EXPECTED ROLES OF NURSES AND MIDWIVES IN BOTSWANA

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ABSTRACT

The roles and tasks of nurses and midwives have developed significantly over the years, calling for adjustment to consumer needs and expectations. This qualitative study was conducted to explore the perceived tasks and roles of nurses and midwives. The results of this study will provide guidance in developing a culturally relevant sub-Saharan nursing and midwifery practice model, and curriculum development. The larger descriptive cross-sectional qualitative regional study

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involved nine sub-Saharan African countries. We present the Botswana component of this study. Respondents were patients, community leaders, and nurse leaders, selected through purposive sampling from different settings. The University of Botswana Office of Research and Development, and the Ministry of Health Research and Development Committee gave permission for the study. Participants gave written informed consent, completed a 16-item demographic questionnaire, and engaged in focus group discussions about the perceived tasks and roles of nurses and midwives. Qualitative data were textually analysed to generate themes and subthemes, supported by verbatim excerpts. Respondents stated that nurses and midwives in Botswana operate at different levels of the health care system, with dependent, interdependent and independent roles. Nurses and midwives were expected to be receptive, patient, respectful, compassionate, and knowledgeable about their work. The perceived roles included caring, collaboration, advocacy, leadership, supervision, mentoring, management and other expanded roles. Participants highlighted the expanded roles that nurses and midwives performed beyond their scopes of practice and education, hence the need for regulation, training and incentives.

Keywords: roles, tasks, nurses, midwives, consumer needs, role expansion

INTRODUCTION AND BACKGROUND INFORMATION

The healthcare environments have changed significantly, driven by changing demographics and epidemiology. The roles and functions of nurses and midwives have also developed significantly over the years, calling for adjustment to the needs of consumers and the prevailing health problems. These changes may affect the roles and tasks of nurses and midwives, and the public perceptions of these roles. There is a need to include changing roles into nursing and midwifery education programmes to meet the greater needs of clients (Glen, 2004:709). Furthermore, there is increased emphasis on policy and legislative reform, development of standards of care driven by the need for quality improvement.

Nurses and midwives make a substantial contribution to health delivery systems in primary, acute and community care settings (Tawfik and Kinoti, 2006:3). The World Health Organization (WHO, 2009:8; 2013:6) estimates that 35 million nurses and midwives make up the greater part of the global healthcare workforce. Tawfik and Kinoti (2006:3) also indicate that one major feature of the demographic profile of health workers in Botswana is that younger workers are leaving the workforce and more are also dying from AIDS, exacerbating the workforce shortage.

According to O'Shea (2013:47), nurses and midwives continue to assume responsibility for tasks that are increasingly complex and complicated. This could be compounded by the scarcity of other health human resources. Some of the roles are most likely often confused as the key functions of the nurse/midwife by those receiving

the care. The consequence of this is a blurred and confused role clarity and piling of tasks, which can lead to the risks of inadequate haphazard care, increased practice errors and litigation.

Nursing and midwifery education in Botswana was a product of historical foreign colonial and missionary penetration into the country, and early nursing education was tied to western health care system (Khupe, 1987). After independence, most of the early senior nurses with advanced studies who developed nursing and midwifery curricula, policy development, standards and scope of practice were educated abroad. In this respect, early nursing and midwifery practice may have not been relevant to the socio-cultural patterns of the people of Botswana.

The WHO Munich Declaration on Nurses and Midwives (2000:1, paragraphs 57–67) urged governments to review the present use of nurses and midwives in community based and family care, and determine how best to strengthen their role to raise the quality of care. Kane (2007:9 and 95) purports that staffing ratios, skill, organisation, and leadership undoubtedly play a role. Furthermore there is a need for assessing community perceptions and their expectations of the roles of nurses and midwives.

SIGNIFICANCE OF THE STUDY

This research is expected to yield results that will assist the development of culturally relevant nursing and midwifery education, practice standards, and scopes of practice. This will also guide any required changes in nursing and midwifery regulation to ensure legal coverage of expanded roles. Once clarity of roles and tasks is achieved, nurses and midwives will know what the public and employer expect from them. In turn, employers and public will also know what is legally expected from the nurses and midwives, thus reducing confusion and frustration for all players in the health care delivery system.

AIMS OF THE STUDY

Purpose of the study

The purpose of this qualitative study was to explore the perceived tasks and roles that nurses and midwives in Botswana perform from the perspective of key informants such as patients, community leaders, nurse leaders and nurse managers, in order to inform the development of a nursing and midwifery practice model that is relevant to the needs and expectations of the populations in Botswana and sub-Saharan Africa at large.

Study objectives

The objectives of the study were to:

1. Determine the key roles and tasks of nurses and midwives as perceived by significant others, namely stakeholders such as patients, community leaders, nurse managers and nurse leaders.
2. Identify the perceived tasks and roles that nurses and midwives perform, which they are not expected to perform.
3. Explain the perceived tasks and roles that nurses and midwives are expected to perform, which they do not perform.
4. To determine additional tasks and roles that nurses and midwives are expected to perform.

METHODS

Design

The study entailed a cross-sectional qualitative descriptive study among key informants in Botswana who receive nursing care or who have worked with nurses and midwives. This was part of a joint regional study involving 10 countries in sub-Saharan Africa.

Setting

The study was conducted in selected settings, which typically represent different sets of populations from remote rural and peri-urban villages to towns and cities in Botswana, with populations ranging from 21, 450 (village) to 250 000 (city). These included Gaborone, Ghanzi, Maun, Francistown, Lobatse, Jwaneng, Kanye and Mahalapye.

Study population

Respondents were patients, community leaders, and nurse leaders who reside in the selected settings. These were selected by purposive sampling based on eligibility criteria. Patients were included if they were admitted in a health facility either in the ambulatory or inpatient department, aged 21 to 65 years of age, able to read and write in Setswana, consenting to participate and well enough to participate in focus group discussions (FGDs) of one to two hours. Patients with hearing, vision and mental impairment and those unable to read and sign consent independently were excluded.

Community leaders included *Dikgosi* (tribal chiefs) and their headmen, council secretaries and/or chairpersons, councillors, district commissioners or their representatives, and village development committee chairpersons, or their representatives. They were included if they could read and write in Setswana/or English, and if they were in sound physical and mental health that would not hinder their full participation.

Nurse leaders consisted of a range of nurses who hold leadership positions in the Ministry of Health and major health and other institutions and organisations. Most of them came from public health institutions.

Recruitment procedures

Nurses in charge in the selected health facilities assisted in the selection of a mix of patients. The patients were from different hospital units, including outpatient, female and male medical and surgical units, maternity (excluding the labour and delivery ward), logging mothers in the children's wards, and orthopedic wards, who were capable of assembling at the site selected for holding FGDs. Patients were then approached individually to explain the study and the consent process. Those who agreed were asked to meet the researcher in the selected office allocated by the nursing authorities. A total of five focus groups of patients were conducted at the health facilities (3 in the hospitals and 2 in the clinics).

Community leaders included *Dikgosi* (tribal chiefs) and their headmen, councillors, council secretaries, council chairmen, District Commissioners and their assistants, in three villages. Community leaders were identified through their known positions and were individually sent a written request to participate in the study, and if they agreed to join the researchers and other respondents at the given location and time. A total of 5 to 10 members of the group were expected. Once at the setting, consent procedures were followed for each individual prior to the start of FGDs. A total of three focus groups were held with community leaders in different villages. The FGDs were held either at the district office, the tribal administration office or the council offices, depending on space availability.

The nurse leaders were recruited on the basis of the leadership positions they held. They were contacted in writing individually through their offices and given the prerogative to send their representatives if they were not able to come. They consisted of representatives from health training institutions, Ministry of Health, and professional nursing and midwifery organisations. They were invited individually to participate in a focus group at a set date and time.

Ethical considerations

A Country Advisory Committee, which was approved by the Ministry of Health, was selected to guide the study and oversee ethical conduct of the study. The study was approved by the relevant institutional review boards. Written permission was also obtained from the health facilities and districts or regional offices where respondents were recruited. Community leaders and nurse leaders were individually written to, requesting them to participate. Patients were selected through the assistance of the nurses in charge of facilities and units in the health facilities. Each patient was also requested to participate individually, and to read and initial a consent form after a full

explanation of the purpose, specific objectives, design and ethical considerations of the study. All respondents were also requested to sign a confidentiality statement for protection of information discussed at FGD meetings.

Study measures

A brief 5 item socio-demographic questionnaire was completed by each respondent at the start of the FGDs. The instrument asked about the respondent's age, educational level, position, whether they have received care from or have worked with nurses and midwives before, and in what capacity they did. The FGD guide entailed questions discussed in the study aims. All study measures for patients and community leaders were translated into Setswana for easy comprehension.

Data collection, analysis and management

The focus group discussions of 5 to 10 members per group were guided by the research objectives in Setswana. Respondents were requested to use fake names throughout the data collection process, and their written information was coded to eliminate any identifiers. Probing, paraphrasing, rephrasing, summarising techniques were used to facilitate discussions and generate information. All FGDs were audio recorded and transcribed verbatim into text. All data were secured under lock and key both during travel and at the PI's office.

The textual transcripts were translated into English, read in their entirety and analysed line by line using qualitative description analysis to generate discussions on respondents' perceptions about the tasks and roles that nurses and midwives perform, are not performing but expected to perform or are performing but are not expected to perform. The main themes were generated and the emerging sub-themes were categorised under these main themes.

RESULTS

Socio-demographics of respondents

A total of 8 focus groups were conducted as scheduled in the selected settings. A total of 68 people consisting of 45 patients, in five focus groups ranging between 8 and 10 people, 18 community leaders in 3 focus groups ranging between 5 and 8 people, and one group of 5 nurse leaders participated. Table 1 presents the sample characteristics.

Table 1: Characteristics of the sample

	Patients	Community Leaders	Nurse Leaders
Age	19 to 63 years Mean age 29 years	29 to 70 years Mean age 45 years	43 to 54 years Manager 45 years
Gender	16 men and 29 women	7 women, 11 men	All women
Educational level	No education (2), Primary education (5), Junior secondary education (10), had senior secondary education (6) The rest had tertiary education	Std 7 (grade 7) to university degree (most had university degrees)	All had university degrees and post graduate qualifications in a nursing specialty
Having received care from nurses before	All had and were receiving care from nurses	Only three said they had never received care from nurses while the rest had	All had received care from nurses
Having worked with nurses before	All had worked with nurses either as patients or in some community work such as AIDS campaigns	All had worked with nurses as members of the extension team (which entails all community leadership)	All are nurses and had worked with other nurses as trainees, trainers, and supervisors

Emerging themes

The themes and their corresponding sub-themes are presented below. The main themes were: understanding of nursing and midwifery, expected characteristics and behaviours of a nurse, most important roles that nurses and midwives perform, and tasks that nurses and midwives perform but are not expected to perform.

Understanding nursing and midwifery

This theme addresses the perspective of participants regarding what nursing and midwifery are. Participants provided the following information below.

The nurse/midwife is the backbone of the health care system

Participants explained or clarified what they understood about nursing or midwifery. They explained that a nurse is the backbone of the health care system in Botswana and that in the majority of health facilities she/he is often the sole health worker providing all levels of care. One community leader said:

> We do not see any other health worker except a nurse. May be that is why we expect a lot from the nurse. You are talking about pharmacists and laboratory personnel, but we never really see those, let alone seeing a doctor (FDG male).

In addition one patient said:

> Ever since I was admitted here a week ago I have only been seen by a doctor once, but nurses are there all the time, whatever I need I call a nurse because that's who I see all the time. Sometimes they call the doctor and he doesn't come (FDG male patient).

They also clarified that a midwife is the person responsible for conducting deliveries. One participant said:

> A midwife is a nurse who only works with mothers who give birth. Sometimes she takes care of children, but the women should know more about that (FDG male).

Nurse leaders were clear about the role of the midwife, such as caring for child-bearing families during pregnancy, labour, delivery, after birth, child care, family planning, family/maternal education and anticipatory guidance. They also know that midwifery in Botswana falls under the category of advanced practice nurses if they have a post-basic diploma or nurse specialists if they have a master's preparation.

The nurse/midwife has independent, interdependent and dependent roles

The nurse was also described as having independent and interdependent roles. Participants said they understood that a nurse frequently has to do certain activities on her own without relying on anybody. They also indicated that the nurse may need the help of a doctor to deal with some complicated cases. This is recognition of the collaborative role of the nurse as a team player. However, they complained that they hardly ever see a doctor in their remote villages.

The nurse/midwife operates at different levels for specific roles

Community leaders and patients explained that nurses and midwives have different responsibilities according to their level of education and preparation. They knew that nurses are different cadres, such as those who visit them in the community (community health nurses), those who teach (nurse educators), and those who manage health facilities. On the other hand nurse leaders enumerated the different advanced practice and specialist levels of nursing, including, nurse-midwife, family nurse practitioner, nurse-anesthetist, nurse manager, nurse educator, pediatric, occupational health, community health, ophthalmic, psychiatric/mental health, oncology, neonatal, critical care, trauma and adult health nurse.

Expected characteristics or behaviours of a nurse/midwife

Respondents indicated that they expected a nurse/midwife to be most receptive and welcoming to patients. She/he must be kind, calm and collected even during times of emergency or when patients are scared or upset. They are expected to be polite, respectful, sympathetic, responsive and timely in carrying out nursing duties. One respondent said:

> They are not supposed to leave us on a queue and go for tea for too long. We understand that they need a break, but they take too long. Even when they come in the morning they take time charting with each other while we wait for them. They need to understand that we as patients are tense because the hospital is not a place where you want to be (FDG female).

Nurse leaders also concurred with these expectations. They added the observational role, that the nurse must be alert and observe changes in patient behaviour and take appropriate action.

Most important roles that nurses and midwives perform

Respondents stated a number of roles that nurses and midwives routinely performed. These included caring roles, providing different tasks of care. Other roles were leadership and management roles, teamwork and advocacy roles.

Caring roles

Community leaders and patients clarified the caring role of a nurse as including care to individuals, families and communities who needed nursing care. They provided physical care, emotional/affective, spiritual (praying with patients or inviting priests to pray, or anointing patients during life threatening situations or at the time of death). They also allay anxiety to patients who are distressed, and support families during bereavement. Other roles include consultation, making diagnosis, prescribing and dispensing and giving medications, prescribing investigations (laboratory and X-ray), taking and transporting specimens including taking blood, were included as caring tasks of the nurse. The tasks included attending to basic needs of patients such as bathing, feeding, grooming, helping them to walk, giving medications, inserting and changing drips. Caring behaviours mentioned by all included that the nurse/midwife must receive patients with kindness, give hope to patients for recovery, give emotional support, respond empathetically to patients, allay anxiety and display humility.

Respondents expected every aspect of care from the nurse/midwife to meet patients' needs, especially in the rural areas where the nurse is often the only health care provider available. In addition they have the responsibility of explaining procedures to patients and clarifying roles of different health care providers so that they know what to expect

from them. It was further explained that nurses often fail to provide some of these basic care routines expected of them. One participant said:

> It is not unusual to find a patient not bathed, miserable in bed in dirty linen, with food on the bedside locker that was dished hours ago, which indicates that the patient had not been attended to (FDG female).

The nurse leaders, however, embraced all the other roles mentioned. They enumerated other caring tasks by nurses/midwives such as providing holistic care to individuals, families, including conducting assessments, making a nursing diagnosis, prescribing appropriate nursing care, making plans to provide nursing care. Nursing care activities mentioned by the nurse leaders included checking vital signs and routine comprehensive head-to-toe examination. Nurses also perform functions that meet personal hygiene needs of patients (bathing, turning, positioning and ambulating patients, caring for back and pressure parts, giving passive exercises, grooming, oral care, hair care), counselling, support, suturing wounds, removing stitches, dressing wounds. Nurses also advocate for patients, provide immunisations, respond to patients in a timely manner, orientate patients to their environment and visit patients at home and make referrals as per patients' needs. They monitor and evaluate care activities and clients' responses. However, nurse leaders did not seem to concur with the idea of nurses performing other roles such as venipuncture, consultations in out-patients settings, medical prescriptions, and dispensing, which they thought were the role of an advanced practice nurse or nurse specialist, and other health workers such as doctors, pharmacists and laboratory personnel. They suggested that nursing legislation and standards should assist in clarifying these roles.

Leadership management, supervision, mentoring and teaching roles

Respondents believe that a nurse/midwife manages health facilities to ensure that resources are available and that the work routines flow smoothly to meet patients' needs. In hospitals they serve as managers in the wards, and provide overall management of the health facility and collaborate with other health care providers for their interdependent roles. They lead health care teams in many programmes and in specific units. They are expected to prompt students in the clinical area; orientate new employees; mentor new nurses and other health workers, including junior doctors. One nurse midwife said, 'Many young doctors have passed through my hands, and I have mentored them and taught them routine maternity care' (FDG female nurse leader).

Tasks that nurses and midwives perform but are not expected to perform

Community leaders did not have much under this theme because they expect the nurse/midwife to perform any tasks required for patient care as they are often the only health

care provider at their disposal. However, they did not expect a nurse to perform major operations. They clarified that it is the task of the doctor.

The nurse leaders explained that they did not expect major surgery, including cesarean sections to be performed by nurses or midwives. Also, in accordance with the *Nurses and Midwives Act*, they would not expect a nurse to perform a venipuncture to give intravenous drugs or blood, unless in an emergency, but they could change a drip or give prescribed drugs intravenously through an already inserted cannula. They also agreed that an advanced practice nurse such as a nurse midwife or family nurse practitioner can perform such tasks, taking cognizance of the reality of the health care situation and patents' needs, but that relevant clauses must be in the regulations and covered in the legislation. They lamented that other patient personal hygiene tasks such as bathing, feeding patients and transporting uncomplicated patients, sluicing, checking vital signs, transporting blood specimen, should be shared with other health workers such as auxiliary staff, under the supervision of the nurse/midwife; so that the nurse/midwife can focus on other more compelling tasks.

DISCUSSION OF FINDINGS

Nurses and midwives are the frontline service providers in the remotest areas of the country, and must cover a wide range of health care services for which they should be trained for. Wakaba *et al*. (2014:2) also reported similar sentiments for Kenyan nurses. The community leaders expect nurses to be welcoming, kind and respectful to patients, concurring with the findings by Seboni *et al*. (2013:5) and Ugochukwu *et al*. (2013:123). Nurse midwives are usually the first providers of care at birth and death of individuals (Schwartz, 2009). The participants alluded that midwives' care is safe. Schwartz (2009) supports this finding and maintains that midwives' care is safer than that of medical doctors.

There were some differences between nurse leaders and the community (patients and community leaders) in their perception of certain roles and tasks performed by nurses/midwives. While community leaders spoke of a nurse as expected to everything at any level, nurse leaders further identified the different advanced practice and specialty roles of the nurse. The latter seemed to have reservations about certain roles expected by the community. This role confusion was also identified by Daly and Carnwell (2003:159) in the UK and Blanchett (2015:75) in Rhode Island, attributable to the changing roles of the nurse, community expectations versus nurses' perception of their roles. However, the expanded role of the nurse/midwife must be regulated and legislated, to protect them from being subjected to litigation. They should be trained, and they should acquire necessary levels of competence and be accountable for their newly acquired practices. Seboni *et al*. (2013) purport that nurse midwives must advocate for the patients against ill treatment and exploitation by other health care workers, as well as for progressive policies and adequate resources for provision of health care.

Daly and Carnwell (2003:160) clarify the differences between role extension, role expansion and role development. Role extension refers to the inclusion of a particular skill or a particular area of practice responsibility that was not previously associated with the nurse, but associated with another professional domain, for example, giving intravenous injections. Role expansion refers to roles encompassed within the specialist role of the nurse that involves greater responsibility, accountability and autonomy in the area of specialisation that may also have been previously associated with another professional domain. The education of such is often more formal and entails the contribution of other professional and educational institutions. Role development refers to higher clinical autonomy brought about by new demands in the quality of care and health resources. These new roles are normally associated with higher academic qualifications at institutes of higher learning to improve cognitive and perceptual domains. The WHO Munich Declaration on Nursing and Midwifery (2000; 1) emphasises that nursing should be concerned with meeting immediate individual and family needs. This therefore suggests that clarification is needed in the laws and policies of levels of independence, interdependence and dependence as new roles emerge and are expected to be taken by nurses.

CONCLUSION AND RECOMMENDATIONS

It is clear from the data and discussions that nurses and midwives are expected to acquire additional responsibilities and perform additional tasks that were not originally the domain of nursing or midwifery, dictated by the ever changing needs of patients, developments in health care systems and resource constraints. However, from the literature, it is also critical that clarity be maintained, and as levels of responsibility, accountability, autonomy and recognition change, the educational levels must also change so that the nurse is competent to practise within the scope of new roles and tasks safely. Participants also add that if the nurses are to perform these roles, then appropriate reward systems must be in place to match new expectations.

Implications for nursing and midwifery regulation and policy

The regulatory system must keep up with the changing roles of the nurse and accommodate these in the scope of practice and clinical standards so that the nurse and midwife are legally covered in the performance of the expanded, extended or developed roles expected by the community. The Nursing and Midwifery Council must also ensure that nurses/midwives acquire the appropriate level of education required for the role. Modalities for working out new roles, shared roles and shifted roles must be worked out with proper consultation, to reduce public and stakeholder confusion on the roles and tasks of the nurse.

Implications for nursing and midwifery education

Curricula for schools of nursing and other educational institutions must accommodate newly prescribed (expanded, extended or added) roles to keep up with new client needs and changes in the legal framework of nursing and midwifery practice.

Implications for nursing research

Further research is need to clarify the basic roles of the nurse and clarify the expanded, extended and added roles, and community expectations, in order to inform regulatory/ policy, educational and practice changes required from the perspective of other health care providers to avoid role confusion and clashes.

LIMITATIONS OF THE STUDY

This study is a qualitative study and reports only respondents' expectations about the roles and tasks of nurses and midwives. The results can only apply to the group that has been studied and cannot be generalised. Therefore the results are not generalisable to a wider population in Botswana.

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