Shaping the Role of sub-Saharan African Nurses and Midwives: Stakeholder's perceptions of the Nurses' and Midwives' tasks and roles

Authors:
Naomi M. Seboni[1]
Mabel K.M. Magowe[1]
Leana R. Uys[2]
Mary Bi Suh[3]
Komba N. Djeko[4]
Haouaou Moumouni[5]

Affiliations:
[1]University of Botswana, Gaborone, Botswana

[2]University of KwaZulu-Natal, Durban, South Africa

[3]University of Buya, Buya, Cameroon

[4]Ministry of Health, Kinshasa, Democratic Republic of the Congo

[5]Ministry of Health, Nyiami, Niger

Correspondence to:
Mabel Magowe

Email:
magowem@mopipi.ub.bw

Postal address:
PO Box 41324, Gaborone, Botswana

Dates:
Received: 22 July 2012
Accepted: 14 Feb. 2013
Published: 31 May 2013

How to cite this article:
Seboni, N.M., Magowe, M.K.M., Uys, L.R., Bi Suh, M., Djeko, K.N. & Moumouni, H., 2013, 'Shaping the Role of sub-Saharan African Nurses and Midwives: Stakeholder's perceptions of the Nurses' and Midwives' tasks and roles', *Health SA Gesondheid* 18(1), Art. #688, 11 pages. http://dx.doi.org/10.4102/hsag.v18i1.688

To explore the role expectations of different stakeholders in the health care system on the roles and tasks that nurses and midwives perform, in order to clarify and strengthen these roles and shape the future of nursing education and practice in sub-Saharan Africa. Qualitative focus group discussions were held with different stakeholders (nurses, health service managers, patients and their caregivers, community members and leaders and other health professionals) in eight African countries in order to establish their role expectations of nurses and midwives. Three questions about their role expectations and the interviews were taped, transcribed, and translated into English and analysed. There was consensus amongst the stakeholders regarding eight role functions: taking care of patients; giving health information; managing the care environment; advocating for patients; services and policies; providing emergency care; collaborating with other stakeholders; and providing midwifery care to women, infants and their families. There was disagreement amongst the stakeholders about the role of diagnosis and prescribing treatment. Nursing derives its mandate from communities it serves, and the roles expected must therefore form part of nursing regulation, education and practice standards. Health planners must use these as a basis for job descriptions and rewards. Once these are accepted in the training and regulation of nursing, they must be marketed so that recipients are aware thereof.

Om die rol verwagtings van verskillende rolspelers in die gesondheidsisteem aangaande die rolle en take van die verpleegkundiges en vroedvroue te ondersoek, om daardeur uitklaring en helderheid en bekragtiging van hierdie rolle te verkry, waardeur die toekoms van verpleeg-onderwys en praktyk in sub-Sahara Afrika gevorm kan word. Kwalitatiewe fokus groepe is met verskillende rolspelers (verpleegkundiges, gesondheidsdiens bestuurders, pasiënte en hulle versorgers, lede van die gemeenskap, leiers en lede van andere gesondheidsprofessies) in agt Afrika lande gehou om hul rolverwagtings van verpleegkundiges en vroedvroue te bepaal. Drie vrae is oor die rolverwagtings gevra. Die onderhoude is opgeneem, getranskribeer, in Engels vertaal, en geanaliseer. Daar was konsensus tussen rolspelers oor agt rol funksies: versorging van pasiënte; die gee van gesondheidsinligting; bestuur van die sorgomgewing; voorspraak vir pasiënte; dienste en beleid; voorsiening van nooddienste; samewerking met ander rolspelers; en voorsiening aan moeder en kindersorg vir vroue en hul gesinne. Ooreenstemming is nie bereik aangaande die rol van diagnose en voorskryf van behandeling nie. Verpleging kry sy mandaat van die gemeenskappe wat gedien word en daarom behoort die rolverwagtings deel te vorm van verpleeg-regulasie, onderwys en praktyk- standaarde. Gesondheidsdiensbeplanners behoort hierdie verwagtings as basis te gebruik vir werksbeskrywings en erkenning. Na die aanvaarding van hierdie verwagtings in verpleegopleiding en regulering, moet dit bekend gemaak word sodat die gemeenskap daarvan bewus is.

Introduction

Western health care systems and the inherent educational programs in Africa developed during the period of colonisation, largely based on western disease patterns, educational systems and human resources rather than a conceptualisation of the actual situation in African nations. For example, nursing texts usually do not deal with tropical diseases or the lack of resources in delivering care, leading to a disjunction between theory and practice and lack of clarity in roles and tasks for different health professionals. There is therefore a growing need for the nurses and midwives in Africa to identify and describe their own role function. This study is a multi-African country nursing project that identified the role functions as seen by various stakeholders in African communities. Gathering this information will strengthen nursing's contribution and

leadership in making the necessary educational and practice changes, and will guide the development of a model to the international community of nurses who are interested in improving health care in their country and/or in working with or in sub-Saharan Africa.

Background

The directive of the World Health Assembly (2009) urges member states to provide universal access to comprehensive primary health care (PHC) services. This requires adoption of appropriate delivery models that are people-centred, promote participation of communities and ensure an appropriate skill mix of workers in a multidisciplinary context (Zurn *et al*. 2004). In 2008 the World Health Organization Regional Office for Africa (WHO/AFRO) conducted a survey of educational programmes in nursing and midwifery in Francophone African countries because of 'perceived gaps in meeting the health needs of the community (and) inadequate capacity of health care providers' (WHO/AFRO 2008:v1). They found that 'neither nursing nor midwifery have clearly defined competencies that students should exhibit on graduation' (WHO/AFRO 2008:vi) and that there is a lack of regular or systematic evaluation of nursing and midwifery programmes. One of the recommendations of this study was to develop competency-based curriculum frameworks in order to provide guidance to these countries. To accomplish this task in a meaningful way, it is essential to base such competency frameworks on empirical evidence of the current health care and health service needs.

In 2007 WHO/AFRO developed an 'action framework' for the strengthening of nursing and midwifery (WHO/AFRO 2007:2). In this document, the roles of nurses and midwives in Africa were summarised as follows:

> The care they provide includes, inter alia, health promotion, prevention measures, the detection of abnormal conditions within the family and the community, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. In this regard, the work of nurses and midwives also extends to issues such as gynaecology, family planning and childcare. They are expected to do basic diagnostics, and must be able to confidently provide counselling on a variety of ailments especially those pertaining to the mother and child. In addition, the nurse and midwife should be able to manage a basic health facility within a community, generate and interpret health statistics and submit appropriate reports as required. (WHO/AFRO 2007:3)

The International Council of Nurses (ICN) (2003) also formulated a framework for the competencies of nurses, and although they do not use the term 'role', they classified the competencies under the broad headings of professional, ethical and legal practice, provision of care, management of care and professional development. What has been missing from these formulations of role done by a group of ICN experts is an empirical basis for the formulation.

The Nursing and Midwifery Professional Framework (East, Central and Southern Africa College of Nursing [ECSACON] 2001:1) stipulates that nurses and midwives roles fall under three broad categories: provider and collaborator functions, professional practice, and health advocacy activities. The provider interventions should focus on promotive, curative, preventive, rehabilitative and palliative care within the PHC framework. These roles and interventions, identified by nurse leaders in the ECSA region, served as the foundation for the development of nursing competencies and standards.

Information is lacking on role and task analysis for nurses and midwives in the different countries in sub-Saharan Africa. To address this gap and define the nursing roles clearly, research is required in order to explore the perceptions of different stakeholders in the health care system about the roles and tasks nurses and midwives perform (Duckett 2005), so as to shape the future of nursing education and practice in sub-Saharan Africa. This study will focus on obtaining information on the nurse and midwife role expectations of stakeholders who perform or receive services from the nursing and/or midwifery professions in eight sub-Saharan African countries (ECSACON 2001:2). The stakeholders include other health professionals, the community, patients, caregivers and their families, nurses and health administrators.

Aims of the study

The research question addressed was: What are the role expectations of patients, other health professionals, the community, and health administrators of the nurses and/or midwives in the African context?

The following three questions were asked in each focus group:

1. What do you think are the most important roles or functions of the nurse and/or midwife in your country?
2. What should they be doing that they are not doing?
3. What are they doing that they should not be doing?

Conceptual framework

The theoretical framework of this study is based on role theory. Although this theory was developed in the 1950s through to 1960s, it continues to be the basis of many current studies. The theory describes the process of how people are socialised into roles and how they function in these roles. Of the seven ways of describing roles as identified by Biddle and Thomas (1966:1), the prescriptive roles (tasks that are overtly prescribed for the group of people) were chosen because they deal with the aggregate roles of nurses as a group and not with the roles taken by any individual nurse. All covert aspects of roles, such as motives and values, were not addressed directly in this study.

In this theory, a role is performed when a group puts the rights and duties that constitute the status of a specific occupation into effect. Every group 'has a series of roles derived from the various patterns in which (they) participate, and at the same time a general role clearly represents the sum total of these roles and determines what those members of the occupation

do for the society' (Biddle & Thomas 1966:3) A role is made up of tasks, which are meaningful units of work activity, generally performed on the job by one worker within some limited time period (Uys, Groenewald & Mlambo 2003). Role expectations 'are position-specific norms that identify the attitudes, behaviours and cognitions that are required and anticipated for a role occupant' and the prescriptive or normative descriptions of an action held by one group about the role of another group (Hardy & Conway 1978:28) The roles of nurses and midwives in the health system are often socially- and historically-shaped, and tend to resist change.

There may be either consensus or disagreement about a specific role, and the latter may be polarised ('camps' of divergent opinion) or non-polarised (wide variety of opinions) (Biddle & Thomas 1966). If a group performs similar tasks, they show uniformity of role, and if they prescribe and describe the tasks similarly, they show role consensus (Biddle & Thomas 1966:3).

According to role theorists, role accumulation may lead to role strain or a difficulty in meeting role demands (Goode 1960). However, it may also lead to benefits, which Sieber (1974) identified as increased status, security and gratification.

Significance of the work

The identified perceived roles of nurses and midwives in sub-Saharan Africa by all significant stakeholders will set a stage for the development of a comprehensive model of nursing and midwifery practice. It will also provide guidance for evidence-informed practice, regulation and education of nurses and midwives.

Methodology

Design

This is an exploratory qualitative study in which focus group discussions (FGDs) were held in eight African countries: four Francophone countries (Democratic Republic of the Congo [DRC], Senegal, Niger and Cameroon, and four Anglophone countries (Botswana, Kenya, Nigeria and Tanzania). The countries were selected to include both Francophone and Anglophone countries, and to represent different regions of the continent (South, East, Central and West).

Sample size and sample selection

The sample selection of members of the stakeholder focus groups was based on purposive sampling of opinion leaders from the identified groups listed below. They were chosen based on their ability to articulate the expectations of a particular group, their knowledge of the health care system of the country, and their ability to articulate the role of nurses and midwives in that system. Each of the countries involved had an Advisory Board for the study who approved the sample selection. The focus groups comprised the following groups of stakeholders:

- Nurses (Nursing Regulatory Body, National Nurses Association and Nurse Educators).
- Health Service Managers, Patients or recent patients and their primary caregivers.
- Community members such as pastors or teachers.
- Community leaders such as traditional or political leaders.
- Other health professionals (Medicine, Pharmacy, et cetera).

The groups varied in size between five and 10 per group for a total of 253 FGD participants across the eight countries (Botswana – 73, Cameroon – 40, Kenya – 7, Niger – 49, Nigeria – 35, Tanzania – 21, DRC – 18, Senegal – 10). All groups included both men and women. The variation was because nobody who turned up for a meeting was turned away.

Data collection procedures

In each country, two nurse researchers conducted the FGD interviews using the most common language (namely, French, English, or dominant tribal language) suitable for the focus group participants. One researcher asked questions of the group, whilst the other observed interactions and took field notes. The group sessions lasted between 45 minutes and two hours each. All sessions were tape-recorded and transcribed verbatim into text. If the focus groups' discussions were not done in English, the transcription was translated into English for analysis. The transcription and translation were checked by the country researcher and the regional coordinator.

Ethical considerations

Each research team followed the research ethical processes stipulated in their respective countries. Ethical research boards based at the universities or Ministries of Health mainly reviewed and approved the proposals. Permission to conduct the study was sought from the managers of settings where participants were recruited, and permission was requested and received from all the focus groups members. The benefits and risks of participating in the study, the consent process, and the measures for ensuring confidentiality were explained. Participants gave either written or verbal consent. They were also advised to use pseudonyms in order to conceal and hence protect their identity.

Data analysis

Focus group transcripts were analysed using the template analysis style (Crabtree & Miller 1999), with the roles of nurses as themes. Initially, line by line analysis of paragraphs, statements and words was conducted to generate themes. Themes that emerged from the data and could be classified as roles were listed, and exemplars of the role were provided from the codes. The themes were checked by a second researcher to establish whether all role themes were captured in the analysis.

Using the analyses of each country's research teams, a core group of the investigators then gathered to analyse, theorise,

and synthesise the combined themes of the eight countries. All the roles listed in each of the eight countries were then put into a table to examine which ones had consensus and where disagreement within roles existed. In addition, role deficiencies were identified based on stakeholders' displeasure about nurses' role performance, but not with the role itself. The roles and role aspects were then synthesised and described.

Three major steps were taken to ensure credibility of the data. Firstly, trustworthiness was strengthened through triangulation of data sources. This was done by interviewing a total of 197 stakeholders in each of the eight countries to ensure that a broad perspective was obtained. All data were audio-tape-recorded to capture the participants' descriptions and responses accurately. The exception was Kenya where the researcher was not able to secure participation from a range of stakeholders and held focus groups with only nurses. It is believed that the different stakeholders offer multiple perspectives and thereby provide a broader and complementary perspective on the roles of nurses and midwives. Secondly, focus group discussions were facilitated by researchers who did not have a prior relationship with the group members. And thirdly, a different person transcribed the interview tapes, whereafter the interviewer checked the transcribed data for accuracy. To ensure that data are dependable, interview guides were used to ensure consistency of data collected over the different locations and times. The prolonged engagements of participants for up to two hours, audio-recording and use of field notes strengthened the dependability of the data. The rigour in the study methods, such as use of interview guides, can assist with the reliability of the study in other countries. To ensure confirmability, member checks were conducted throughout the interviews through affirmations, paraphrasing of the respondents' statements to maintain clarity, and summarising at the end of interviews.

To increase the validity of the coding and interpretation of results, the principal investigator (PI) assumed primary responsibility for creating, modifying and updating the codebook. This was done by encoding the data from the first country and developing an initial codebook that outlined the criteria that were to be used to classify roles. The country PI from the first country then reviewed the coding and the code book and when consensus had been achieved between the PI and the country PI, this code book was used to encode the data from subsequent countries.

Findings

Sample description

Unfortunately, the characteristics of the FGD participants' samples were captured for only four of the countries. Table 1 indicates the demographics of the respondents: age, gender, level of education, and the category of stakeholder. In the four countries for which demographic data is available, male and female respondents are relatively balanced, and most respondents had some secondary education.

In Kenya, the focus groups involved only nurses. Therefore, so as not to not allow nurses to dominate, the sample data, randomly chosen, from only one FGD consisting of seven nurses from one district hospital, were used in the study.

Role expectations

Of all the roles discussed and described in the focus groups, six major roles stood out as agreed upon roles of the nurse. Many of these roles have 'role aspects', which we have defined as a cluster of identified tasks within the role. These were identified and described.

TABLE 1: Characteristics of participants of FGDs in four of the sampled countries (N = 197).

Country	Total of participants	Constituency	Age ranges	Sex		Education			
				Male	Female	Number	Primary	Secondary	Tertiary
Botswana	73	Nurses leaders	43–54		4	-	-	4	-
		Patients	16–66	16	29	2	5	16	22
		Community leaders	29–70	11	7	M	M	M	M
Cameroon	40	Nurses	22–50	3	6	-	-	8	1
		Patients	16–60	4	6	-	8	2	-
		Community members	24–70	6	2	-	7	1	-
		Managers	35–55	2	4	-	-	4	2
		Other health professionals	21–50	2	5	-	-	4	3
Niger	49	Nurses	M	6	5	-	-	8	1
		Patients	M	8		-	8	2	-
		Community members	M	8	2	-	7	1	
		Managers	M	8	4	-	-	4	2
		Other health professionals	M	4	4	-	-	4	3
Nigeria	35	Nurses	M	2	6	-	-	8	1
		Patients & caregivers	M	2	6	-	8	2	-
		Community members	M	1	4	-	7	1	-
		Managers	M		8	-	-	4	2
		Other health professionals	M	3	3	-	-	4	3
Total	**197**	-	-	**92 (47%)**	**105 (53%)**	**-**	**-**	**-**	**-**

Source: Data gathered during focus group discussions
M, missing data; FGDs, focus group discussions.

The most agreed upon roles of nurses, described in almost all groups and all countries, were taking care of patients and providing health education. The majority of groups also noted four additional roles that nurses undertake, namely, (1) managing the care environment, (2) advocating for patients, (3) providing emergency care, and (4) collaborating with other health professionals. These six roles can be considered as major consensus roles, or agreed upon functions of the nurse across Francophone and Anglophone countries in Africa. An additional role was described by groups in two countries, and not opposed in any other country. This role, labelled as having minor consensus, is the provision of midwifery services.

The one role that was contested and labelled as a role involving disagreement was that of diagnosing and giving treatment. The interesting thing about the disagreement regarding this role is that in some groups the disagreement focused on a *specific role aspect*, although the groups had consensus on the role as a whole. In other cases, the role disagreement included the total role, or was bi-polar in character, with the groups taking opposite stances. There were also two role aspects that were considered problematic: providing basic nursing care and cleaning the environment. Another area of concern is the dissatisfaction noted with regard to how the functions involved in home visits were fulfilled.

Role 1: Major consensus

Taking care of patients

Across all countries and all groups the nurse was seen as being responsible for caring for patients. A number of behaviours or tasks were listed that reflected what different stakeholders experienced as being cared for by the nurse. Being cared for encompasses physical, psychological and emotional aspects of care, meaning that the role cannot be attitudinally neutral. The role aspects outlined under this role include: acknowledging the worth of patients and their families; assessing the condition of the patient and monitoring it continually; providing counselling; and assisting with activities of daily living (basic nursing care).

Showing respect

In African countries, one greets and acknowledges another person by asking questions related to the well-being of the other person and their family. It is seen as demeaning to be given orders without first being recognised, and discourteous to give orders without recognising the person. In large hospital systems this depersonalisation of patients adds to the sense of 'not being cared for', thus the welcome is seen as important by stakeholders. It is not surprising then that the role descriptions often included the way a role is fulfilled, or how a patient is treated and cared for, not just the bare essentials of providing care.

A community leader stated:

> 'When this patient is received well and ensured of good treatments from a nurse, he or she starts to feel peace and become comfortable. The nurse must honour the patient and treat them well by providing information and guide the patient step by step, nurse should not be very harsh, but be friendly to the patient and this will make patient to express their problem and finally become satisfied and regain lost peace. For the person who is sick his peace comes when he feels he has received the right care and treatment. A nurse must play a role of receiving patient nicely and show empathy and respect'.

Assessing and monitoring conditions

Once the nurse is present there is the belief by all stakeholders that he or she quickly assesses the issue and knows what steps need to be taken to improve your situation. A patient described it in the following manner:

> 'Upon receiving you, the nurse takes your temperatures and blood pressure and pulse. In the case of a pregnant woman the midwife may need to deliver the baby. They must give pain medication, nurse you and determine what assistance you need. For example she/he may determine that if you have a headache you need headache pills like Panado or give you paracetamol. This will be determined by what you have told the nurse about your problem'.

Psychosocial counselling

Another aspect of the role that received significant attention was that of providing psychosocial care and counselling. The ability to listen carefully to the patient and the family and ask questions to clarify issues, as well as to probe when necessary, was all seen as helping patients restore their health.

In both Tanzania and Botswana, Community members were very vocal in sharing their opinions and there was a great deal of agreement. As one member stated:

> 'I want to add on the counseling. Some patients may quickly tell you some things and avoid others which may be the more serious problems. A nurse may need to dig more information and have time for counseling. For example some patient may say I have backache while they have a sexually transmitted disease. If you dig deep you may be able to trace the real problem, and this can only happen if you give patients more time and use counseling techniques. Otherwise you will only deal with the headache being presented and ignore more serious complications'.

However there was a caveat to the sharing that should be noted. The HIV pandemic and the governmental and health professionals push for the testing of all citizens has made people concerned regarding the privacy of the results of testing. Although HIV testing is not mentioned in the community members' statement, the implications of sharing health information in non-health settings are seen as a source of concern. This concern is voiced by a Tanzanian health services manager:

> 'On my side I do expect that nurse should be keeping the patient's secret. You know patient information is confidential and it is the role of nurse to maintain this confidentiality. I think this is very important for nurse to understand that patient's results are a secret between her and patient himself so nurses are not required to tell anybody the secret of patients without patient consent'.

It should be noted that the nurse in the group was quick to respond and note that there is a code of ethics that nurses follow in providing care.

What is basic nursing care?

One of the most controversial areas in describing the nurse's role was the discussion of what tasks are included under the category of assisting with activities of daily living, often referred to as basic nursing care.

Another aspect of this role, providing direct basic nursing care, was generally seen as being inadequately performed. Basic nursing care is the component of care that deals with assistance with the activities of daily living for those persons who are physically or mentally compromised. Stakeholders complained that 'most of the procedures they are supposed to perform have been taken over by relations e.g. turning of patient, bed bathing, giving of bed pan. They say it is non-nursing job'. Other community members, however, argued that there should be other helpers in the care system that could do such jobs, such as feeding patients that need help. Of interest was a comment that linked feeding patients with really caring about the person, but still insisted on delegation of this role. This aspect of care has often been delegated to family members, and some stakeholders felt that this is not the role of the nurse:

> I see nurses feeding patients. I am not sure if they do that because of love, or because it is part of nursing. May be a nurse do that because of a relationship that she/he has with the patient? But I believe that other people can do that. I feel that government should train and hire other cadres who can do that, because nurses are also human and end up doing some of those things because they feel pity for the patient and want to help them with their needs. But if there are people trained for that the nurses will be relieved to focus on their core functions.

Although the greatest focus was on the delivery of care in formal health care systems, there was a great deal of support from stakeholders regarding the nurse's role in home visits – following patients into their homes. The reasons for the home visits were most commonly related to checking on adherence to medication regimes to relieve the person from having to return to the hospital. However, the problem is less a willingness to be involved in home visits than the logistics, as stated by a Kenyan nurse:

> 'We are supposed to do follow up at home to our clients especially those with mental illness but sometimes we lack finance and transport. You find that nobody is there to supervise and see whether they take their drugs at home. They don't take their drugs so after two weeks they come back. We should have some finance to follow them to their communities.'

It should be noted that in many African countries there are few community-based 'safety nets' for people discharged from hospitals, and there is an increased emphasis by the governments on nurses serving as the link through provision of nursing services in the community setting, more specifically, in the patient's home.

Role 2: Major consensus

Providing health education

As strongly supported as the caring role, stakeholders expect nurses and midwives to provide health education that equips clients with the knowledge and skills to prevent infectious diseases and protect them from illness, to participate in treatment and self-care, and to promote and maintain good health. As part of the PHC model, health education related to these areas is to be provided to individual patients and their caregivers, groups, families and communities. According to the respondents, nurses should be able to educate regarding how to prevent epidemics, signs and symptoms of diseases, immunisations and other preventative strategies, family planning, and HIV testing and prevention. In addition, they should be able to inform patients, clients, families and communities about available health services and programmes. Some stakeholders felt the role was inadequately fulfilled.

It was clear that nurses were aware of their health promotion role, but there was no indication as to whether they felt adequately prepared. In citing the role, a respondent stated:

> 'As a nurse you must also do the preventive and promotive care to the clients and the community at large. This one must be through education where we are supposed to give educational preventive measures of conditions like diarrhoea, cholera, and dysentery. We tell them the measures they are supposed to employ or use so that they can avoid infections'.

Role 3: Major consensus

Managing the care environment

The nurse has the responsibility of organising and managing the health care environment. Many of the descriptions of this role pertain to the nurse ensuring the procurement and availability of all supplies and their proper use, including medications. Although this was mentioned by all groups, there was limited discussion with respect to how it was performed.

One of the aspects of this role that provoked some disagreement is the maintenance of a hygienic care environment. The division was between nurses and family members regarding whose role it was to perform house-keeping duties and maintaining the patients' hygiene. One group of respondents, mainly patients and their families, felt that the nurses should clean the wards, whilst others felt they should make sure the environment is clean, but perhaps not do it themselves. The issue lead to some heated exchanges:

> At times when they enter in a ward and find people there they should understand that it is their place to clean the ward instead they start pouring insults on the patients that the way the patients are dirty is just a reflection of how dirty they are in their homes.

The nurses, though, noted that when they focus on cleaning and scheduling activities they are not available to provide direct care:

> Due to the shortage, nurses sometimes have to do ward cleanness while patients wait for him or her. Cleanliness is not the function nurses are required to do because they have not gone to school to study for. There should be special people helping nurses to do such activities such as cleanliness, sending specimen to the laboratory and taking result from laboratory, looking for ambulance and other activities which are not care based activities. Nurses should remain with their responsibility of taking good care of their patients.

Role 4: Major consensus

Advocating for patients, services and policies

This role involves ensuring access to services needed by clients. It also involves advocating for adequate resources, provide effective care in the hospitals, clinics, communities and in homes. Nurses and midwives felt that they needed to advocate for their clients in order to ensure their safety, access to timely services, and protection from financial exploitation. Amongst all stakeholders it was believed that they are entitled to the provision of quality cost-effective care. Nurses believed that their advocacy can be used to solve patient's problems, such as speaking on behalf of their patients to stop doctors from providing unsafe treatment or mismanagement and/or exploiting the patient by referring them to the doctors' private clinics, which could be very costly. In addition to watching out for the patients' best interests, it was also expected that nurses and midwives advocate for adequate resources in all health care settings. Some stakeholders also saw the involvement of the nurse in policy-making as being part of this role.

One patient respondent indicated that the chain of events which provides a patient with access to care and the medication and treatment needed, may break down totally due to lack of essential funds in the family:

> 'There is no emergency fund [*in the clinics*] and it is an imperative in an underdeveloped country like ours. The State has a great responsibility: it must make drugs available, provide hospitals with adequate resources, … and play a key role in safeguarding the fundamental principle of access to public service and continuity. The nurses, however, must raise this issue or at least participate, enlightening because they have a duty to inspire public policies in their field'.

Role 5: Major consensus

Providing emergency care

Nurses are supposed to provide emergency care in any setting in which they are providing care, including homes. Their willingness to do this was noted by some stakeholders as being somewhat lacking. A patient from Cameroon notes:

> 'Nurses are on night duties and an emergency situation arises but they are always very reluctant to react to the emergency. I think that is a serious problem that is supposed to be addressed'.

Since there were no nurse responses with regard to this role description, it is difficult to know if the issue was reluctance because of lack of knowledge, experience, or just laziness.

Role 6: Major consensus

Collaborating

Nurses as primary caregivers need to collaborate with other members of the healthcare team. The collaboration role includes maintaining good working relationships within the larger health care system, referring patients appropriately, and educating other health care workers. The importance of maintaining good working relationships with nurse managers in other systems was seen as essential for guaranteeing that patients would receive adequate follow-up care. It was also noted in a number of responses that nurses must provide information and teach skills on basic nursing care to community workers and family caregivers who will 'take over' when the patient leaves the health care setting.

For some, collaboration was seen as following prescribed instructions:

> Collaborative care utilises the skills care prescribed by the physician. These treatments are not applicable without consulting the doctor or care protocol previously established that the nurse may apply in certain circumstances.

Others saw it as assuming the duties of the physicians when they were not available:

> You may also stay for the whole day waiting to be seen by a doctor and he does not show up, and the nurses do not do anything about it. They must help each other, what is important is that we get the assistance we need.

Role 7: Minor consensus

Provide midwifery care to women, infants and their families

It is surprising, given the traditional nature of the midwifery role in nursing and the heavy emphasis placed on decreasing infant mortality, that the respondents did not consider this to be a major consensus role. In fact, Only Botswana and Cameroon respondents mentioned the role:

> When it comes to women's health it is the responsibility of the midwife to care for the woman during pregnancy and delivery, to make sure that the pregnancy is safe, and the delivery is also safe to prevent death of the mother and her baby.

Role 8: Major disagreement

Making a diagnosis and giving (prescribing) treatment

Of all the roles discussed, the issue regarding who can make a diagnosis and prescribe treatment was the most controversial. Community members, in particular, believed these skills to be essential to nursing, especially when they practised in remote areas with no or few other health professionals available:

> Nurses have been taught to do many things, depending on the communication between the nurse and the patient. I think the first thing is for the nurse to take vital signs, and I think the nurse can do that. The second thing is consultation, which I think the nurse can also do. I mean where a nurse asks a patient about the history of his/her illness and examines the patient. The nurse can do that. The 3rd thing is for the nurse to see what the patient needs to cure the illness, and prescribes the medicines. I think the nurse can also do that so that the patient can be helped. If the nurse suspects some things that require further investigation, she/he can order blood and other laboratory investigations and send them to the laboratory. I believe that nurses can carry out all these duties.

But other stakeholders, mainly health care managers from Francophile countries, saw this as over-stepping boundaries and doing tasks that were not for nurses to do, saying that they were 'acting as doctors':

> Some of the nurses have turned their profession to become doctors. They tend to do consultation, they tend to prescribe, and some even go as far as operating. They have abandoned

> what they taught them in school and started doing many things, probably because of their longevity in the profession of whatever, they now acquire some of those skills; they are supposed to be doing their profession.

The tasks included in 'acting as a doctor' are not only diagnosing and treating, but include other aspects of care, such as discharging patients or doing surgical procedures. The assumption of all these roles is often justified by the absence of doctors:

> Giving IV injections, setting IV line, blood transfusion are some of the activities nurses perform which they are not supposed to do. The reason is that you cannot watch your patient die because the doctors do not come on call, if you call them, they will switch off their phones. What are nurses supposed to do in that circumstance?

The issue appears to be not only concern for the nurses' ability to carry out the function, but may be viewed by some as being a threat to the viability of other health care jobs:

> They [*nurses*] want to become lab technicians, they want to become pharmacists, they want to become whatever thing they are not. So I don't know whether they minimise their job or they don't take it seriously. The nurse is supposed to be the one that attends to patients or administers drugs as expected. Today the nurses are neglecting that function, they are shifting away. I don't know whether they don't like that job.

Despite the controversy, it is most likely that the words of a Community Leader from Botswana will be heard and serve as the rationale for what might be considered as expanding the nurse's role in many countries:

> 'I know very well that those tasks belong to these other people, but I am saying that the nurse who is placed in these remote areas should not function in the same as those in the hospitals, they must be trained to do more because we do not have those other people. It should therefore become a part of the nurses' function because of the circumstances. We know that they are capable of doing that. They should also be paid for doing those tasks just like the owners are paid. That will not only cut costs, but it will also encourage them to feel motivated to carry out those tasks, if they are trained for them, they are recognized by those who regulate their functions and part of nursing and they are recognized by the government by paying them for the extra work. The very ones of consultation, assessment, drawing blood, prescribing and dispensing medicines. The nurses can do those well if trained, and be encouraged if they are paid'.

Discussion

The role expectations that stakeholders have of the nurse and midwife reflected similarities in all the studied countries. There was consensus on a majority of role functions and this suggests that, generally, the sub-Saharan societies have similar health needs and role expectations of a nurse-midwife. However, there was also disagreement across a number of countries, indicating that role-confusion problems are not restricted to one country. This calls for a model of nursing practice that fits the sub-Saharan context.

Consensus regarding Nursing/Midwifery role: The roles described by stakeholders reflect the expectation that nurse and/or midwives will not only be active in hospitals, but also in community settings and in primary care services (clinics of health centres). They described the functions to involve both preventive and promotive roles, and did not limit their expectations to curative or rehabilitative roles.

Two of the roles identified, collaborator and advocate, correspond directly to the roles described by ECSACON (2001:3) but the third ECSACON role (professional) is captured in a total of six more specific roles. The role identified in this study as 'Managing the care environment' is also one of the competencies identified by the ICN (2). This empirical study of role expectations of stakeholders therefore provides a more explicit description of the roles required of nurse and/or midwives in Africa, but also supports the roles identified by nurses themselves.

The role of caring for patients in hospitals is clearly the role most closely associated with nurse and/or midwives. The disagreement around the role aspect of cleaning the work environment is an interesting one. Some may not have seen its relevance, whilst others may have, but argued that it could be performed by non-professional staff, so that the nurse could focus on the core business of providing nursing care.

The participants expect nurses and/or midwives to perform outreach services in order to ensure continuity of care and to prevent relapse. To do this may require changes in curriculum for some schools of nursing because both education and experience tended to centre on institutionalised care – even for those serving in the community-based or PHC clinics. Follow-up care is essential for both nursing and midwifery care. In African regions the majority of maternal and infant morbidity and mortality cases occur after discharge from the hospital. It is also reasonable to assume that follow-up care will be beneficial to those with chronic illnesses, encourage adherence to drug regimens, and support other out-patient treatment modalities.

Some stakeholders expressed dissatisfaction with the provision of basic nursing care, claiming that nurses neglect these duties, do not render this kind of care in an ethical manner, and fail to respect the culture of those they serve. Whatever else nurses do, it seems that the quality of basic nursing care determines, to some extent, the perspective of the stakeholders about how appropriate nursing care is. Nurse and/or midwife interventions are expected to be provided in an ethical and professional manner in order to create authentic relationships (Watson 2006).

The role of cleanliness in patient safety has recently received much attention, for instance the 'Clean Care is Safer Care' project of the WHO. The initial focus of 'Clean Care is Safer Care', launched in October 2005, was to promote best hand hygiene practices globally, at all levels of health care, as a first step in ensuring high standards of infection control and patient safety (WHO 2011). The vision of 'Clean Care is Safer Care' is to make infection prevention and control a priority

in health care everywhere. A clean health care environment is therefore not simply a matter of an attractive environment, but has a definite impact on the health of patients. Therefore, responsibility for this aspect of patient care does lie with the nurse, but the issue remains as to whether she should do it directly or ensure that someone hired for the job carries it out.

Nurses in Africa may not be aware of the high level expectations that their societies have about them, such as being able to advocate on their behalf regarding sufficient health resources and protection from harm and exploitation. Most governments have signed the Abuja Declaration which declares they will allocate at least 15% of their GDP to health care services for their people (African Union 2001). According to the stakeholders, the nurse and/or midwife is in a prime position to play an active role in advocating for the implementation of this increased investment in health care. The participation of nurses and/or midwives in policy development is also seen as part of the advocacy role. As Cara, Nyberg and Brousseau (2011) note, inadequate resources will jeopardise the role performance of a nurse and midwife and create even more disparities in health care services.

Another stakeholder requirement is that nurses and/or midwives equip the communities they serve with knowledge and skills in order to engage in effective self-care. The increase of health literacy is critical in order to empower communities, families and individuals to prevent illness and self-manage their own care. This demands a well-planned and pertinent health education component in nursing curricula that teach techniques for behaviour change. This focus in learning and teaching is inadequately addressed in current education and practice situations. It needs to focus on the role of a nurse and midwife as a health educator and specifically address health promotion and prevention of illnesses that are prominent in the country and the region.

These collaborative and management roles of the nurse and/or midwife should be seen in the context of the PHC strategy in the delivery of care in all settings. The strong global push for PHC calls for partnerships with the communities served and with other stakeholders in health care. They argue that effective services that are timely and cost-effective are not a luxury but a right for the societies served. Properly managed care will enhance speedy recovery and rehabilitation and save costs. PHC strategy also encompasses collaboration with the community, the family, the individual, other health workers, members of the civil society, and organised groups such as non-governmental organisations (NGOs), community-based organisations (CBOs) and faith-based organisations (FBOs), in order to enhance health service delivery and thus enable the served populations to attain the optimum level of health possible (Scott & Hofmeyer 2007). The effectiveness of this approach will be measured by the effectiveness of the ability of educational programmes for health care professionals to move away from teaching traditional acute care knowledge, in traditional institutionalised health care settings, and to embrace more interactive, community-based care.

Challenges to the Role Development: The disparity of views on the topic of diagnosis and treatment seems to be based on need versus tradition. The disagreement amongst stakeholders in most of the countries on nurses performing non-traditional roles seems to be influenced by the setting in which care was received (hospital versus clinic), where a client lives (urban versus rural) and by a shortage of other health care workers. The context seems to clearly define the needs and the expectations of a nurse. For example, the stakeholders who lived in the remote rural areas, and those who experienced a lack of access to doctors, due to shortage or unavailability, as well as those who received care from the clinics, argued that nurses should diagnose patients, order laboratory tests, take blood and prescribe medications. Nurses expressed that they felt that these tasks were appropriate to their role. Allan and Barber (2004) purport that these roles enable nurses to ensure continuity of care.

In the light of the severe and widespread shortage of doctors and pharmacists, the role of registered nurses and midwives in the African region must logically include diagnosis and treatment of all minor and selected common conditions, prescription of the specified medications, and obtaining of blood and other specimens. This extended role requires the nurse and/or midwife to have good assessment skills in order to arrive at the correct diagnosis so as to form the basis for planning and execution of care. Role extension needs to be viewed positively by nurses as it enhances their autonomy and provision of independent holistic care. Of course there will always be nurses who see this broader role as making them more vulnerable to criticism, or, as in high resource countries, to liability (Rycroft-Malone *et al*. 2008).

An incredibly important strategy and first step in order for nurses and/or midwives to fully absorb this role without negative perceptions from both other nurses and stakeholders, would be for the African nursing and midwifery professions to articulate and market their own roles to the community and other health service providers in order to ensure support and appropriate utilisation of services. Needless to say, the nurses' work in and contribution to these roles also need to be recognised and rewarded by the health service authorities.

Midwifery care is perceived as not only providing care and delivery to pregnant women, but also as catering to women's health, care of children and provision of family planning so that women will have planned and wanted pregnancies and be able to space their children. The fact that the role of midwives was not mentioned in most of the country was disturbing. Several factors may have contributed to this. Firstly, especially in Anglophone countries, a nurse-midwife is usually viewed as a nurse by the communities, so they would not distinguish between midwife and nurse. In Francophone countries, it may be more related to the shortage of midwives since this profession is still new. Lastly, the fact that the investigators did not ask about the midwife role as a role separate to nursing in the interview questions may also account for the lack of information.

The respondents expect nurses and midwives to provide emergency care in communities and in health service settings and to refer to the patients where necessary. This role points to the fact that nurses and/or midwives are an important health resource in communities with limited resources. The nurse's knowledge and skill is often the only resource on which the community or the health service can depend on an emergency.

Recommendations

Based on these results, the recommendations are as follows:

- Nursing education should give attention to teaching all the relevant roles, including outreach and follow-up and health education, in appropriate settings. Efforts should also be made to empower practising nurses to be comfortable in and sure of their roles, since this will facilitate their collaboration with other health care providers.
- Nursing practice should ensure respectful and professional service, participation of nurses in policy development, and that nurses take responsibility for a clean care environment. Nurses should also practise the full range of their extended roles.

Further research should develop a relevant and comprehensive model of the roles of nurses and midwives.

Limitations of the study

The lack of demographic data from four of the eight countries and the limited sample from Kenya are a limiting factor. Nevertheless, the demographics from the other countries provide some support for the sample including a wide range of age groups, both genders, and people with different educational backgrounds.

Not having a specific question about the role of the midwife might have created the perception in respondents that the study excluded this category of health professional. Since nurse-midwives are common in the African settings, the researchers used the term 'nurse' broadly, but this was not made explicit during the focus group discussions.

Conclusion

The stakeholders in health care, patients, their families, community members, health service managers and health workers shared their role expectations of a nurse and midwife in the African context in this study. They agreed on the majority of roles, but disagreed on the role of diagnosing patients medically and prescribing their medications. However, it can be argued that nurses and midwives need to engage in extended roles in order to ensure access to health care by all who require it as well as continuity of care to the clients in all settings where health care is provided.

A health profession that responds to the role expectations of the stakeholders it serves has the potential to make a difference in the health status of the population it serves. Inviting the views of 'outsiders' into the profession and using these constructively in defining and shaping the profession increases the chances of the profession being 'fit for purpose'. This study therefore provides valuable information on which to base nursing curricula, certification examinations and health services planning in the African context.

The methods used to examine roles assumed by nurses and the expectation of stakeholders may serve as an important strategy for the international community of nurses as they develop programmes of nursing, meet the WHO demand for PHC systems, and develop strategies for educating the public on the nursing profession. In African countries there is great momentum to move the nursing profession forward, and the accelerated speed with which they are making changes does not allow for some of the smaller steps American and European countries may have needed and taken as they moved forward. It is hoped that delineating some of the processes and discussing some of the issues involved will provide a better picture to the international community of how African nursing is shaping its destiny.

Acknowledgments

Competing interests

The authors declare that they have no financial or personal relationship(s) which may have inappropriately influenced them in writing this paper.

Authors' contributions

L.R.U. (University of KwaZulu-Natal) was the project leader; N.M.S. (University of Botswana) was the regional principal investigator and wrote the article; M.M. (University of Botswana) was the country PI for Botswana and revised the article; M.B.S. (University of Buya) was the country PI for Cameroon; K.N.D. (Ministry of Health) was the DRC country PI; and H.M. (Ministry of Health) was the country PI for Niger. M.M., M.B.S., K.N.D. and H.M. participated in data collection, and all authors participated in the data analysis.

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