STRATEGIES FOR ENCOURANGING HEALTHCARE FACILITIES,TRAINING INSTITUTIONS,AND REGULATORY AUTHORITIES,TO ADOPT MODELS IN INCREASING NURSES AND MIDWIVES INVOLVEMENT IN CESARIAN SECTIONS.

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THE KEY STRATEGY

The key strategy is to foster interprofessional and multi-professional collaboration in decision making regarding patient treatment and care.

- Collaboration between physicians, and nurses/midwives is essential to healthcare delivery and is associated with

  -High-quality patient care,

  -Greater patient satisfaction,

  -And better health outcomes.

-This has been the emphasis in current practice of medicine and nursing/midwifery globally

- Hence, it is imperative that doctors and nurses/midwives have a particular set of interprofessional collaboration skills.

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- Mutual respect, trust, and efficient communication are essential for a successful collaborative process [5].
- The importance of a collaborative approach in professional practice should be highlighted because doctors and nurses collaborate on patient care **and have complementary roles** [6]. **This is important to be understood by all professionals.**
- Healthcare team members must be aware of the other professions' roles and contributions.
- Effective collaboration in healthcare requires deliberate information sharing and shared accountability for patient care

- The importance of physician–nurse/midwife teamwork and collaboration in producing exceptional clinical outcomes and high-quality patient care has been supported by several studies [8, 9].
- In a collaborative relationship, the doctor and nurse/midwives share duties, work out issues and decide how to create and carry out patient care plans.
- **Both parties must have equal decision-making authority, accountability, and power to manage patient care effectively.**

- There must be evidence of the parties' mutual regard, trust, and open communication [5].
- Members must appreciate one another's opinions and knowledge in order to win each other's respect [1].
- Additional elements affecting physician–nurse/midwife collaboration is job prioritization, comprehension of professional responsibility, respect, and equal power [10].
- **EQUAL POWER= equal weight of their contributions**
- Providing high-quality patient care that improves outcomes requires effective cooperation and positive connections [11–13]. **As a result, there are fewer deaths, as it ensures patient security, satisfaction, and speedy recovery**

- Additionally, positive doctor–nurse interactions improved drug utilization and reduced behavioral disturbances [16].
- It has been demonstrated that ineffective physician–nurse/midwives collaboration irritates medical professionals at work and lowers the quality of patient treatment [10].
- The views and attitudes of doctors and nurses should be similar regarding teamwork. However, numerous studies demonstrate differences in perspectives and attitudes concerning doctor–nurse/midwive collaboration.

They disagree on what constitutes an effective working partnership [17].

- Nurses/Midwives are more enthusiastic about working together than doctors [20 ,21], whereas physicians view collaboration as less critical [22].
- In the past, nursing–physician relationships were characterized by physician authority and nurse compliance, with doctors being represented as paternal and directive. Nurses were only supposed to concentrate on patient care and follow the doctors' orders [17,23].

- However, the need for collaboration between nurses and doctors is currently an area of emphasis in nursing schools globally [25].
- Due to the complexity of patient care in today's culture, nurse–physician collaboration necessitates that nurses and doctors coordinate patient care to ensure quality and safety. Supporting nurses' independence and developing their practical nursing skills are essential for developing professional knowledge and autonomous behavior.

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Regarding caesarean section in Tanzania,

-There are three main occasions in decision to Caesarean section

1.When a nurse-Midwife diagnose danger signs/risk and call a doctor

-Here a doctor may just ask nurses to prepare a patient for caesarean section without discussing together and agree whether the patient truly needs caesarean section (the doctor doesn't bother to be acquainted with the cause).

-A doctor may wish to discuss the matter with the nurses/midwives before preparing the patients (this is good)

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- 2.When a doctor decide cesarean section by himself/herself and order nurse-midwives to prepare a patient for cesarean section after the doctor has discussed with the patient(without involving a midwife/nurse).This deprives of a professional discussion between nurses and midwives before involving the client, resulting to unnecessary cesarean section.
- 3. When a doctor or a nurse discover a need for cesarean section, they discuss together, and agree what to be done, and each of them perform his/her professional roles to fulfil the necessity of the needed cesarean section. **This is the recommended practice and reduces the number of the unnecessary cesarean section and maximize benefits.**

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- The challenges of the option 3 is that, sometimes, the education gap between doctors and nurses renders doctors more authoritative in decision making, believing that the nurse/midwife at lower level may not have a rich knowledge to discuss the matter with the doctor.
- Sometimes, it is the feeling of a doctor that he has the authority to give orders that other professionals must follow without questioning or discussion. This does not reflect collaborative decision marking, and it minimizes benefits in outcomes.

WHAT SHOULD THE MINISTRY OF HEALTH DO TO IMPROVE COLLABORATIVE DECISION ?

- 1. At the central level, ensure that administrative positions of the ministry of health are not predominated by one profession. The current practice of the ministry where most of the departments are headed by a single profession conveys a negative impression/message to workers in lower levels, and may be contributing to impaired interprofessional collaboration.

2. Even in a department headed by a person from one profession, the organogram of the department/unit should ensure that interprofessional representation in coordination of activities is well reflected.

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3. Employ Nurses with equal level of education to doctors that can work with minimal knowledge gap among them. The current practice of preferring to employ lower cadre nurses/midwives to work with doctors with higher level of education does not foster collaboration.

4. The ministry should use interprofessional collaboration as one of the indicators for monitoring and evaluation of qualified practices at the ministry and all institutions under it

5. The Ministry should empower, and demand the regulatory authorities (TNMC and MCT) to closely monitor and reinforce interprofessional collaboration as one of the quality issues.

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WHAT SHOULD LEARNING INSTITUTION DO?

1. Interprofessional education (IPE) should be incorporated into the curricula of medical and nursing/midwifery schools to promote an understanding of the complementary roles of doctors and nurses and to facilitate the growth of an interdependent relationship between them [26]. Medical and nursing students must take IPE courses [27],
2. The learning institution must collaborate with health facilities to provide on job trainings

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WHAT SHOULD REGULATORY AUTHORITIES (TNMC and MCT) DO?

1. Ensure that all training curriculum has a component of inteprofessional collaboration before getting approval.

2. All staff who are reported to have challenges with their practices or interprofessional collaboration, and happen to be punished should be given an opportunity to pursue the course before resuming their practice.

3. Each of the staff (doctors and Nurses/midwives) MUST be evaluated on the aspect of interprofessional collaboration as a requirement for licence renewal. The renewal document should contain a component of interprofessional collaboration which is signed by a professional practitioner of a respective profession for verification (Doctors signed by nurses, and nurses signed by doctors).

4. Provide interprofessional committees to discuss cross cutting issues regarding interprofessional collaborations

5. Provide certified seminars and trainings about inter-professional collaborations, which adds to CPD points. These certificates should be the requirement for holding leadership positions in health facilities.

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WHAT SHOULD HOSPITAL FACILITIES DO?

1. Ensure that all decisions about the patient care and treatment are done in a multidisciplinary manner. Each opinion is respected, considered, and discussed.
2. Ensure that a person is not selected as a head of unit/hospital or in-charge, until proved to be inter-professionally collaborative.
3. Establish tools for monitoring interprofessional collaboration under quality assurance.
4. Hospital management should offer continuing IPE and cooperation opportunities for all interdisciplinary team members [17].

WHAT SHOULD INDIVIDUAL DOCTORS AND NURSES/MIDWIVES DO?

1. Always love to work and respect multiprofessional and interprofessional collaborative contribution to care.

2. Always be aware that the main goal of our daily job activities should be to prioritize clinical patient better outcomes than unnecessarily defending or protecting our own professional's statuses and esteem at the expense of patient's outcomes.

- By doing so, we will acknowledge our strengths and weaknesses, which will be complemented by other profession for better outcomes.

3. Cultivate love, respect, and acknowledge others' contribution to care. Always prioritize 'we' than 'I'.

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