Article

A Comparative Study of the Development of Nursing and Midwifery Educators in Togo and South Africa: Implications for Nursing and Midwifery Education

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Abstract

Background: The critical role of nurses and midwives in the maintenance and promotion of health has been highlighted throughout the Covid-19 pandemic, which coincided with the World Health Organisation (WHO) Year of the Nurse and the Midwife 2020. Both these events have been a reminder of the worldwide shortage of nurses and midwives and the need to educate more nurses and midwives to meet current and future health needs. High-quality nursing and midwifery practice requires nursing and midwifery educators with both clinical and teaching skills.
Aim: This comparative case study aimed to identify factors that may influence the development of nursing and midwifery educators in Togo and South Africa.
Method: Using a case study research design informed by the Primary Health Care Nursing Roadmap Framework, the study examines the factors in two countries in Sub-Saharan Africa, Togo, and South Africa, which influence the development of nursing and midwifery educators. The collection of data in Togo took the form of an educational needs assessment and document review. In South Africa, semi-structured interviews were held alongside a content analysis of curriculum documents.
Results: The case studies identified social and cultural factors which affected the development of nursing and midwifery in Togo, and South Africa. The learning needs of nurse and midwifery educators in Togo were identified.

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Conclusion: The case studies enabled the comparison of two countries in which the development of nurse and midwifery educators has been very different. The development of educators in Togo requires the provision of a programme of development in the country. Such a development could be supported by international links which will contribute in addition to mutual learning between the partners.

Keywords: Education; Faculty; Nurses; Midwives; Sub-Saharan Africa

1. Introduction

It has been recognised by the World Health Organisation (WHO) and others that one of the greatest challenges to achieving Universal Health Coverage (UHC) and Sustainable Development Goals is the need to increase the numbers of healthcare practitioners and, in particular, nurses and midwives (WHO, 2016; WHO, 2020a). As Drennan and Ross (2019) have shown in their policy and other literature reviews, the nursing workforce's shortfall is a global issue. It is estimated that six million more nurses need to be trained by 2030 to meet the predicted shortfall which impacts particularly on countries in Africa (WHO, 2020a). Sub-Saharan Africa is particularly hard hit by the lack of nursing and midwifery personnel, having 11% of the world's population, suffering 24% of the global disease burden but with only 3% of the world's health care workforce (Edmondson et al., 2017).

Increasing the number of nursing and midwifery personnel requires sufficient and well-prepared nursing and midwifery educators. WHO (2016) identified this pre-requirement in the Global Strategy on Human Resources for Health: Workforce 2030 (see Figure 1). These educators need teaching and clinical expertise to prepare nurses and midwives for work in primary health care (PHC) focused health systems. Even in countries with well-developed nursing and midwifery education programmes, most of the nursing and midwifery educators have acute hospital expertise rather than having primary or public health care competencies. Bvumbwe and Mtshali (2018, p.2) note: "Efficient production of nurses with relevant competencies remains a critical role of nursing education. Improvements in nursing and midwifery education are recognised as essential in increasing workforce numbers and enhancing the quality of health care and health systems." In their review of nurse education in Sub-Saharan Africa, these authors identified six themes that need addressing to improve nursing education in this region: curriculum reforms; professional regulation; transformative teaching strategies; collaboration and partnerships; capacity building and infrastructure and resources. The review draws on literature to support the need for reform in all these areas and nursing education and midwifery programmes in the region, for example, in relation to changes in curriculum delivery from didactic/educator-centred teaching to interactive/student-centred approaches (Jones, et al., 2018).

These findings and recommendations are reinforced in the WHO (2021) Global Strategic Directions for Nursing and Midwifery 2021-2025 which identifies, within the

priority area of education, the deficits in the preparation of midwifery and nurse educators: 'Shortages of quality faculty to educate midwives and nurses are a widespread problem, particularly at the bachelor degree level and above' (WHO, 2021p.7). The report identifies the development of nurse and midwifery faculty as a policy priority: 'Ensure that faculty are properly trained in the best education methods and technologies, with demonstrated expertise in content areas' (WHO, 2021p.10). In summary, without sufficient well-prepared nursing and midwifery educators there can never be sufficient nurses and midwives to meet health care needs.

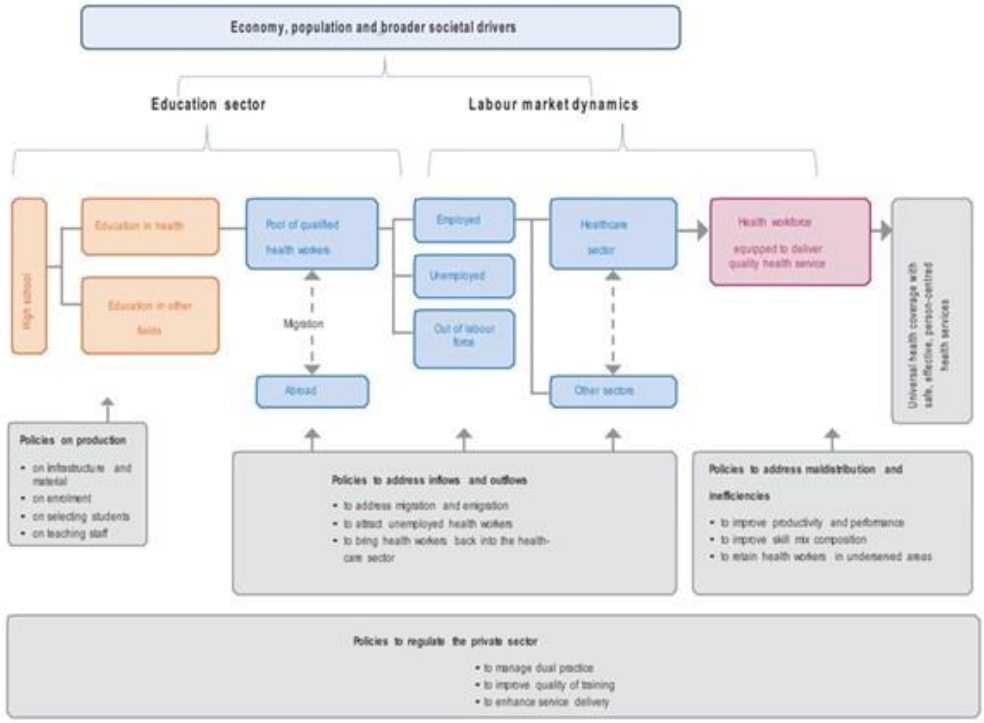

Figure 1: Policy levers to shape health labour markets.

(From "Global strategy on human resources for health, *Workforce 2030*" (WHO, 2016, p.13).

As indicated in Figure 1 the provision of health workers, in this case nurses and midwives, rests on having sufficient educators for these professions. To examine the issues around the provision of nurse and midwifery educators, this paper presents a comparative case study of two African countries: Togo and South Africa. In addition to the connections made between nurse and midwifery researchers at a conference hosted by the University of South Africa (UNISA) and the UK charity International

Collaboration for Community Health Nursing Research (icchnr.org), these countries are chosen because they are significantly different in the context of the qualifications of the nurse and midwifery educators, approaches to curriculum delivery and teaching resources. In South Africa, most of the midwifery and nursing educators have master's level qualifications and the approaches to curriculum delivery are mainly facilitative and didactic sometimes. Unlike Togo with limited resources, the curriculum delivery approaches are didactic, and the educators only hold a clinical practice diploma in nursing or midwifery.

In this paper, we first present the theoretical framework which informed the work followed by the research design, case study. Information on each country then provides the context impacting educators of nurses and midwives. The results of the data collected are then presented followed by a discussion and recommendations.

2. Theoretical Framework

This study was informed by a theoretical framework developed both deductively, from pre-existing theory and research, and inductively, from evidence from the practice of PHC nurses (Polit & Beck, 2017; Bryar & Sinclair, 2011). The PHC Nursing Roadmap was developed as part of work commissioned by the International Centre for Human Resources to examine the contribution of PHC nursing to the implementation of PHC reform following the publication in 2008 of *Primary Health Care: Now More than Ever* (WHO, 2008). An in-depth literature review was undertaken by the three authors of the Framework (one from South Africa and two from the UK) and a call for practice examples from nurses working in PHC was made via the website of International Collaboration for Community Health Nursing Research (ICCHNR). This call generated case examples from countries across the world. Drawing on the case examples and the literature, a Framework was developed illustrating the five key elements of effective PHC nursing, the seven workforce elements that underpin effective practice, and the need for PHC nursing services to be embedded in Positive Practice Environments (an approach to workplaces relaunched by the World Health Professions Alliance, 2020) (see Figure 2). The Report was translated into French and Spanish and disseminated in 2012 to all nursing association members of the International Council of Nurses. The PHC Nursing Roadmap provides a framework which may be used in any country to assess the current position of PHC nursing and the areas which need to be developed to improve PHC nursing (Kendall & Bryar, 2017; Spies et al., 2018).

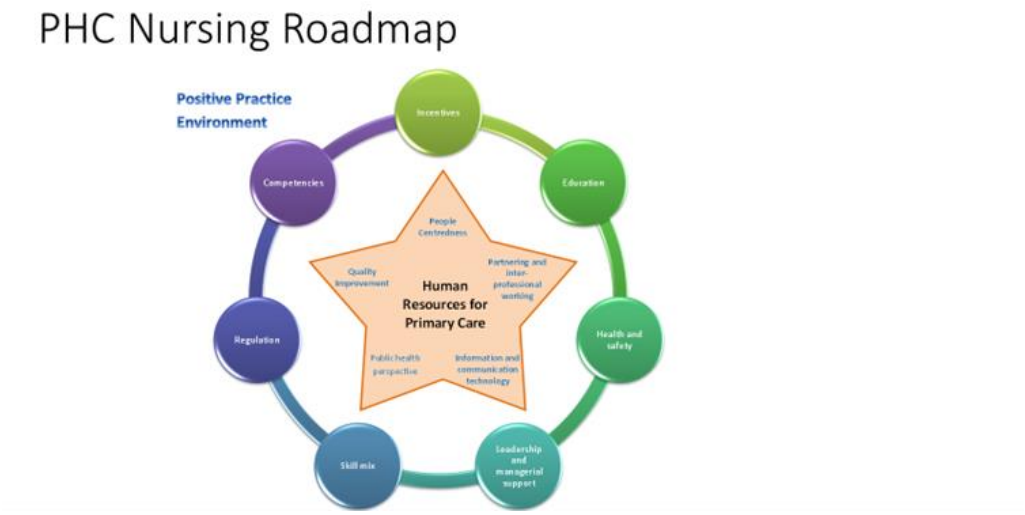

Figure 2: PHC Nursing Roadmap (Bryar, Kendall & Mogotlane, 2012, p.14).

3. METHODS

Design

In this paper, we present two case studies of the development of educators of nurses and midwives in two Sub-Saharan countries, Togo and South Africa. Case study research designs enable the collection of data which may then be used for in-depth analysis of a phenomenon to inform, for example, a service development (Heale & Twycross, 2018). Specifically, this study opts for a comparative case study design, as it enables the identification and in-depth cross-comparison of the factors which may influence a phenomenon, in this case, the development of educators of nursing and midwifery (Takahashi & Araujo, 2020).

Aim of the study

This comparative case study aimed to identify factors that may influence the development of nursing and midwifery educators in Togo and South Africa.

Research questions

1. What are the historical, cultural, and professional factors which have influenced the development of nursing and midwifery in Togo and South Africa?
2. What information does the PHC Nursing Roadmap provide concerning how nurses and midwives are currently prepared in the two countries?
3. What preparation do nurses and midwives have to become educators?

4. What are the specific educational needs of nurse and midwifery educators in Togo compared to the educational needs of nurse and midwifery educators in South Africa?

Data collection

The collection of data was informed by the Framework provided by the PHC Nursing Roadmap.

Case study 1: Togo

In Case Study 1 data were collected by three authors (RB, RB, JS) using a questionnaire which informed observation, interviews and group meetings attended during a visit to Togo. Notes of interviews with nurse and midwifery teachers and school directors were also independently taken by the three authors. Documents collected during the visit also form part of the data collected. A literature search was undertaken concerning nursing and midwifery education in the country but yielded little information reinforcing the need for the assessment visit.

To address the four research questions an educational needs assessment was undertaken to identify in more depth the factors impacting the development of nurse and midwifery educators in this country.

The School of Health Sciences, City, University of London was approached in December 2014 by the charity Vision Togo with a view to identifying and supporting the educational needs of nurses and midwives in Togo through investigating and providing any support needed to the nursing and midwifery educators. Vision Togo, a UK registered charity working to support the delivery of health care in Togo, had become aware during their work of the challenges facing the educators of nurses and midwives in the country. With funding from the Tropical Health Education Trust (THET), an educational needs assessment visit was undertaken in April 2016 by three of the authors (RB, RB, JS). In preparation for the visit, meetings were held with representatives of Vision Togo, and email contact was made, through Vision Togo, with the head of the Ecole Nationale Des Auxiliaires Médicaux (ENAM) in Lomé, the lead provider of nurse education in the country. A plan for the visit was drawn up in collaboration with the partners above. There are only two schools in Togo that prepare nurses and midwives at BSc level. In both schools sampling of teachers was opportunistic. Arrangements were made with the support of Vision Togo for the three representatives from the School of Health Sciences, City, University of London to undertake the needs assessment visit.

To enable the collection of information during the visit in a systematic manner, a questionnaire was developed based on the Framework provided by the Primary Health Care Nursing Roadmap (Bryar et al., 2012) (see Appendix 1).

The underpinning aim of the needs assessment was to gain an understanding of how the seven workforce elements (see Figure 2) impacted the nurse and midwifery educators, health care education and practice in Togo. A series of questions were developed in relation to each of the seven workforce elements. The questions were translated into French by a French-speaking member of the City team and shared with the French-speaking project lead in Vision Togo who discussed the questions with nursing and midwifery educators in Togo. Following this discussion, the questions were modified in French in response to their comments. The questions were then translated back into English by the City team member. The final list of questions was grouped under the seven workforce elements of the Roadmap as shown in Appendix 1. The steps taken in the development of the data collection tool, the needs assessment questionnaire and the data collection process, were aimed at enhancing the study's dependability.

As the focus of the needs assessment was on education, the most detailed information collected was related to the Education questions. However, the questions relating to the other workforce elements were also useful, for example, in identifying issues around the lack of regulation of nurses and midwives and employment practices restricting the employment of nurses and midwives on qualification.

During our visit, we met with nursing and midwifery faculty and visited classrooms used for teaching theory and practical skills. In the main school in Lomé we met with individual teachers and participated in a large group meeting with the head of the school and all the teaching staff. At the smaller school in Kara, we met the head of the school and approximately five midwifery and nurse teachers. We were given copies of documents relating to a new nursing bachelor's degree that had recently been developed and implemented with international input.

As a preliminary needs assessment in preparation for setting up a possible partnership ethics approval was not required. The teachers who participated in the discussions volunteered to participate and could withdraw at any time. Only the name/location of the schools is reported here.

Case study 2: South Africa

In case study 2, ethical approval was gained from the College of Human Sciences Ethics Committee at the University of South Africa. Permission to conduct the study was sought and granted by each of the institutions that participated in the study. Consent was sought and obtained from each participant before data collection. They were reassured that the information they provided would be anonymised and treated with the strictest confidence. Confidentiality was maintained throughout the study.

Data were collected by one of the authors (PS) using individual interviews guided by a semi-structured interview schedule from nursing and midwifery educators of one institution in each of the nine provinces (Gauteng, Kwazulu-Natal, Eastern Cape, Mpumalanga, Limpopo, Northern Cape, North West, and Western Cape) that offer

nursing and midwifery education. Two nursing and midwifery educators with at least two years of experience in teaching and learning in these fields from each of the institutions were selected purposively and interviewed. The semi-structured interview schedule contains the same questions as the ‘education needs assessment questionnaire’(Appendix 1). While this allows for a comparison of data from the two case studies, it strengthens the study’s dependability. The interviews were conducted in private rooms in the institutions where the nursing and midwifery educators work. The interviews lasted for about an hour, they were digitally recorded, and field notes were taken. Data collection also took the form of qualitative document analysis of curriculum documents of the institutions that participated in the study. This approach highlights the study’s confirmability.

Data analysis

Case study1: Togo

The written notes taken during the interviews were analysed iteratively while we were in the country in discussions at the end of each day which informed and extended the collection of data on subsequent days (Hennink et al., 2020). On our return to the UK, the field data we had collected was analysed, using a content analysis approach, informed by the topics in the questionnaire which was based on the Framework provided by the PHC Nursing Roadmap (Cresswell & Poth, 2024). The limited literature we identified was analysed using the same content analysis approach. The data collection and analytical steps strengthened the confirmability of the study.

Case study 2: South Africa

The digitally recorded data were transcribed and analysed using the framework approach by one of the authors, PS (Ritchie & Spencer 1994). It has six distinct but interrelated stages (see Figure 3) (Ritchie & Spencer 1994) that lead to the development of a thematic framework enabling researchers to code and organise data into themes (Ritchie & Spencer 1994). To ensure confirmability, the curricula documents were analysed using content analysis to understand the meaning of the textual material (curriculum documents).

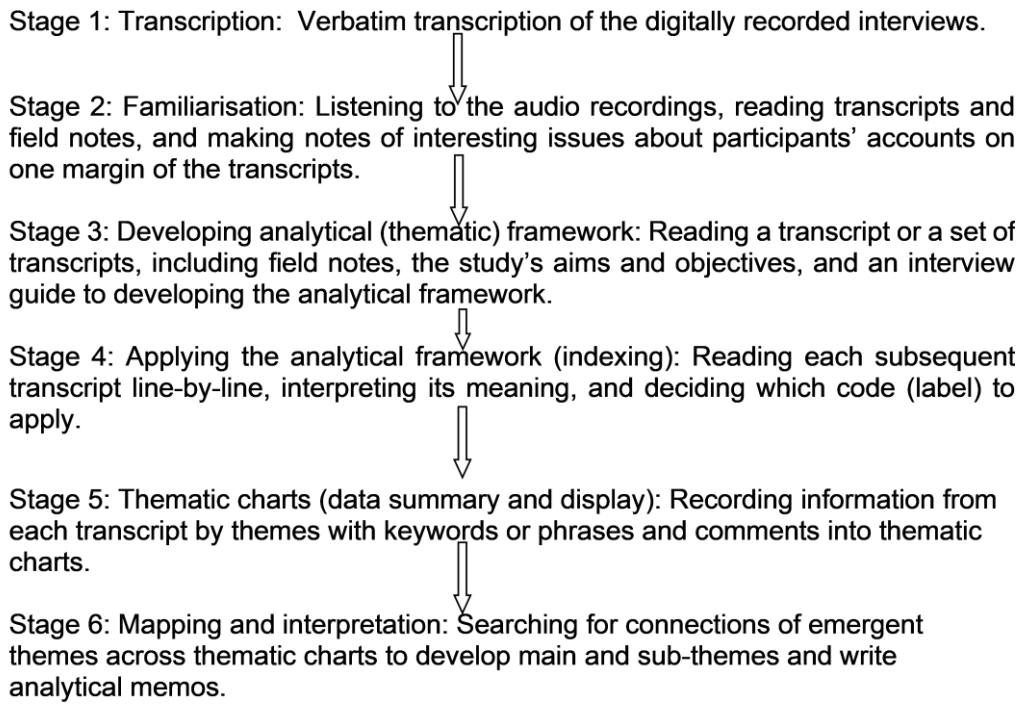

Figure 3: Analytical stages of the framework approach (Ritchie & Spencer 1994)

4. Results

In the following sections, a narrative approach has been taken bringing together the data collected in and about each country through the interviews and literature sources. Firstly, an overview of each country is presented. These are followed by an outline of the current position of nursing and midwifery education in each country. Finally, the data concerning the education of educators of nurses and midwives in both countries are presented. The aim of presenting the results in this manner is to contextualise the education of nurse and midwifery teachers, the focus of the case studies within the respective countries and the nurse and midwifery education in each of the countries. This approach would ensure the transferability of the study findings.

Case Study 1: Togo - Historical and cultural factors

Togo is a small Francophone country which gained independence in 1960. It is a small country situated in sub-Saharan Africa bordered by an Atlantic coast to the south, Ghana to the west, Benin to the east and Burkina Faso to the north. It experiences to a significant degree many of the characteristics of other countries in sub-Saharan Africa. It has a population of 7.6 million, a life expectancy of 60 for men, and 62 for women, maternal mortality of 450 per 100,000 live births and under 5 mortalities of 70 per 1,000

live births (WHO, 2020b). In 2015, there were approximately 2.98 nurses and midwives per 10,000 population in Togo, the fourth lowest number in the Africa Region (WHO, 2019). WHO (2020) reported that there were 2.5 nurses per 10,000 population of whom 79% were male and 21% were female. In the African region, there was a density of 8.7 nurses per 10,000 population in 2020 (WHO, 2020). Most nurses and midwives work in the capital Lomé and in the city of Kara in northern Togo, with rural clinics run by nurses and midwives throughout the country. Sanwogou (2013 p.350) commenting on nursing in Togo states: "The health sector in Togo has experienced a serious deficit in human resources over a long period of time." In 2010 nurses formed 50% of the health workforce in Togo but Sanwogou (2013) was not able to identify any specific nursing strategy for the country.

Case Study 2: South Africa - Historical and cultural factors

South Africa is situated on the Southern tip of the continent of Africa in its sub-Saharan region. Coastlines in the west, south and east, and Namibia, Botswana, Zimbabwe and Mozambique in the north, border South Africa. In 2016, the South African population was estimated at 56.5 million with a life expectancy for men of 60 years and for women of 68 years and an under 5s mortality in 2018 of 34 per 1,000 live births (WHO, 2020c). Approximately, 65% of this population mainly reside in rural areas with a potential for exposure to conditions such as the human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS), and non-communicable diseases (e.g., diabetes and hypertension) (UNAIDS, 2016a).

South Africa bears a significant burden of HIV in the world, with over 7.0 million of its citizens living with this disease. In 2016, HIV/AIDS-related deaths were estimated to be approximately 110,000, with 270,000 estimated new HIV infections (UNAIDS, 2016b). It has an average HIV prevalence of 18%, suggesting that about one in every 20 of its citizens lives with HIV (WHO, 2014). Given this, South Africa is considered to have a generalised HIV epidemic (UNAIDS 2016b).

Non-communicable diseases such as hypertension and diabetes are common among people living with HIV (Peltzer, 2018). Generally, there is an increase in the burden of non-communicable diseases in South Africa, which Oni et al. (2015) claim account for approximately 37% of mortality and 16% of disability-adjusted life years (DALYs). These diseases, including HIV/AIDS and tuberculosis, are prevalent largely in rural provinces. For example, KwaZulu Natal province has a prevalence of 27% of HIV and the Free State province has an HIV prevalence of 26% (UNAIDS, 2016b).

Given the disproportionate distribution of the burden of communicable and non-communicable diseases, the South African health system is built on the principles of PHC for several reasons. Primary health care has the potential to deliver equity in health care, as it ensures easy access to health care services by all South African citizens. It adopts an integrated approach to care and emphasises community participation for improved healthcare, and equitable healthcare delivery for all (Demaio et al., 2014).

Most of the healthcare professionals (80%) providing PHC services in South Africa are nurses (Mash & Blitz, 2015). As its PHC system is nurse-driven, nurses are well placed to coordinate care for patients, including those with complex disease profiles such as patients with a co-morbidity of HIV/AIDS and non-communicable diseases. Yet South Africa experiences a significant shortage of nurses. In 2015, about 391517 nurses were registered with the South African Nursing Council (SANC, 2016a). This figure rose to 401543 in 2016 (SANC, 2016a). Despite the increase, the ratio of nurses to the population, 13.1 per 10,000 population (WHO, 2020a), is regarded as low taking into consideration demand factors like service use patterns and the inclusion of non-practising nurses on the South African Nursing Council's register. The shortage of nurses serves as an obstacle for South Africa to achieve health system effectiveness, including universal coverage.

Education of nurses and midwives: professional factors

In 2014 Klopper & Uys (2013) published a report with the aim of providing a comprehensive review of the state of nursing and nurse education in the 23 countries in sub-Saharan Africa. The authors aimed to inform colleagues planning nurse education exchange programmes, inform funders, demonstrate the role of nurses in policy making and give African nurse educators a voice. Nursing and midwifery education in Africa has a long history and has been strongly influenced by the European colonising countries which occupied the various parts of the continent. Uys (2013 p.12) comments that this influence is still evident today; for example, in Francophone countries, such as Togo, the view of nursing and midwifery reflects that of France: "… where the nurse is still perceived as a handmaiden to the doctor, with very little independent practice, and midwives are almost unknown." Concerns about this ongoing influence are reflected in the title of a symposium held by the South African Student Nurses' Association in 2018: Decolonisation of the Nursing Curriculum by the South African Nursing Students' Association.

Case Study 1: Togo–Education of nurses and midwives

Nurse education was first established in Togo in 1945 in the capital Lomé with a second school for nurses and midwives established in the north of the country in Kara as recently as 2010. Nurses and midwives graduate from these schools as registered nurses or midwives. In addition, there are programmes that lead to a license as a midwife or nurse at a third school in Sekode, near Kara. The schools are administered by government ministries and are not part of a university. There are two universities in Togo, both established since independence: The University of Lomé in 1970 and the University of Kara in 1999. As Uys (2013) comments the lack of a long-standing higher education system has affected the development of more highly educated health professionals. However, the existence of the two universities offers potential in terms of the future development of nursing and midwifery.

Case Study 2: South Africa–education of nurses and midwives

The provision of quality care by healthcare professionals, including nurses, is considered a right for all South Africans. Thus, the South African Nursing Council (SANC), through the Nursing Act No 33 of 2005, regulates the education and training of nurses (Department of Health, 2013a; SANC, 2016a). In this context, the remit of the Nursing Council is to promote the provision of quality nursing services, set standards for the provision of quality nursing education and training, and set and review the scope of nursing practice.

The National Department of Health and the Department of Higher Education and Training are responsible for nursing education and training. The responsibility of the National Department of Health lies in the provision of nursing services, whilst the Department of Higher Education and Training focuses on the education aspect of nurse training. The training and education of nurses take place in facilities entitled "nursing education institutions," which are grouped into three categories: public nursing colleges, private nursing schools and university nursing departments (SANC, 2013b). The nursing education institutions can only train and educate nurses once accredited by the South African Nursing Council which requires nursing education institutions to meet specific quality standards. There are over 200 nursing education institutions, which in total train about 3500 nurses every year with varied qualifications (Mahlathi & Dlamini, 2017). Nurses head the nursing education institutions, and the teachers of these institutions have a master's qualification in nursing while a small number have a doctoral qualification in a nursing-related field.

According to the Nursing Strategy (SANC, 2013a), nursing education institutions offer three nursing programmes with varying lengths of training and education: a higher certificate in nursing, a diploma in nursing, and a bachelor's degree in nursing and midwifery. The higher certificate in nursing programme runs for one year, and nurses who complete the programme are referred to as auxiliary nurses. This programme enables these nurses to develop skills and knowledge to offer basic nursing in all clinical areas. The diploma in nursing programme is offered for two years equipping its diplomats (referred to as staff nurses) with ethics and research knowledge and skills to practice nursing in an accountable manner. The final programme, the bachelor's degree in nursing and midwifery, runs for four years. These graduates, known as professional nurses, are expected to utilise research knowledge and evaluation skills in the delivery of high-quality nursing care. While the variations in the lengths of these nursing training and education programmes are regulated by the Higher Education Qualifications Framework, the graduate nurses are equipped with knowledge and skills to address present and future health challenges in South Africa, including people with comorbidities such as HIV/AIDS and tuberculosis.

Case Study 1: Preparation of nurse and midwifery teachers in Togo

According to Sanwogou (2013), the preparation of nursing and midwifery teachers in Togo is less than optimal. This is a function of the view that most nursing and midwifery educators in Togo only hold a clinical practice diploma in nursing or midwifery and have not gained any qualification in teaching nursing or midwifery (Sanwogou, 2013). A very small number of nurses have master's degrees and in 2016 there were no nurses in Togo with a doctorate. The schools of nursing and midwifery are headed by medical professionals.

On reviewing documents of a new nursing bachelor's degree programme and discussions with the nursing and midwifery faculty, we learnt that most teaching was didactic and that there were very few teaching resources either in the library or practical rooms where what equipment there was, was contained in cupboards. Lack of modern teaching resources may be expected to limit the implementation of modern curricula by nurse and midwifery teachers. We also found that the majority of the nurses and midwives teaching in the Schools did not have teaching qualifications as these are not available in Togo. To obtain such a qualification educators would have to go to a nearby Francophone country for up to two years to complete their qualification. Most educators felt this was impractical as they had families and other responsibilities.

The colleagues that we met were enthusiastic about establishing a link with the School of Health Sciences and we planned to investigate the possibility of obtaining additional funding to support the exchange of educators between Togo and London, to fund learning resources and to develop a two-week educators development programme with the aim of developing skills in teaching both theory and practical skills. Development of the programme for nurse and midwifery educators was dependent on securing funding and was unfortunately halted by the Covid-19 pandemic. As a result of the pandemic, the feasibility of online learning and assessment, which is of course dependent on access to the internet, has been shown, for example in an online development programme for primary care nurses in North Macedonia (Bryar et al., 2023). This new knowledge would be valuable in the development of any future programme for nurse and midwifery educators to be developed with international partners.

Case Study 2: Preparation of nurse and midwifery teachers in South Africa

In South Africa, as in many other European countries (such as Sweden and the UK), a nursing education qualification is a post-registration qualification offered at universities. The nurse lecturers in South Africa are nurses with a four-year first-degree qualification in nursing with an additional qualification in nursing education, registered with the South African Nursing Council. Significant factors that impacted the preparation of nurse and midwife educators, and the development of nursing and midwifery education and practice were the transfer of nursing education to higher

education and the partnership between the South African Nursing Council and the Council for Higher Education in terms of accreditation of nursing education.

The teaching strategies in nursing education institutions vary from didactic to facilitative approaches (Daniels et al., 2015). The methods adopted range from lectures, discussions, videos, and joint project working and seminar presentations by student nurses. Visiting lecturers are sometimes invited but this is often based on need and expertise. The use of the internet is encouraged, as it is a central feature of current information sources. Students are also encouraged to adopt responsibility for their learning and to take an active role in group discussions.

5. Discussion

In 2016 the Triple Impact Report (APPG, 2016) identified the many challenges facing the education of nurses and midwives, not least the need for the educators of these professions to have development opportunities to enable them to lead educational provision and the development of competency-based curricular. This conclusion is also central to the WHO (2020a) report: *State of the World's Nursing. Investing in education, jobs, and leadership*. The histories of the development of nurse education in Togo and South Africa are very different and influenced by the histories of these two countries. In South Africa, the preparation of educators is embedded in the regulation of the professions and in the provision of courses in higher education institutions to address the health needs of South Africans. This includes tackling health inequalities and the high prevalence of HIV/AIDS and comorbidities such as HIV/AIDS and tuberculosis. The graduate nurses in South Africa are better placed to assume these roles of caring for people with HIV/AIDS and implementing interventions for tackling the burden of communicable and non-communicable diseases in the country. In Togo, the lack of regulation of educators coupled with the lack of access to bachelor's and master's degrees for nurses in the country limits their development. Few educators are able to leave the country to study for extended periods in neighbouring countries. This lack of opportunity has an immediate and long-term impact on the delivery of education to nurses and midwives.

The PHC Nursing Roadmap has at its centre Human Resources. The needs assessment visit to Togo was focused on understanding the barriers and facilitators faced by the teachers of nurses and midwives. The teachers are the people who are delivering the programmes to ensure that there are sufficient nursing and midwifery human resources to meet all the health care needs from PHC through to tertiary level care in the country. The Framework ensured a systematic collection of information concerning enabling human resources for health.

Uys (2013 p.12-13) refers to the Africa-US Higher Education Initiative (HEIs), which identified the problems common to higher education institutions in Africa as: "faculty shortage and development; governance, leadership and management; problems with

quality and relevance of qualifications; weak research and innovation capacity; financial austerity and lack of capacity for diversification; poor physical facilities and infrastructure; inability to meet increasing demands for access and

equity." As discussed above, some if not all these issues were evident in the nursing and midwifery schools in Togo. Okoroafor et al. (2022) in a study of health workforce education across Africa identified that in Togo there is an accreditation mechanism for the approval of training institutions. However, in a letter in response to the paper by Okoroafor et al., (2022), Berland et al., (2023p.1) comment in relation to the teaching of nursing and midwifery that: 'In our view, the supply of capable tutors is a critical constraint or "bottle-neck". Many junior tutors have themselves received limited instruction with few opportunities to observe excellent practice and in their new teaching roles, supervisory supports are limited, and their workloads are heavy.' This comment supports our findings during the assessment visit.

The State of the World's Nursing Report (WHO 2020a) indicates that in Togo there is no chief nurse, professional organisations are underdeveloped and there will be a shortage of 20,000 – 30,000 nurses in the country by 2030. The Report also shows that 79% of nurses are men and 21% women, a very different picture to the majority of other countries. Amongst the nurse teachers we met this distribution was evident and shows the economic value of the profession in the country but also raises questions concerning gender equality (APPG, 2016; UN, 2024).

While the report by Uys (2013) is particularly focused on the relationships between African and US HEIs many of the recommendations apply to the educational needs assessment reported here. International partnerships have many benefits for both parties. The APPG (2016) advocates for the mutual learning that takes place in collaborative partnerships between healthcare organisations and institutions in different countries. These partnerships take time to build and require the sharing of knowledge, skills, and resources between partners but as Rolfe et al., (2004p.147) comment: "Part of the power in international collaboration in nursing lies in the comparison between domestic and international practice – so new ideas can be evaluated, and where appropriate, introduced. Sharing knowledge, resources and skills collaboratively has the power to achieve optimal health outcomes more readily than trying to accomplish such outcomes in isolation." Having identified with nursing and midwifery teachers in Togo the challenges they face, it was hoped that together with partners we could begin to address some of these while at the same time continuing to learn about the health challenges in the country (Nursing and Midwifery Education in Togo: needs assessment – Learning at City). In the event, it has not proved possible to take forward these initiatives, but it is hoped the findings and discussion in this article may provide information which could be used by others.

Nurse educators in South Africa have to date neglected the role of indigenous knowledge in the preparation of nurses for clinical practice. The inclusion of this in the

nursing curricula, delivered using participatory approaches (Shaw & Sandy, 2016), would improve the knowledge and skills of nurses and the quality of care and advice they offer to patients who use traditional medicine.

6. Strengths and Limitations

The use of two case studies, Togo and South Africa offered an in-depth exploration of the development of nurse and midwife educators and the delivery of nursing and midwifery education in the two countries. The PHC Nursing Roadmap, which underpins this comparative case study, was developed using case examples from nurses working in PHC across the world, including in South Africa and Togo. This adds to the relevance of the case study and its findings may therefore apply to other countries in the African continent.

In South Africa, data were collected from one institution in each of the nine provinces that offer nursing and midwifery education. It is worth noting that no two institutions are the same, and this is also true for nursing and midwifery educators working within them. Thus, collecting data from all the institutions will add to the rigour of the study. However, the findings of the study provide knowledge for understanding both the preparation of educators and the delivery of nursing and midwifery education in Africa.

In Togo, data was collected making use of a questionnaire and we were given access to teachers and directors at the main institutions for the education of nurses and midwives. One of the main limitations of this educational needs assessment was our lack of knowledge concerning the education and practice of nurses and midwives in France and in Francophone countries. In terms of education and practice setting expectations, it was clear that there were significant differences, for example, in the care of women in labour. Our lack of understanding of the French approach to health care and the education of nurses and midwives was a limitation we had not anticipated.

7. Rigour (Trustworthiness)

Guba & Lincoln's (1994) framework of trustworthiness was used to demonstrate a rigorous approach to the study. The framework has five criteria: credibility, dependability, confirmability, transferability, and authenticity. Examples of their application are given throughout this paper.

8. Conclusions and Recommendations

1. Provision of an in-country or online programme for the development of nurse and midwifery educators in Togo.
2. Support for the development of nurse and midwifery educators by international nursing partners for example through participation in the Nursing Now Challenge: https://www.nursingnow.org/

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Appendix 1

Education Needs Assessment Questionnaire
Education:
• What courses are in place for: nurses, midwives, nurse teachers, nurse managers, advanced nurse practitioners?
• What level are these courses at: diploma, BSc, M, PhD?
• Curricula – practice/theory; hospital/community
• Recruitment of nursing and midwifery students
• How many students are currently on pre-registration programmes?
• Is there a workforce development plan?
• What CPD is available? Who provides this? How is it provided e.g., classroom; one-to-one; online; in country; external to Togo
• Access to journals, newsletters, SMS
Health and safety
• Working conditions in hospitals
• Working conditions in PHC
• Hazards in the workplace
• Infection control
• Safety in the community
• Health of nurses and midwives – physical and psychological
• Access to health care, wellness centres for themselves
• Access to ICT
• Any other issues that affect nurses and midwives' health at work
Leadership and managerial support
• Nursing and midwifery leadership in government
• Nursing and midwifery strategy
• What types of courses are available to develop leaders and managers?
• Recognition of leaders
• Managerial structures in hospitals and the community
• Supervision in practice
Skill mix
• Numbers of nurses and midwives per 1,000 population - locations
• Doctors and dentists – locations

• Other health professionals e.g., physiotherapists
• Auxiliary health workers
• Traditional Birth Attendants
• Community health workers
• Retention of nurses and midwives
• Migration of nurses and midwives
Regulation
• Regulatory body for nurses and midwives
• are there different levels of registration?
• Regulation of nurse/midwife teachers
• Re-registration requirements
• Nurse and midwifery prescribing
• Professional organisations for nurses and midwives
• Professional organisations for nurse and midwifery teachers
Competencies
• What competency standards are used for nurses, midwives and other health care practitioners?
• How are these competencies monitored?
• How are new competencies developed in the workforce?
• What are the competency standards for nurse/midwife teachers?
• What are the competency standards for managers?
Incentives
• Intrinsic rewords – e.g., positive work experiences and job satisfaction; benefit to community; membership of team
• Financial – what is the pay of nurses and midwives; does it vary between hospitals and PHC?
• Work environment
• Access to services e.g., healthcare; housing
• Flexible employment hours
• Support for professional development
Any other issues not covered above