy specific causes (Schutte et al., 2010). In the US, minimal information is provided nationally regarding maternal deaths, which

are included in the National Centre for Health Statistics Report, rather than being reported separately (Gaskin, 2008). However, the US does have the resources available to investigate maternal deaths (Hoyert, 2007).

In developing countries, limitations in resources and funding often restrict the ability to investigate deaths thoroughly. Basic auditing systems are in place; however, causes of death are often determined through review of clinical notes, instead of an accurate post-mortem (UNICEF et al., 2013; WHO et al., 2014). In Sub-Saharan Africa, causes of mortality are commonly determined through anecdotal accounts from family members during census reporting, rather than accurate hospital reports to the government (WHO et al., 2014). The lack of accurate reporting and diagnosis related to maternal and neonatal mortality makes improving outcomes and saving lives even more challenging.

To address the midwifery role of saving lives in Tanzania, the midwifery framework in this country must be considered in order to understand why midwives value mortality prevention so highly (UNFPA, 2011). The maternal and neonatal mortality rates in Tanzania are significantly higher than those in developed countries; thus, midwives are frequently exposed to sick and deceased women and babies, as reported by this study's participants (UNFPA, 2011; WHO, 2014c). Although saving lives is a global midwifery focus, in Tanzania, it overshadows all other elements of the midwives' care due to deaths being so frequently encountered. In Western countries where death is not 'expected', midwives are able to prioritise other elements of the midwifery role, including facilitating informed decision making and providing social and emotional support to women (Homer et al., 2007; ICM, 2005). In Tanzania, the great challenge in reducing mortality rates makes it more difficult for midwives to expand their focus of care to the psychosocial wellbeing of the woman; hence, the daily

effort to save lives remains an absolute priority. Additionally, audits into adverse outcomes and enquiries into deaths are restricted by the insufficient facilities for investigation, such as the lack of post-mortems and poor documentation in patient records (Kidanto et al., 2009a; MOHSW, 2009; Nyamtema et al., 2008a). Compounding these issues, CPD is poorly established for the midwives to enable them to improve their capabilities to be prepared for maternity emergencies (Jones, 2011).

Internationally, to address the issue of saving lives, many CPD programs are already in place that focus on being prepared for maternity emergencies. The PROMPT workshop developed in the UK is one example that has been adopted by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (Draycott, 2013). This program emphasises the importance of teamwork to maximise the capability of managing obstetric emergencies. In the US, a similar program called ALSO (2013) was established in 1991, and is now adopted in several developed and developing countries, including Australia and parts of Tanzania. Successful implementation of the ALSO course in Tanzania is evident in the Kilimanjaro region, where the ALSO course was initiated as part of a research project in 2008 (Sorensen et al., 2011). In 2011, an evaluation of the course identified improvement in postpartum haemorrhage detection by maternity staff at a regional hospital from 1:25 instances to 1:5, and a reduction in postpartum haemorrhage occurrence from 33 to 18% (Sorensen et al., 2011). While effective, there is no evidence of anywhere else in Tanzania the course is being implemented outside the Kilimanjaro area, which is 550 kilometres from Dar es Salaam, where the GHAWA workshops are offered (African ALSO Network, 2013).

In appreciation of the strong drive of the participating midwives to improve their capability to save lives, it is appropriate to emphasise that CPD in Dar es Salaam is

focused on being prepared for maternity emergencies. This focus is of particular importance given that ‘the majority of women dying from complications of pregnancy and delivery, results from selected emergency situations that occur following the onset of labour and immediately after delivery’ (Donkor, 2008, p. 69). Although being prepared for maternity emergencies is included in the GHAWA workshop, it is not heavily emphasised at the beginning of the workshop; rather, a general focus on maternal and newborn healthcare is provided. Modifying the GHAWA workshop structure to focus primarily on life-saving skills may prove effective for engaging midwives. This could also apply to any midwifery CPD program offered in the region with similar circumstances.

Further, to reduce the instances of having to save lives, CPD should also incorporate strategies focused on preventing maternity emergencies from occurring. The main strategy to address obstetric emergencies is improving the capability of midwives to recognise deteriorating patients before major complications arise (CMACE, 2011). This approach includes education regarding prioritising care in a high patient-load setting to ensure those who are most unwell are attended first (CMACE, 2011).

5.6 Prioritising the Midwifery Workload

Recognising unwell women and newborns and prioritising care accordingly was identified by the midwife participants as the most significant element of their practice. They classified prioritising care as receiving verbal handover from the previous shift (clinical handover) and completing patient assessments to enable them to identify and care first for the most acute women and newborns, including deciding how to structure their workload. These approaches in prioritising care are not isolated to these Tanzanian midwives, but are a focus of healthcare both nationally and internationally.

Throughout Tanzania, the need for improved detection of unwell women and newborns and to prioritise care accordingly is recognised. Both are included in the NRMSP 2008–2015, which identifies that effective implementation of handover and assessing patients to recognise those who are unwell by health workers will positively affect maternal and newborn outcomes (MOHSW, 2009). It was encouraging that the midwife participants in this study did not express concern over their ability to undertake clinical handover and patient assessment to prioritise their care. However, it is interesting that flaws have been identified in the skills of clinical handover and patient assessment in detecting deteriorating patients in Western countries, as has a focus on the need to improve them, despite the relatively low mortality rates (CMACE, 2011).

Inadequacies in clinical handover identified in Western countries include varying handover methods, incomplete information on transfer, and lack of agreed care plans (Porteous, Stewart-Wynne, Connolly & Crommelin, 2009). Patient assessment in Western countries is inadequate, with clinicians failing to recognise subtle changes in patients' vital signs prior to cardiac arrest (CMACE, 2011). In the Tanzanian setting, completion of patient assessment is difficult. The midwife participants identified that insufficient resources and staffing prevented them from effectively completing patient assessment and care. However, their desire to improve their skills in patient assessment was a positive finding.

Patient assessment and clinical handover are currently not included in the GHAWA's CPD program (see Appendix A). Given the global acknowledgement of inadequacies in these skills and their effect on maternal and neonatal outcomes, it would be beneficial to incorporate both elements in the program provided to Tanzanian midwives. As identified by the midwives in this study, these two tasks, when effectively completed together, allow for early recognition and response to unwell women and

newborns, which enables the prevention of deaths. However, Western educators must be mindful of the available resources in hospitals when developing these concepts in order to know whether the strategies they teach are realistic and achievable in the current context.

5.7 Workplace Constraints

Emerging from the focus groups were feelings of frustration and hopelessness due to the inability to reduce mortality rates because of three main barriers. The participants knew that women and babies should not die during childbirth and that most deaths were preventable. Nevertheless, due to the persistent combination of three factors—understaffing, insufficient resources and poor clinical knowledge and skills—the ability to save lives was often considered unachievable. The participants' experiences were also a reflection of hospitals and their staff throughout Sub-Saharan Africa, with these factors frequently attributed to suboptimal care and poor maternal and neonatal outcomes in the region (Kidanto et al., 2009a; Kruk et al., 2008; Kwesigabo et al., 2012; Modiba, 2008; Nyamtema et al., 2008a; Prytherch et al., 2012).

Tanzania's inadequate midwifery workforce and subsequent understaffing is a long-standing issue. Reduced numbers of healthcare workers directly relates to the increased likelihood of deaths occurring during childbirth in Tanzania (Manzi et al., 2012), as reflected in the participants' concerns about the effect of insufficient staffing. Further, trepidations over insufficient staffing and high patient loads have been identified repeatedly in studies throughout Sub-Saharan Africa (Lavender et al., 2011; Mbwele, Reddy & Reyburn, 2012; Nyamtema et al., 2008a). While little can be done by organisations such as the GHAWA to directly increase the numbers of midwives in Tanzania, the CPD programs they provide must be mindful of these workplace constraints. In cultivating improvement strategies, it must be accepted that it will be

challenging for local midwives to meet the needs of every woman. Thus, programs need to increase the capability of prioritising care to those who need it most, and cultivate antenatal and postnatal education.

If women have greater self-awareness of the symptoms associated with childbirth problems, they may present to hospital earlier, thereby allowing for more effective and less demanding interventions (Pembe et al., 2010). Education can facilitate healthy behaviours among women, and subsequently reduce the numbers of 'sick' women and babies (Pembe et al., 2010; Sakala & Kazembe, 2011). In turn, public demand on maternity services may be reduced. CPD goals, such as prioritising care and educating women, allow midwives to appreciate the potential for improving the health of women and newborns, despite low staffing levels. This argument was reinforced in a Tanzanian-based study by Manzi et al. (2012), which suggested that, even when short-staffed, healthcare workers will support the implementation of simple strategies if there is an opportunity to save lives (Manzi et al., 2012).

Educators must not only be appreciative of short staffing, but also mindful of the lack of available resources in developing countries. Lack of resources, which was continually reinforced by the midwife participants, is frequently attributed to poor health outcomes in women and newborns, as well as general patients in hospital. Concerning outcomes are continuously cited in the literature, including in several qualitative studies focusing on midwives in Sub-Saharan Africa (Bream et al., 2005; Gross et al., 2011a; Leshabari, Muhondwa, Mwangi & Mbembati, 2008; Maputle & Nolte, 2008; Mselle et al., 2013; Pettersson, 2007). As a result, there has been widespread demand for increased government expenditure and improved distribution processes throughout the health system in Africa to improve the care provided to all who access the system (Gross et al., 2011a; Knight, Self & Kennedy, 2013; Leshabari et

al., 2008; Mbwele et al., 2012; Nyamtema et al., 2012; Pettersson, Johansson, Pelembe, Dgedge & Christensson, 2006).

Through their NRMSP, the Tanzanian Ministry of Health identified the need for essential resources to be available at every healthcare facility in order to provide appropriate obstetric and neonatal emergency care. This was at a cost of nearly USD\$130 million over seven years (MOHSW, 2009). While the international recommendation is for 15% of a country's budget to be committed to healthcare in the African Union, Tanzania only allocates 11%, of which 38% of this minimal amount is still reliant on international donations (African Union, 2007). As this is well short of the NRMSP target and the World Bank recommendations for health expenditure (World Bank, 2013; MOHSW, 2009), it is questionable whether there will be an improvement in the provision of hospital supplies in the foreseeable future.

Due to the lack of resources, it is difficult for Tanzanian midwives to address saving lives to the same extent as Western midwives. Certainly, these challenges are well outside the capability of small operations, such as the GHAWA organisation. Nonetheless, as with low staffing, lives can still be saved despite restricted supplies (Kidanto, Wangwe, Kilewo, Nystrom & Lindmark, 2012). In their NRMSP 2008–2015, the Tanzanian Ministry of Health identified several low-resource and cost-effective strategies for maternal and neonatal mortality reduction, including promoting breastfeeding for diarrhoea prevention, as no contaminated water is involved, and neonatal resuscitation, which can be completed without an oxygen supply by using room air or direct mouth-to-face contact (MOHSW, 2009). Similarly, strategies have been applied to complex maternity problems. In an audit by Kidanto et al. (2012), the researchers analysed the effectiveness of 14 low-resource improvement strategies for eclampsia management (see Appendix O) at a tertiary maternity hospital in Dar es

Salaam. The strategies included birthing a woman within 12 hours of an eclamptic seizure and checking the foetal heart rate every 30 minutes to detect foetal compromise (Kidanto et al., 2012). Substantial improvements were found in the management and outcomes of women with eclampsia. Additionally, the number of women who had a full blood picture to determine their haematological status increased by 65%, with zero maternal deaths in the re-audit compared with 30 in the first audit (Kidanto et al., 2012).

Encouraging low-resource strategies, such as those previously described, can also lead to improved workplace satisfaction among midwives, as they see the potential for saving lives, even if circumstances are not ideal (Prytherch et al., 2012). This potential for improvement was evident in a qualitative study conducted by Prytherch et al. (2012) in rural Tanzania that explored job satisfaction among maternal and newborn healthcare workers. Interviewing 25 nurse-midwives, eight managers and two policymakers, the participants acknowledged limitations in staffing and equipment in hospitals. However, they still spoke passionately about their role, identifying that what led them to be a healthcare professional was seeing the role as serving the community. The nurse-midwives expressed feelings of satisfaction when they did their job well (Prytherch et al., 2012).

Indeed, the current researcher's own experiences in Sierra Leone proved that, with low-resource strategies, both maternal and neonatal mortality rates can be significantly reduced and the working environment can thrive. Improvements in outcomes were realised by only using the resources available at a Sierra Leone government hospital at the time, including limited antibiotics to treat suspected infection, no foetal monitoring and no oxygen supply. The strategies initiated included giving broad spectrum antibiotics for symptoms of infection, and neonatal bag and mask ventilation using room air. The strategies saw a reduction in neonatal mortality from 1:8

to 1:45 babies, and not a single maternal death in 600 births (Aberdeen Women's Centre, 2011). The most effective strategies were neonatal resuscitation using only air, rather than oxygen, and providing magnesium sulphate to women with severe pre-eclampsia, as per WHO (2011, 2012a) recommendations, rather than waiting until they had a seizure, which the researcher witnessed at the government hospitals in both Sierra Leone and Tanzania.

When implementing improvement strategies in developing countries such as Tanzania, the expectations for reducing maternal and neonatal mortality rates cannot be the same as a Western setting. This disparity exists because it is impossible to deliver the same service with the vast differences in resource availability. However, significant improvements in maternal and neonatal outcomes can still be achieved in a developing country, as demonstrated with the eclampsia audit in Tanzania by Kidanto et al. (2012), which resulted in a reduction in maternal mortality from 30 during the first audit to zero during the second (Kidanto et al., 2012). However, to achieve success with low-resource strategies, midwives must have up-to-date and hands-on education to enable them to effectively implement such strategies (Kidanto et al., 2012).

5.8 CPD Education

Continuing professional development (CPD) is the process of participating in learning activities relative to the environment in order to maintain and increase professional knowledge and competence (Australian Nursing and Midwifery Council, 2009b). In the current study, the Tanzanian midwife participants identified their urgent need for CPD to improve their ability to help women and newborns. These views were consistent with previous findings from studies conducted in Sub-Saharan Africa that identified the need for improved CPD (Gross, Schellenberg, Kessy, Pfeiffer & Obrist,

2011b; Lavender et al., 2011; Modiba, 2008; Mrisho et al., 2009; Nyamtema et al., 2008b).

Inadequate skill levels in midwives have been widely attributed to maternal deaths in the literature. This assertion was reflected in a systematic review of 43 studies from Sub-Saharan Africa that identified that 86% of maternal deaths were attributed to the inadequate skills of doctors and midwives (Knight et al., 2013). Not only have investigations into maternal deaths concluded this, but so have the opinions of midwives themselves. Similar to the midwife participants from the current study, midwives from Mozambique identified that their lack of knowledge impeded their ability to provide emergency care (Pettersson et al., 2006). While emphasising the need for improved skills, the Mozambique midwives' highlighted the importance of ensuring that any CPD education they receive be relevant to their cultural setting and available resources. They stated that, 'there is no use attending these lectures [if] when we later face reality, we do not have the possibility to perform as we have been taught' (Pettersson et al., 2006, p. 154). Thus, it is imperative that educators providing CPD be culturally competent in doing so in order to ensure that the education they provide is relevant (Pettersson et al., 2006).

5.9 Cultural Competence in Western Midwifery Educators

There has been increasing involvement from Western countries in the establishment of CPD for healthcare workers in Sub-Saharan Africa (African ALSO Network, 2013; Jones, 2011). In the GHAWA program, midwifery educators from Western Australia travel to Tanzania to conduct two-week CPD workshops for local midwives (Jones, 2011). Most of the midwife participants from this study had completed or were completing the GHAWA workshop. It must be noted that they did not directly indicate that the information provided to them during the GHAWA

workshops was inappropriate, and they were very appreciative of the learning opportunity. However, it was evident from the interviews with the Tanzanian midwives that the workshops could be improved. This included the GHAWA educators teaching comprehensive health assessment and documentation to the midwife participants. The workshops did not consider the equipment and time needed to complete the tasks taught, which were difficult to achieve in the Tanzanian hospital setting, as expressed by the Tanzanian midwives. Education was also provided regarding incubators, yet these are not available in all maternity units in Dar es Salaam and are not serviced if they stop working.

One must consider that the educators providing the workshops to the participants came from working in the Western context with very different experiences of maternal and neonatal deaths. The program offered was based on the Western Australia setting, and there was limited consideration of changing the program to reflect the Tanzanian context because the educators had minimal exposure to the hospital settings. While the GHAWA initiative to provide CPD programs for Tanzanian midwives was well intended, there was little formal preparation for the educators. The Western midwifery educators were offered minimal written information and no formal training regarding the clinical context of the health system in which they would be working in Tanzania. As one of these educators, the researcher found that she was challenged in her attempts to deliver Australian-based education strategies, and frequently needed to modify CPD material as she gained awareness of the cultural context in Tanzania.

Information gathered from the Tanzanian midwives regarding CPD identified that the GHAWA workshop curriculum could be improved with the knowledge attained through the present study. This useful knowledge includes appreciation of the overwhelming influences of high mortality rates and the subsequent focus on saving

lives. As a result, CPD should primarily focus on being prepared for maternity emergencies, while gradually incorporating the wider scope of midwifery practice, which is already reflected by the Tanzanian midwives. In turn, the abilities of local midwives could be enhanced, which would positively affect not only maternal and neonatal outcomes, but also the global midwifery focus of women-centred care.

5.10 Women-centred Care

It is important to establish an understanding of the underlying philosophy with which Tanzanian midwives provide care to women in the local context. Besides being confronted with high mortality rates on a daily basis, as well as other constraints, such as low staffing and inadequate resources, it was evident that the Tanzanian midwives functioned within a medically-based model of midwifery care (Sandall et al., 2013). This was reflected by them referring frequently to the women and babies for which they cared as ‘patients’ who ‘needed help’. The concept of a ‘patient’ who ‘needs help’ corresponds with a medical philosophy of care, which focuses on the unwell patient (Hatem, Sandall, Devane, Soltani & Gates, 2008; Sandall et al., 2013). In comparison with a medical philosophy, the ICM (2005) Philosophy of Midwifery is founded on the belief that birth is a normal process, and that, for low-risk women, a midwife is ideal as the leading care provider, with medical involvement only as required. The ICM (2008) CoE highlights the need for midwives to collaborate effectively with other professions in order to deliver women-focused care. Collaborative care is viewed as important for all women, particularly those with medical and obstetric complications (ICM, 2005, 2008).

Having a good relationship with obstetric doctors was reported positively by most of the Tanzanian midwife participants. This positive working relationship is in contrast to the often-challenging relationships between midwives and doctors globally,

as a result of the opposing philosophies of care and the medically-led hospital environment (Siassakos et al., 2011; Taylor, 2005). The relationship between the midwife participants and doctors in Tanzania may be a positive reflection of their very frequent collaboration in a high-risk setting, and the need for their interaction to manage the high numbers of complex cases. With awareness of this dynamic, there are considerations for the development of CPD—primarily, the inclusion of the medical team in the CPD provided by the GHAWA.

Several programs internationally, including the ‘In Time’ maternity emergency management course run by the tertiary maternity hospital in Western Australia, deliver joint CPD to doctors and midwives about being prepared for maternity emergencies, in appreciation of the importance of teamwork to effectively manage urgent situations (Draycott, 2013; Women and Newborn Health Service, 2014). Alternatively, in settings where doctors are not readily available or midwives are required to manage very complex situations, another strategy is to expand the Tanzanian midwives’ knowledge and scope of practice in accordance with national regulations to enable them to manage difficult medical and obstetric issues (ICM, 2011b).

In light of the possibility of broadening Tanzanian midwives’ knowledge and scope of practice, Western educators must be mindful of issues that may arise due to potential lack of adherence to professional ethics. Such implications include whether midwives should be enabled to prescribe complex medications and perform vacuum extractions, which is not typically within a midwife’s scope of practice. Incorporation of the ICM (2008) CoE, such as Section III, is important in addressing such situations, including that midwives ‘ensure that the advancement of midwifery knowledge is based on activities that protect the rights of women’ (p. 3).

5.11 CoE

The Tanzanian midwives in this study expressed limited awareness of the ICM (2008) *Code of Ethics for Midwives*, which provides the ethical framework for midwives to practice globally. Despite their lack of awareness of this document and its implications, there was evidence that the participants' were practising in accordance with the ICM ethical principles, as indicated in the accounts of their practice. Section Ia of the Code states that 'midwives develop a partnership with women in which both share relevant information that leads to informed decision making' (ICM, 2008, p. 1), which is reflected by the Tanzanian midwives seeing themselves as 'educators' of the community. The Code also states that midwives 'respectfully work with other health professionals ... when the woman's need for care exceeds the competencies of the midwife' (ICM, 2008, p. 2). The midwife participants emphasised their focus on collaborating with other members of the healthcare team. The Tanzanian midwives also highlighted their need to build on their knowledge base to save lives, which is in accordance with Section Iif: 'midwives actively seek personal, intellectual and professional growth throughout their midwifery career' (ICM, 2008, p. 2).

It is expected that international ethical codes should be adaptable to any setting and situation. In appraising the ICM (2008) CoE, it is evident that the CoE is appreciative of cultural differences in midwifery because it focuses on a set of values aimed to be adaptable to any context: 'to improve the standard of care provided to women, babies and families throughout the world' (p. 1). The key components of the CoE include treating women with respect, collaborating with colleagues, providing women with correct information and choices, and ensuring safe and competent care (ICM, 2008). These components are adaptable to any setting, irrespective of the resources and care options available. In settings where the CoE is not well understood,

it is essential that midwifery educators provide recommendations for practice in accordance with the CoE to promote the safe and respectful treatment of women. Indeed, this was included in the CPD program developed by the GHAWA midwifery educators. However, the education could be expanded to meet the self-identified needs of midwives in a manner that reflects the CoE (ICM, 2008). For example, midwives can be enabled to be 'responsible for their decisions and actions' (ICM, 2008, p. 2) via CPD education on clinical handover, patient assessment and prioritising care.

5.12 Status of Midwifery

The status of midwifery in Tanzania was expressed by participants as being low in their community due to the public perceiving that midwives had a lack of knowledge in their specialty, low salaries, poor working conditions, and a poor attitude towards women in their care. These conditions and public perceptions influenced the midwives' feelings of professional worth and appreciation.

Although the participants stated that they were actively approached by the community to assist with pregnancy and medical problems, they still believed that they were considered as having a lack of knowledge. It is not uncommon for midwives to struggle in gaining professional recognition due to lack of knowledge (Brodie, 2013; Larsson, Aldegarmann & Aarts, 2009; Pollard, 2008; Reiger & Lane, 2013). In Sub-Saharan Africa, qualitative studies involving midwives, midwifery students and childbearing women have concluded that midwifery knowledge is often inadequate, and results in the community's low opinion of the profession (Gross et al., 2011b; Kidanto et al., 2012; Lavender et al., 2011; Mbwele et al., 2012; Nyamtema et al., 2012; Pettersson et al., 2006). Supporting these views were Kenyan midwifery students interviewed about their experiences on the labour ward (Lavender et al., 2011). These

students reported that midwives were negative role models because they did not know how to accurately document patient observations (Lavender et al., 2011).

The effect of a lack of knowledge on those around the midwives was evident in a qualitative study by Pettersson et al. (2006) in Mozambique. Through interviews with 16 midwives, the participants identified that the women for whom they cared doubted their professional abilities. This resulted in poor relationships between the midwives and the women (Pettersson et al., 2006). Pettersson et al. (2006) supported the concept that ensuring a midwife's skills can improve their respect in the community, stating that 'the first step toward enhancing the midwives' profile is to improve midwifery education, as this will provide ... much needed recognition' (p. 162).

This need for improved education to enhance professional status was expanded by Professor of Midwifery Pat Brodie (2013) from the University of Technology, Sydney, in her commentary article on the appreciation of midwives in developing countries. Brodie (2013) acknowledged that midwives in developing settings often work in challenging and unsafe environments, and emphasised that this can be 'disempowering and demoralising' for them (p. 1075). Therefore, to encourage an improved midwifery image, and subsequently morale, she stated that 'skilled, empowered midwives earn respect from women and communities by providing competent care' (Brodie, 2013, p. 1076). Given the international acknowledgement that skilled midwives are essential to reducing maternal and neonatal mortality, it is important to identify strategies for Tanzanian midwives to feel confident and valued in order to optimise their professional satisfaction and subsequently attract more people to the midwifery profession (Brodie, 2013; UNFPA et al., 2014).

Alongside the barrier of lack of knowledge in improving midwifery status, low salaries and poor working conditions were other factors that the midwife participants

perceived to influence the low status of midwives in the community. These factors are not isolated, as both are common in Sub-Saharan African hospitals (Brodie, 2013; Pettersson, 2007). Owing to their situation, the participants felt that the government did not acknowledge their working conditions because there was no effort to increase their low pay or address understaffing. This view has also been stated by other midwives and healthcare workers in Sub-Saharan Africa. In Mozambique, midwives were frustrated that the government did not appreciate the high patient numbers and inadequate resources they were forced to deal with (Pettersson et al., 2006). Healthcare workers from rural Tanzania voiced the same concerns, and added that the lack of government appreciation led to poor morale among healthcare workers (Prytherch et al., 2012).

The midwives in the current study believed that the community's image of midwifery in Tanzania was further degraded by the belief that the midwives had poor attitudes due to being 'uncaring' and 'speaking badly' to women. This belief was due to the undesirable actions of only some midwives, which then resulted in the community assuming that all midwives behave in the same manner. Negative attitudes and the subsequent indifferent behaviours of midwives have been extensively acknowledged in studies exploring the experiences of childbearing women in Sub-Saharan Africa, including accounts of women being threatened and slapped by midwives during labour, and midwives telling family members to care for the labouring woman themselves (Eustace & Lugina, 2007; Maputle & Nolte, 2008; Mselle et al., 2011; Mselle et al., 2013; Shimpuku et al., 2013).

The Tanzanian midwives in the current study, although disagreeing with such practices, attributed the 'bad attitude' of midwives to an unachievable workload with insufficient staffing—a commonly identified issue in the region (Kwesigabo et al., 2012; Maputle & Hiss, 2010; Modiba, 2008; Prytherch et al., 2012). Undoubtedly, it

would be extremely frustrating and exhausting to work with such significant organisational constraints, although this does not justify cruelty towards others. For these reasons, CPD should focus on the need to maintain professional pride, decency and respect, thereby ensuring the principles of the ICM (2008) CoE.

Respect between midwives and those for whom they care is a two-way concept. This need for mutual respect was expounded by Brodie (2013), who stated that 'midwives need to experience respect, support and kindness themselves if they are to be an external source of compassion' (p. 1076). Nonetheless, it is the responsibility of midwives to initiate a better relationship with women, as a power imbalance can occur in the hospital setting in favour of the healthcare provider. Evidence of this can be found in Bangser et al.'s (2011) study, which undertook individual interviews with 137 women from Tanzania and Uganda who had experienced complications from poorly managed obstructed labour. The women revealed accounts of midwives bribing them in order to deliver care, which was only possible because the midwives had skills that the women needed (Bangser et al., 2011).

It is essential that all midwives (not only Tanzanian midwives) treat women in their care with respect, which can then lead to greater cooperation by the women, in order to facilitate a smooth caregiving period. Higher community status would result, thereby improving the experience of midwives in both their workplace and personal lives. While organisations such as the GHAWA are not in a position to address such challenges as low salaries and poor working conditions, they can assist midwives by improving their knowledge and scope of practice. Doing so will result in better quality care and a subsequent improved rapport with the community as maternal and neonatal outcomes improve, and respect for midwives develops.

5.13 Limitations and Strengths

The small sample size was the primary limitation in revealing the self-perceived identity of Tanzanian midwives. However, the study was within the bounds of criteria for sound data collection. It was not possible to recruit more midwives to increase the sample size due to the researcher's limited period of time in Tanzania. The study included rich description in presenting a profile of the participants, and the resulting themes and subthemes in the study context have enabled the reader to determine the transferability of the findings. Transferability is a concept recognised in qualitative research as being analogous to generalisability for quantitative studies. It guides researchers in the presentation of their findings (Beck & Polit, 2010). Although this study focused only on Tanzania, it is hoped that the thorough descriptions provided in this paper will enable readers to determine whether the findings are transferable to other developing country settings. While analyses of the interviews was descriptive, and cannot provide an exact account of the midwives' views, it was useful to gain insight into issues and experiences the midwives encountered and the perceptions of their role, which helped highlight the issues and experiences of Tanzanian midwives during clinical practice. This knowledge can enable educators to adapt their content to better suit the midwives' needs and priorities.

Further factors that must be considered as limitations include the midwifery researcher not being local and thus being reliant on the presence of an interpreter, which may have disrupted the flow of data collection. The strict interview structure also required the midwives to quickly recall information from vast aspects of their experiences.

While acknowledging that midwives do not work in isolation, the study's objective was to gain an optimal understanding of the midwives' experiences. In-depth

focus groups enabled meaningful insights to be gained from the midwives, with the participants providing detailed and previously unknown understandings of their self-perceived role. Further strengthening the study was the involvement of midwives from three separate hospitals, and, within those hospitals, different religious and social backgrounds, thereby providing a broad range of views on the phenomena. A striking and confirming element in the data collection and analysis was the degree of data saturation. All three focus groups identified the same phenomena, thereby optimising the researcher's confidence that the themes and subthemes were correctly identified and that maximum understanding was attained.

5.14 Recommendations

The following recommendations are made based on the major findings of this study. These findings revealed that Tanzanian midwives' overwhelming focus is on saving the lives of women and newborns. The ability to prioritise care and undertake patient assessment were considered fundamental to the midwives' ability to save lives. However, significant workplace challenges restrict the midwives' ability to save lives. As a result of the working environment, knowledge base and attitude of midwives, the midwifery profession has low status in the Tanzanian community.

These recommendations are made to assist Western midwifery educators to address these concerns when providing CPD to Tanzanian midwives, thereby ensuring that cultural competence is achieved. It must be acknowledged that the implementation of these recommendations is conditional on the availability of educators and necessary resources, and on staff being released to undertake CPD activities. These recommendations are also provided to increase research findings on the cultural competence of Western midwifery educators in Tanzania and the perceptions of Tanzanian midwives from those they encounter in their practice.

5.14.1 Recommendation 1: Ensure that the major focus of CPD for Tanzanian midwives is on saving lives.

Relevant CPD is required in order to improve the capability of Tanzanian midwives to reduce maternal and neonatal mortality rates, as well as to reflect the values of the midwives. This will ensure that the education provided is culturally competent. This may be achieved by:

- emphasising the focus of saving lives at the beginning of CPD
- incorporating being prepared for maternity emergencies into CPD, particularly at the beginning of the program, in order to engage the midwives
- ensuring that strategies for saving lives are achievable in the local context—that is, that they are reflective of the resources available
- referring to the International CoE (ICM, 2008) to ensure that all education delivered reflects the global principles of midwifery practice.

5.14.2 Recommendation 2: In CPD for Tanzanian midwives, include information on preventing and managing maternity emergencies.

Rather than waiting for maternity emergencies to occur, the capability of midwives in preventing complications and detecting deteriorating patients early should be a priority of CPD. This also reflects the priorities of the Tanzanian midwives, which further ensures cultural competence. This may be achieved by:

- including information in the CPD curriculum on how to improve clinical handover, patient assessment and recognition of clinical deterioration in a low-resource setting
- emphasising the importance of and how to deliver education for pregnant and postnatal women regarding maintaining the health of both themselves and their newborn, as well as signs of problems and when to access care.

5.14.3 Recommendation 3: Involve medical practitioners in CPD workshops for Tanzanian midwives.

Including doctors as participants in CPD workshops is important in the Tanzanian context. Greater collaboration between the medical and midwifery professions can improve inter-professional respect and subsequent care of high-risk women. Expanding midwives' scope of practice should also be considered in settings where doctors are not readily available. This recommendation may be achieved by:

- undertaking emergency drills that emphasise collaboration and teamwork between the professions
- engaging in multidisciplinary problem-solving case study discussions focusing on the best management of complex maternity situations in the Tanzanian context
- promoting doctors to participate in teaching midwives to undertake skills development and mastery appropriate to the Tanzanian context.

5.14.4 Recommendation 4: Cultural preparedness for Western midwifery educators.

To optimise the potential for cultural preparedness amongst Western midwifery educators who will be working in developing countries such as Tanzania, cultural competence education should be provided prior to departure. This will enable the educators to have a greater understanding of the social determinants of health in the respective countries, and hence have the ability to provide programs that meet the community health needs. Methods of providing this education may include:

- seminars
- workshops
- on-line learning activities

- mentoring from educators who have worked in Tanzania or respective country
- Indigenous guest speakers from the relevant country.

5.14.5 Recommendation 5: Further research.

The current study revealed existing gaps in knowledge that could be addressed through further research. These areas for future research could include:

- an exploratory study using methodology such as interviews or focus groups to understand the experiences of the Western Australian GHAWA midwifery educators' who provide CPD workshops to Tanzanian midwives, and their experience of achieving cultural competence. This study could provide an understanding of the value of cultural preparedness for midwifery educators.
- a mixed-method approach involving Tanzanian midwives who have completed the GHAWA workshops in order to ascertain whether the programs have met their needs, the effect of the programs on their practices, and retention of the knowledge gained through the workshops.
- exploration of Tanzanian women's and doctors' impressions of the midwifery role via interviews or focus groups. This would ascertain whether the midwives' perceptions from the study are reflective of the views of those with whom they interact.
- an explorative study via focus groups or interviews to gain better understanding of the general public's impression of midwives' role in Tanzania. A better understanding of the community's perception of midwives could guide strategies that are aimed at improving the midwives' public profile.

The implementation of these recommendations should be considered in the context of Dar es Salaam, Tanzania. Based on these results and a comparison with the

previous literature, improvements can be made in meeting the educational needs of Tanzanian midwives in order to contribute to the achievement of the UN (2013) MDGs 4 and 5.

5.15 Conclusion

This study endeavoured to gain an understanding of midwifery in Tanzania based on Tanzanian midwives' perceptions of their professional role. By addressing the study objectives, the findings aimed to provide insight and inform recommendations to improve CPD education, thereby meeting the educational needs of Tanzanian midwives in a culturally appropriate manner.

Based on the study findings, it became apparent that Tanzanian midwives' overwhelming focus is on saving the lives of women and newborns. This is in accordance with the ICM CoE, but is most heavily aligned with the UN MDG 4: Reduce child mortality and MDG 5: Improve maternal health. Such insight was previously unknown and is invaluable to the shaping of CPD.

As a result of these findings, recommendations were suggested to improve CPD offerings to ensure an essential focus on saving lives through both preparedness for maternity emergencies and the recognition of deteriorating patients. The midwives' accounts likewise emphasised the importance of ensuring that CPD is relevant to the low-resource context in which it is being implemented.

An appreciation of the challenges faced by Tanzanian midwives in gaining recognition in the community is also significant. Relevant CPD can be developed that is aimed at improving the interactions between midwives and women, as well as emphasising the value of CPD in professional status. However, in order to do this, educators providing such CPD must be culturally prepared to do so. Further research regarding perceptions of the midwifery role from the viewpoints of the women for

whom they care and the general community could also enhance strategies aimed at improving the Tanzanian midwives' public profile.

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Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

Appendix A: GHAWA Maternal and Child Health Program

Two-week Course

Week 1	
Day 1	
8:30–9:30	Program introduction <ul style="list-style-type: none"> • Discuss the program objectives and requirements, the importance of critical thinking skills, the teaching/learning modalities involved, and the participants' involvement and responsibility. • Pre-program evaluation
10:00–11:00	Understanding what is normal
11:00–11:20	Morning tea
11:20–13:00	Abdominal palpation
13:15	Take-home quiz, questions and close
Day 2	
8:30–10:00	Birth management and monitoring of women
10:00–10:20	Morning tea
10:20–12:00	The importance of observation and documentation (including Apgar scoring and partogram)
12:00–13:00	Lunch
13:00–15:30	Clinical placement on ward with program educators
15:30	Take-home quiz, questions and close
Day 3	
8:30–9:00	Review clinical placement of Day 2
9:00–10:30	Neonatal resuscitation (theory)
10:30–10:50	Morning tea
10:50–12:00	Neonatal resuscitation (Clinical workshop)
12:00–13:00	Lunch
13:00–15:30	Clinical placement on ward with program educators (identify case study)
15:30	Take-home quiz, questions and close
Day 4	
8:30–9:30	Review clinical placement of Day 3 (discussion and questions regarding case study)
9:30–11:00	Pre-eclampsia
11:00–11:20	Morning tea
11:20–12:30	Postpartum haemorrhage management
12:30–13:30	Lunch
13:30–15:15	Case studies
15:15	Take-home quiz, questions and close
Day 5	
8:30–10:30	Maternal collapse and basic/advanced life support (theory)
10:30–10:50	Morning tea
10:50–12:00	Maternal collapse and basic/advanced life support (clinical workshop)
12:00–13:00	Lunch
13:00–15:30	Clinical placement on ward with program educators
15:30	Take-home quiz, questions and close

Week 2	
Day 6	
AM shift	Clinical placement on ward with program educator
PM (after-lunch session)	Classroom revision: <ul style="list-style-type: none"> • Drill (Group 1 and 2 together) • Drill (Group 2 observe and Group 1 perform, switch) • Teamwork: Situational awareness
Day 7	
AM shift	Clinical placement on ward with program educator
PM (after-lunch session)	Classroom revision/assessment and work on case study presentation: <ul style="list-style-type: none"> • Maternal collapse and basic adult life support (competency assessment)
Day 8	
AM shift	Clinical placement on ward with program educator
PM (after-lunch session)	Classroom revision (and assessment continue): <ul style="list-style-type: none"> • Teamwork and communication • Importance of observation, assessment and documentation • Resit if necessary—maternal collapse and B/ALS (competency assessment)
Day 9	
AM shift	Clinical placement on ward with program educator
PM (after-lunch session)	Classroom revision/assessment and work on case study presentation: <ul style="list-style-type: none"> • Neonatal B/ALS (competency assessment)
Day 10	
AM shift	Clinical placement on ward with program educator
Later in the morning	Work on case study presentation and classroom assessment (continue): <ul style="list-style-type: none"> • Resit if necessary—neonatal B/ALS (competency assessment)
PM (after-lunch session)	Individual case study presentation: Each participant will give a 15-minute presentation on a chosen topic identified on Week 1: <ul style="list-style-type: none"> • overview of a topic of interest • case study • learning objectives • goals for implementing.
	Post-program evaluation.

Appendix B: UN MDGs

1. To eradicate extreme poverty and hunger
2. To achieve universal primary education
3. To promote gender equality and empower women
4. To reduce child mortality
5. To improve maternal health
6. To combat HIV/AIDS, malaria and other diseases
7. To ensure environmental sustainability
8. To develop a global partnership for development (UN, 2013).

Appendix C: Confidential Enquiry into Maternal and Child

Health Recommendations

1. Pre-pregnancy counselling for women with pre-existing illness, but ideally for all women
2. Professional interpretation services when required
3. Immediate access to multidisciplinary specialist teams for care
4. Clear communication—urgency of referrals to other medical departments made clear
5. Training for professionals involved in maternity care
6. Critical care—recognise the acutely sick patient, involve seniors and critical care services
7. Systolic hypertension above 150 mmHg requires urgent treatment in pregnancy
8. Sepsis—prevention, early recognition and prompt management of infection and sepsis, particularly genital tract infection
9. Robust mechanisms for critical incident reporting and reporting death
10. Improvement in specialist maternal autopsy services (CMACE, 2011).

Appendix D: Tanzanian Institutions in Partnership with GHAWA

1. The Advanced Practice Midwifery School Muhimbili Campus
2. Hubert Kairuki Memorial University
3. Amana District Hospital
4. Mission Mikocheni Hospital
5. Muhimbili National Hospital
6. Temeke District Hospital
7. Mwananyamala Hospital
8. Masaki Community Health Centres (Jones, 2011).

Appendix E: Study Information Sheet—English



INFORMATION SHEET

TITLE OF PROJECT:

TANZANIAN MIDWIVES' PERCEPTIONS OF THEIR PROFESSIONAL ROLE

Dear midwife,

You are invited to participate in this study.

Purpose of study

The purpose of this study was to explore and describe Tanzanian midwives' perceptions of their professional role in the context of their clinical experience. With greater understanding of what midwifery means to Tanzanian midwives, educators from both Tanzania and the GHAWA project will be able to model education to suit the needs of local midwives.

The GHAWA involves a collaborative partnership between the Department of Health of Western Australia, five Western Australian universities, the two Tanzanian training institutions of Hubert Kairuki Memorial University, and the Advanced Practice Midwifery School Muhimbili Campus, along with several hospitals and health clinics around Dar es Salaam.

Research questions

This research will explore the following:

1. examine the self-identified elements of the role of Tanzanian midwives working in their local context, in alignment with the *International Code of Ethics for Midwives* (ICM, 2008)
2. describe the perceived cultural factors that contribute to how Tanzanian midwives establish their professional role
3. provide recommendations for CPD education midwifery programs in Tanzania, as well as those teaching with the GHAWA.

The above questions will be addressed using focus group interviews, which is where five to eight midwives are interviewed in a group, with each midwife participating. You will be asked what being a midwife means to you, what you think midwifery means to the community and your colleagues, how things could be improved for Tanzanian midwives and how you think midwives from Western countries understand what it means to be a midwife in Tanzania.

Approval

Approval was granted by the Human Research and Ethics Committee at Curtin University, and the Ethics Committees of the participating hospitals and universities in Dar es Salaam. If you need verification of approval of the project, or have any concerns about the project, this can be obtained by writing to any one of these Ethics Committees.

Procedures

If you agree to participate in this study, you will be required to sign a consent form. Following this, you will be asked to meet in a small group of about five to eight

midwives also participating in the workshop at a time arranged as a group. The focus group interview will then take place. It is expected to take about 50 minutes.

During the interview, the researcher will ask a question and each midwife will be asked to respond to the question. You can tell the researcher if you do not understand a question, and the researcher may repeat your response to you to confirm that they have understood your point of view correctly.

A voice recorder will be used throughout the focus group interview to record your responses to the questions. Your words will then be transcribed into a written report. On this written report, you will be coded so your identity is protected. No names or other identifying information about you will be entered into the computer program. At no point will your name, personal details or where you work be mentioned to anyone except the researcher. Your opinions will also be used in a research report, **but you or your workplace will *not* be identified in any way.**

You are also expected to not reveal the identity or opinions of others in the focus group.

Risks, discomforts and benefits

If you feel uncomfortable answering any of the questions, you are welcome to express your concerns. You are, of course, free to decline to answer any questions during the focus group interview. While the universities have given permission for the project to be conducted, your participation is entirely voluntary. There are no risks involved with your participation, nor will refusing to be involved in the project disadvantage you. You are free to withdraw from this study at any time.

There are no direct personal benefits to being involved in this research. It is anticipated that your wider midwifery community will benefit from this research in upcoming years through improved education methods.

Confidentiality

All the information that you provide, along with your personal details, will be treated in strict confidence. Access to the stored data will be restricted by a password known only by the investigator and stored safely in a locked cupboard at an area allocated by the GHAWA Research Subcommittee.

The results of the project will be reported, although it will not be possible to identify individual subjects because names will not be included in the reported material. On completion of the project, all data will be stored in a secure and confidential location with the project investigators for five years. After this time, all data will be destroyed.

Request for further information

You are welcome to discuss any concerns or questions regarding this project with the researcher at any time. You should feel confident and secure about your involvement in the study. If you have any questions or concerns regarding the project, please contact A/Professor Rene Michael, Chairperson of the GHAWA Research Subcommittee, on (61) 08 9266 2058 or r.michael@curtin.edu.au. You may also contact the ethical committee at your university or hospital.

Thank you for considering participating in this project.

Brooke Jones

GHAWA Researcher

Email: b.jones@live.com.au

Mobile: (+61) 422 554 594

Appendix F: Study Information Sheet—Swahili



FOMU YA RIDHAA

JINA LA UTAFITI:

MTAZAMO WA WAKUNGA TANZANIA KATIKA JUKUMU LAO LA KITAALAMU

Ndugu zangu,

Nawakaribisha kushiriki katika utafiti huu.

Lengo la Utafiti

Lengo la utafiti huu ni kuanzisha uelewa katika fani ya Ukunga Tanzania, ikiwa ni pamoja na mambo ya kitamaduni ambayo wewe kama mkunga Tanzania unajisikia kuchangia kwenye hii fani yako.

Kuna taarifa finyo ipatikanayo kuhusu kuwa mkunga katika Tanzania. Kwa kuwauliza wakunga kama vile wewe mwenyewe juu ya kazi yako, waelimishaji kutoka Tanzania na mradi GHAWA wataweza kutoa elimu bora ambayo itakidhi mahitaji ya wakunga wa Tanzania.

Mradi wa GHAWA unahusisha ushirikiano kati ya Idara ya Afya ya Australia Magharibi, na Vyuo Vikuu vitano vya Australia Magharibi, taasisi mbili za mafunzo Tanzania ambazo ni Hubert Kairuki Memorial University, na Chio cha Ukunga Muhimbili, pamoja na hospitali kadhaa na kliniki za afya karibu Dar es Salaam.

Maswali ya Utafiti:**Utafiti huu utachunguza yafuatayo:**

1. Kuchunguza au kutambua mambo ya msingi yahasuyo fani ya ukunga kwa mkunga wakitanzania.
2. Kulezea tamaduni ambazo zinachangia jinsi wakunga wakitanzania wanavyojitambulisha katika fani yao ya ukunga.
3. Kutoa mapendekezo yanayoweza kuboresha mitaala kwenye taasisi ya elimu Tanzania pia kwa waelimishaji wanaohusika na Global Health Alliance WA.

Maswali yote hapo juu yatashughulikiwa kwa kutumia mahojiano vikundi, ambapo wakunga 5 hadi 8 watahojiwa kwenye vikundi, na kila mkunga anapaswa kushiriki ipasavyo. Utaulizwa ni nini kazi yako kama mkunga, nini maana ya ukunga kwako, na ni kwa jinsi gani ukunga unaweza kuboreshwa Tanzania.

Idhini

Utafiti huu umeidhinishwa na chuo kikuu cha Curtin cha Mafunzo ya chini ya hatari (Idhini number SON & M 25-2012). Utaratibu huu na kukubaliana na Taarifa ya Taifa ya Maadili ya kimaadili katika Utafiti Binadamu (Sura ya 5.1.7 na Sura 5.1.18-5.1.21). Kwa habari zaidi juu ya utafiti huu wasiliana na watafiti waliotajwa hapo chini au chuo kikuu cha Curtin kamati ya Binadamu Utafiti Kamati ya Maadili. c / - Ofisi ya Utafiti na Maendeleo, Chuo Kikuu cha Curtin, GPO Box U1987, Perth 6845 au kwa simu + 61 8 9266 9223 au kwa barua pepe hrec@curtin.edu.au.

Taratibu

Kama upo tayari kushiriki katika utafiti huu utahitajika kusaini fomu ya ridhaa. Hivyo basi utapangwa kwenye vikundi vyenye wakunga 5-8, pia utatakiwa kushiriki katika semina kama kikundi kwa ule muda utakaopangwa ambapo mahojiano yatafanyika. Inatarajiwa kuchukua muda wa dakika 50.

Wakati wa mahojiano mtafiti atauliza maswali na kila mkunga atatakiwa kutoa majibu kwa kila swali. Unaweza kumwambia mtafiti kama huelewi swali, na mtafiti anaweza kurudia majibu yako kuthibitisha kwamba mtazamo wao upo usahihi.

Kinasa sauti kitatumika katika mahojiano kwenye kila kundi wakati wakujiibu maswali. Maneno hayo yatatafsiriwa kwenye ripoti itakayoandikwa katika mfumo maalumu ili kufanya utambulisho wa kila mshiriki uwe salama. Majina au taarifa zinazoweza kubaini mtu hazitaingizwa katika programu ya kompyuta au kutajwa na mtafiti. Maoni yako yatatumika katika ripoti ya utafiti **lakini wewe au ofisi yako ya kazi havitatajwa.**

Unatarajiwa kutotoa taarifa yeyote ama maoni yako kwenye kikundi kingine.

Hatari, usumbufu na Faida

Kama wewe hujisikii ama unawasiwasi kujibu maswali yoyote, unakaribishwa kueleza matatizo yako. Unaweza kukataa kujibu maswali wakati wa mahojiano kwenye vikundi.

Vyuo vikuu vya Australia vimetoa ruhusa kufanya mradi huu, ushiriki wako ni wahiari kabisa. Hakuna hatari kushiriki katika mradi huu hivyo basi hakuna hasara katika kushiriki na pia unaweza kujitoa katika mradi huu wakati wowote.

Hakuna faida binafsi ya wewe kujihusisha katika utafiti huu. Inatarajiwa kwamba jumuiya ya wakunga Tanzania itanufaika kutokana na utafiti huu katika miaka ijayo kupitia njia bora za elimu. Utapewa chakula na kinywaji pamoja na zawadi ya fedha ya shilingi za Kitanzania 15,000 kukushukuru kwa muda wako.

Usiri

Taarifa zote zitakazojadiliwa zitashughulikiwa kwa siri kali. Majadiliano yote yatarekodiwa na na maelezo yatachukuliwa. Nakala ya kurekodi itachukuliwa na kuingizwa katika mfumo wa kompyuta ili kutambua masuala muhimu yaliyojadiliwa kwenye kila kundi. Itakuwa si rahisi kwa wewe kutambulika katika nakala hii au katika uchambuzi huu baadaye kuhusu kile ambacho ulisema katika kikundi. Nakala au uchambuzi wowote utakaofanyika utapatikana kwa watafiti tu ambao watakuwa na neno la siri, na kuhifadhiwa kwa usalama katika kabati lililopo katika eneo lililotengwa na timu ya utafiti.

Matokeo ya mradi huu yataripotiwa, ingawa hakutakuwa na uwezekano wa kubainisha somo la mtu binafsi kwani hakutakuwa na vitambulisho au majina yatakayojumuishwa katika repoti hii. Katika kumalizia mradi huu, takwimu zote zitahifadhiwa katika eneo salama na la siri na watafiti wa mradi huu kwa miaka mitano. Baada ya muda huu, data zote ziharibiwa.

Ombi kwa ajili ya Habari Zaidi

Mnakaribishwa kujadili matatizo yoyote au maswali kuhusu utafiti huu na mtafiti wakati wowote. Unapaswa kujisikia ujasiri na salama kuhusu ushiriki wako katika

utafiti. Kama una maswali yoyote au wasiwasi kuhusu utafiti huu, tafadhali wasiliana / Profesa Rene Michael, Mwenyekiti wa Kamati Ndogo ya Utafiti GHAWA, +61 8 9266 2058 au r.michael @ curtin.edu.au. Unaweza pia kuwasiliana na msimamizi Dk Rose Laisser, Mkuu wa chuo cha Ukunga katika Hospitali ya Taifa Muhimbili, kupitia +255 786 699 714 au barua pepe rlaisser@hotmail.com.

Asante kwa kushiriki katika mradi huu.

Brooke Jones

Chuo Kikuu cha Curtin;Mwanafunzi Stashahada ya Falsafa

Barua pepel: b.jones @ live.com.au

Simu: 255 787 966 092

Appendix G: Study Consent Form—English



You are freely making the decision whether or not to participate in this project. Your signature verifies that you have decided to participate in the project, having read and understood all the information provided. Your signature also officially states that you have been given adequate opportunity to discuss this project with the investigators and have had all your questions answered to your satisfaction. You will be given a copy of this consent document to keep.

I, _____

Please PRINT

of _____

_____ (Address) Phone _____

Freely give my consent to participate in this project: I am over 18 years of age.

I understand and accept the nature of the study, which has been explained to my satisfaction by researcher Brooke Jones. I give permission for any results from this project to be used in research publications and conferences, on the understanding that confidentiality will be maintained. If I have further questions, I may contact Brooke Jones at b.jones@live.com.au or on (+61) 422 554 594.

I have been given and read a copy of the information sheet and consent form.

I understand that I may withdraw from the study at any time without effect on my professional status.

I understand that all the information given will be treated in strict confidence with numerical coding, be password protected, and be kept in a secure cabinet by the researcher for five years. After this time, all data will be destroyed.

Participant's Signature _____ *Date* _____

Investigator's Name _____ *(Please Print)*

Investigator's Signature _____ *Date* _____

Appendix H: Study Consent Form—Swahili



GlobalHealthAlliance
Western Australia



Unafanya uamuzi aidha kushiriki au kutoshiriki katika utafiti huu. Sahihi yako inathibitisha umesoma na kuelewa maelezo yote yaliyotolewa kwako na kukubali kushiriki katika utafiti huu. Kutia saini fomu hii kunathibitisha kwamba umepata fulsa ya kutosha ya kujadiliana na matafiti huyu kuhusu utafiti huu na maswali yako yote yamejibiwa kwa ufasaha na umeridhika nayo. Utapewa nakala yako ya fomu hii.

Mimi, _____ (*Tafadhali
chapa*)

wa _____ (*Anwani*)

Sanduku la Posta _____

Simu /Barua pepe _____

Natoa idhini yangu kushiriki katika utafiti huu: Mimi nina zaidi ya miaka 18.

Naelewa na kukubali asili ya utafiti huu, ulioelezwa na Brooke Jones on +61 422 554 594.

Na toa idhini yangu kwa ajili ya matokeo yoyote yatakayotolewa na mradi huu kutumika katika machapisho ya utafiti na mikutano, nikielewa kuwa usiri utazingatiwa. Kama nina maswali zaidi naweza kuwasiliana na Brooke Jones kwa njia ya simu +61 422 554 594 au barua pepe: b.jones @ live.com.au, au msimamizi wa utafiti huu Profesa Michael Rene kwa njia ya simu + 61 419 193 609

Nimepewa na kusoma nakala ya taarifa hii pamoja na fomu ya idhini. Naelewa kwamba naweza kujitua katika utafiti huu wakati wowote bila madhara yeyote kwangu. Naelewa

kwamba taarifa zote zilizotolewa zitatumika kwa uangalifu, ipasavyo na kuhifadhiwa kwa usalama hata ikibidi mtafiti kutumia namba au neno la siri katika kuzihifadhi.

Naelewa kwamba utafiti huu utakapokuwa unamalizikia, takwimu zote zitahifadhiwa katika eneo salama na la siri na watafiti wa mradi huu kwa miaka mitano. Baada ya muda huu, data zote zitaharibiwa.

Sahihi ya mshiriki _____ Tarehe _____

Jina Mtafiti _____ (Tafadhali chapa)

Sahihi Mtafiti _____ Tarehe _____

Appendix I: Demographic Questions—English

Tanzanian Midwives' Perceptions of Their Professional Role

Please complete the following questions:

What is your age?

Are you married?

Do you have any children?

If yes, how many?

What is your religion?

What is your tribe?

What is your qualification?

Where did you train in nursing/midwifery?

For how long have you been qualified?

What is the name of the hospital at which you work?

How long have you worked there?

Appendix J: Demographic Questions—Swahili

Mtazamo wa Wakunga Tanzania katika wajibu wao kitaalamu.

Tafadhali kamilisha maswali yafuatayo:

Je, una umri gani.....?

Umeoa/Umeolewa.....?

Je una mtoto.....?

Kama ndiyo, ni wangapi.....?

Je, nini dini yako.....?

Je, nini kabila lako.....?

Je, umefuzu elimu gani.....?

Wapi ulipata mafunzo ya uuguzi/ukunga.....?

Je ni muda gani tangu ulipohitimu/ulipofuzu.....?

Jina la hospitali unayofanya kazi kwa sasa.....?

Umefanya kazi kwa muda gani katika hospitali hii?

.....?

Appendix K: Focus Group Questions—English

Can you tell me what you do on your normal day at work?

Of all the things you do at work, what is the most important?

What do you enjoy the most about being a midwife?

Why did you become a midwife?

What do other people think about midwives?

Which other professionals do you work with and what is it like to work with them?

What do you find difficult about your job?

How could things be changed for midwives in Tanzania?

Have you ever been told about the *International Code of Ethics for Midwives*?

Appendix L: Focus Group Questions—Swahili

MASWALI YA KIKUNDI

Je, unaweza kuniambia unafanya nini katika siku yako ya kawaida kazini?

Kati mambo yote unayofanya kazini, ni kipi cha muhimu zaidi?

Nini unachofurahia zaidi ukiwa kama mkunga?

Kwanini uliamua kuwa mkunga?

Je, watu wengine wanafikiri nini kuhusu wakunga?

Ni wataalamu wapi wengine unaofanya nao kazi pamoja, na unajisikia aje kufanyanao kazi kwa pamoja?

Ni kitu gani kinakupa ugumu katika kazi yako?

Nini kifanyike/kibadilishwe kwa wakunga nchini Tanzania?

Umewahi kuambiwa/kusikia kuhusu Kanuni ya Kimataifa ya Maadili kwa Wakunga?

Appendix M: Research Ethics Approval—Curtin University



Memorandum

To	Ms Brooke Jones/ Professor Rene Michael / Ms Janice Butt
From	Professor Dianne Wynaden
Subject	Protocol Approval SON&M25-2012
Date	22 August 2012
Copy	

Office of Research and Development
 Human Research Ethics Committee
 Telephone 9266 2784
 Facsimile 9266 3793
 Email hrec@curtin.edu.au

Thank you for your "Form C Application for Approval of Research with Low Risk (Ethical Requirements)" for the project titled "*Tanzanian midwives' perception of their professional role*". On behalf of the Human Research Ethics Committee, I am authorised to inform you that the project is approved.

Approval of this project is for a period of twelve months 22nd August 2012 to 22nd August 2013.

The approval number for your project is SON&M 25-2012. Please quote this number in any future correspondence. If at any time during the twelve months changes/amendments occur, or if a serious or unexpected adverse event occurs, please advise me immediately.

Professor Dianne Wynaden
 Minimal Risk Coordinator/ Ethics Advisor
 School of Nursing and Midwifery

Please Note: The following standard statement must be included in the information sheet to participants:
This study has been approved under Curtin University's process for lower-risk Studies (Approval Number SON&M 25-2012). This process complies with the National Statement on Ethical Conduct in Human Research (Chapter 5.1.7 and Chapters 5.1.18-5.1.21).
 For further information on this study contact the researchers named above or the Curtin University Human Research Ethics Committee c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth 6845 or by telephoning 9266 9223 or by emailing hrec@curtin.edu.au.

Appendix N: Research Ethics Approval—Tanzania

TANZANIA COMMISSION FOR SCIENCE AND TECHNOLOGY (COSTECH)	
<p>Telephones: (255 - 022) 2775155 - 6, 2700745/6 Director General: (255 - 022) 2700750&2775315 Fax: (255 - 022) 2775313 Email: rclearance@costech.or.tz</p>	<p>Ali Hassan Mwinyi Road P.O. Box 4302 Dar es Salaam Tanzania</p>
RESEARCH PERMIT	
No. 2012-440-NA-2012-199	18 th October 2012
1. Name :	Brooke Eve Jones
2. Nationality :	Australian
3. Title :	Tanzanian Midwives' Perception of their Professional Role
4. Research shall be confined to the following region(s):	Dar es Salaam
5. Permit validity:	18 th October 2012 to 17 th October 2013
6. Local Contact/collaborator:	Dr. Rose Laisser, Head, Midwifery School, Muhimbili National Hospital, P.O. Box 65006 Dar es Salaam
7. Researcher is required to submit progress report on quarterly basis and submit all Publications made after research.	
 M. Mushi for: <u>DIRECTOR GENERAL</u>	

Appendix O: Strategies for Eclampsia Management

1. The patient should be seen (by a resident/registrar) within one hour of arrival in the eclampsia ward and thorough history documented, including age, parity, gestational age, number of fits, time of first fit, source of admission, current pregnancy history and past medical history.
2. General clinical state (pulse, blood pressure, temperature and so forth) on admission should be recorded by a senior admitting nurse, including documentation of treatments received and time it started, and any treatment given as emergency before doctor's order.
3. A specialist or consultant obstetrician should be involved in planning the management by reviewing the resident's plan within one hour.
4. Anti-hypertensive treatment should be given to all patients with severe hypertension (diastolic blood pressure ≥ 110 mmHg).
5. The treatment and prophylaxis of seizures should start immediately with magnesium sulphate and continue for 24 hours after last fit or delivery, depending on which comes first (dose as per eclampsia treatment protocol).
6. Respiratory rate and tendon reflexes should be monitored every half an hour when magnesium sulphate is used.
7. Ante/intrapartum fluid balance chart should be maintained and input output recorded.
8. Full blood count, renal and liver function tests, and urinalysis should be done at least once (full blood picture, urine for albumin test, serum creatinine, urea, liver enzymes [Alanine Aminotransferase (ALT), Aspartate Aminotransferase (AST) and Alkaline phosphatase]).

9. The foetal heart rate should be monitored every 30 minutes in all undelivered patients.
10. Steroid therapy should be given in all pregnancies where gestational age is 28 to 34 completed weeks in case of a need for prolongation of pregnancy.
11. The patient should be delivered within 12 hours of the first convulsion.
12. Monitoring blood pressure and urine output should continue for at least 48 hours after delivery (Kidanto et al., 2012).