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Research Article

Health Literacy and Respectful Compassionate Care Competencies for Nursing and Midwifery Bachelor Students in Tanzania: A Qualitative Study among Lecturers and Clinical Instructors

Chuck Mtuya[1], Alberta Oosterhoff[2,3*], Wolter Paans[2], Stella Mushy[4], Lemi Nyanda[5], Vivian Saria[6], Edith Tarimo[4], Rose Laisser[7]

[1]Faculty of Nursing, Kilimanjaro Christian Medical University College, Moshi, Tanzania

[2]Research Group Nursing Diagnostics & Family Care, Hanze University of Applied Sciences, Groningen, Netherlands

[3]Department of Demography, University of Groningen, Groningen, Netherlands

[4]Department of Nursing Management, Muhimbili University of Health and Allied Sciences, Dar es Salaam, Tanzania

[5]Bugando Medical Centre, Mwanza, Tanzania

[6]Kilimanjaro Christian Medical Centre, Moshi, Tanzania

[7]Faculty of Nursing and Midwifery, Catholic University of Health and Allied Sciences, Mwanza, Tanzania

***Corresponding author:** Alberta Oosterhoff, PhD is an assistant professor at the University of Groningen, Department of Demography, and the Hanze University of Applied Sciences, Research Group Nursing Diagnostics & Family Care, Groningen, Netherlands

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Abstract

Objective: In the context of a programme to improve people-centered care, launched by the Tanzanian Ministry of Health, an international project **(HEALCARe)** was initiated to enhance the health literacy **(HL)** and respectful compassionate care **(RCC)** competencies of Bachelor's nursing and midwifery students. Part of the project involved exploring the perceptions of different stakeholders regarding what facilitates these students' competencies. This paper specifically reports the perceptions of faculty lecturers and clinical instructors. **Methods:** We conducted nine focus groups with lecturers and instructors from three Tanzanian universities and their teaching hospitals, with a total of 65 participants. **Results:** Through thematic analysis, seven themes were identified: 'knowledge of HL,' 'knowledge of RCC,' 'modules with clear key components in the curriculum,' 'expert teaching in the faculty classroom,' 'priority of supervision in the clinical setting,' 'learning methods, materials and resources,' and 'evaluation tools and monitoring the transfer from theory to practice.' **Conclusions:** The findings show that students need to be supported in transferring the theory taught in class to clinical practice in patient care. The curricula of all universities and corresponding hospitals should specifically address the training of HL and RCC competencies. This will facilitate the improvement of students' competencies, contributing to better health outcomes in Tanzania.

Keywords: Focus group discussions; Health literacy (HL); Nursing and Midwifery; Respectful compassionate care (RCC) competencies; Tanzania

Abbreviations: BMC: Bugando Medical Centre, COREQ: Consolidated criteria for reporting qualitative research, CRERC: College Research and Ethics Review Committee, CUHAS: Catholic University of Health and Allied Sciences, FGD: Focus group discussion, HEALCARe: HEAlth Literacy and respectful compassionate CARe, HL: Health Literacy, HSSP: Health Sector Strategic Plan, HUAS: Hanze University of Applied Sciences, KCMC: Kilimanjaro Christian Medical Centre, KCMUCo: Kilimanjaro Christian Medical University College, MNH: Muhimbili National Hospital, MUHAS: Muhimbili University of Health and Allied Sciences, NIMR: National Institute for Medical Research, RCC: Respectful Compassionate Care, UMCG: University Medical Center Groningen, WHO: World Health Organization

Introduction

Tanzania is in the process of transforming healthcare provision to achieve universal health coverage for better health outcomes in the population [1,2]. In the context of this transition, this paper presents a study aiming to improve health literacy and respectful compassionate care competencies in nurses and midwives, by reviewing and developing the bachelor curricula in three universities in Tanzania [3].

In line with the World Health Organization **(WHO),** Tanzania's fourth Health Sector Strategic Plan [4] included the view that in order to improve universal health coverage, person-centered healthcare should be provided [1,5]. Part of this national programme was the star rating of health facilities, using a series of indicators, including patient satisfaction and patient rights [6].

A mid-term review of the HSSP IV confirmed some improvements in the quality of person-centered care but also revealed that, in addressing patient rights, most facilities had a low score [4]. Patients, particularly from rural settings, still experience inadequate information needed from nurses and other healthcare staff to self-manage their health [7]. In addition, mistreatment of clients in health facilities in Tanzania continues to occur [8]. About 70% of women in urban Tanzania reported experiencing at least one instance of mistreatment during labour and delivery [9]. Based on patient reports of disrespect and abuse, it was concluded that the levels and types of disrespect and abuse reported represent fundamental violations of women's human rights and suggest a failing health system [9, 10]. Therefore, action was urgently needed to ensure acceptable and dignified quality care for all women [9].

In response to disappointing improvements in person-centered care and in adherence to patients' rights, the consecutive national programme [2] incorporated specific considerations on respect and compassion in nursing and midwifery care [2]. Respectful care has been defined as any type of care that supports and encourages a person's self-respect rather than undermining it, regardless of personal differences [11]. Compassion is associated with a number of values, including empathy, sensitivity, kindness, warmth, and, most importantly, the ability to care for others [12]. The national programme HSSP V states that respectful care should be expanded to all services in the health sector to treat patients ethically, with dignity and respect, in both maternal and child health, as well as in all other care [2].

It, therefore, covers guidelines for the provision of 'respectful compassionate care' **(RCC),** which refers to individualized care that considers patients' autonomy, dignity, choices, and preferences [2]. The RCC guidelines are strongly related to the WHO policy framework for person-centered healthcare, including compassion and respect [13].

Since RCC incorporates the healthcare providers' understanding of the patient's context, meeting the patient's intrinsic needs, and guiding the patient's decision-making, it is apparent that nurses and midwives' professionalism should be considered [2]. Although basic nursing and midwifery training emphasize ethics and professionalism in treating all patients in a respectful manner, the results of this training are not yet reflected in all clinical practices [3]. One of the reasons for the discrepancy between training objectives and clinical practice is that RCC topics are not integrated into the educational programmes thus far. Although a training manual on compassionate care and patients' rights is available in Tanzania, its implementation has not been realized explicitly in the undergraduate student nursing curriculum [3].

Another reason for the discrepancy between training objectives and clinical practice is the education system, which does not adequately support competence development in nursing and midwifery students. While competence-focused training has been introduced as the standard in the country, most health training institutions in Tanzania do not follow this approach and remain in a traditional knowledge-driven education system [14]. As a result, nurses and midwives, but also lecturers and clinical instructors, as well as graduate and undergraduate students, remain unaware and therefore inadequately equipped to apply respectful compassionate care in practice.

In order to enhance the RCC competencies in the professional practice of future nurses and midwives, the concept of health literacy was adopted. Health literacy **(HL)** refers to the ability of individuals to access, understand, appraise, and use information and services in ways that promote and maintain good health and well-being for themselves and those around them [15,16]. By

improving people's access to information regarding their rights in the healthcare environment and their capacity to use it effectively, HL is critical to empowerment [16]. Since HL can be related to all clinical situations, nurses and midwives should be able to identify patients' unmet HL needs and have the competence to address these needs, especially with vulnerable patients [17].

Therefore, the capacity of healthcare professionals to address patients' HL needs is considered to be an HL competence, thus a quality of the professionals themselves [18]. In this understanding of the concept, all persons involved, at the individual as well as the organizational level, can profit from improving access to health and health information. HL reduces barriers for all patients, but it makes a particular difference to those who are most disadvantaged [17]. Training and educating nursing and midwifery professionals and students about the importance of health literacy is vital [17]. The application of health literacy as a concept might generate nursing and midwifery professionals' consciousness in relation to how to improve their knowledge, as well as their skills and attitudes. By doing so, this will contribute to avoiding disrespect, mistreatment, or abuse, thus enhancing RCC competencies [2].

In order to introduce the concept of health literacy to improve respectful compassionate care competencies, it was agreed among three universities in Tanzania to develop a training programme for undergraduate nursing and midwifery students. This HL training programme was consolidated by an Erasmus+ capacity-building project, which was launched as the HEAlth Literacy and respectful compassionate CARe **(HEALCARe)** project [3]. The aim of the project was to improve the competencies of graduates through the development of the curriculum for bachelor nursing and midwifery students. Participating partners in the project were the Faculties of Nursing of three universities in Tanzania, along with their corresponding practicum sites in aligned teaching hospitals, i.e., Muhimbili University of Health and Allied Sciences **(MUHAS)** and Muhimbili National Hospital **(MNH)** in Dar es Salaam, the Catholic University of Health and Allied Sciences **(CUHAS)** and Bugando Medical Centre **(BMC)** in Mwanza, and the Kilimanjaro Christian Medical University College **(KCMUCo)** and Kilimanjaro Christian Medical Centre **(KCMC)** in Moshi.

International partners were the Hanze University of Applied Sciences **(HUAS)** and the University Medical Center Groningen **(UMCG)** in the Netherlands, the University of Galway in Ireland, and the University of South-Eastern Norway in Norway [3]. The European partners involved in this project had previous experience and expertise in the application of HL in capacity-building projects [19].

All project partners agreed to participate in potential modifications to the curriculum and in the development of training materials for future training of undergraduate nurses and midwives. On completion, the graduates who participated in the training programme are expected to have gained health literacy knowledge, practical and interpersonal skills, as well as attitudes based on ethical values in nursing care to ultimately practice respectful compassionate care. The modification will be realized by reviewing and developing teaching modules with learning content and corresponding learning outcomes to be implemented in one or more of the years of study in the existing curriculum [3].

To inform the quality development of these modules, the understanding of opinions, experiences, and expertise of all stakeholders, such as students, lecturers, and clinical instructors, is essential. Therefore, prior to and during the curriculum review, an overall study was conducted to measure and explore those opinions, experiences, and expertise among these different stakeholders. The overall study consists of quantitative as well as qualitative components. This particular part of the study, which has been presented in this paper, is a qualitative study, addressing specifically the perspectives of lecturers and clinical instructors. The aim of this study was to explore what facilitates the health literacy and respectful compassionate care competencies for nursing and midwifery bachelor students in Tanzania from the perspectives of lecturers and clinical instructors, in order to contribute to the quality development of the curriculum and ultimately to improve the quality of care in Tanzania for better health outcomes [2,3].

Materials and Methods

Study Design

A multicenter exploratory qualitative design was used, based on the interpretative paradigm, by collecting data from the participants' perspectives, from the emic point of view [20]. Focus group discussions (**FGDs**) with a semi-structured discussion guide were chosen as the appropriate data collection method, since group discussions enable interaction within a group of experts from the same professional domain [21]. After data collection, deductive-inductive thematic analysis was applied, through an iterative process of multiple interpretation rounds [20,22].

Study Setting

The study was conducted in Tanzania at the Faculties of Nursing and Midwifery of three universities and their corresponding teaching hospitals in Dar es Salaam (**MUHAS** and **MNH**), Mwanza (**CUHAS** and **BMC**), and Moshi (**KCMUCo** and **KCMC**). These faculties use one identical harmonized curriculum for teaching at the faculty and for the clinical internships. All of these partners participate in the HEALCARe project [3].

Participant Recruitment and Sampling

We used purposive sampling [21] to recruit lecturers from the

Tanzanian Faculties of Nursing and Midwifery of the partnering universities, and clinical instructors from the universities' teaching hospitals. Project members used their contacts within the faculties for face-to-face recruitment with eligible lecturers based on the following inclusion criteria: **(1)** providing teaching courses and training sessions in the midwifery and nursing curriculum in one of the participating faculties and their corresponding hospitals, involved in curriculum development**; (2)** speaking fluently either Kiswahili or English; **(3)** willing to participate in a focus group discussion voluntarily.

From the participating hospitals, eligible clinical instructors were recruited with the following inclusion criteria: **(1)** working in the hospital with experience in supervising students during their internship in the clinical setting; **(2)** speaking fluently either Kiswahili or English; **(3)** willing to participate in a focus group discussion voluntarily. After recruitment, the participating lecturers and clinical instructors were mixed and allocated to groups, with a maximum of eight participants in each focus group, preferably four lecturers and four clinical instructors. A total of nine FGDs were conducted; three FGDs from each university and its teaching hospital.

All participants were informed about the aim of the study. They were invited to provide information from their own perspectives and were informed that there would be no 'wrong answers' [20]. It was clearly stated that there were no direct benefits nor any harms due to participation. All invited participants gave their written informed consent, and no participants withdrew from the study.

Data Collection

Data from the nine FGDs were collected between May and October 2022. Prior to the discussion, participants were requested to fill in a questionnaire concerning their gender, age, job title, education level, and number of years of experience in either lecturing or clinical supervision. Consequently, each FGD was conducted by one guiding moderator, who was one of the authors, or another well-trained and experienced interviewer from the university faculty. Assistant moderators contributed to observations and governed the audio-recordings. All discussions were audio-recorded with participants' permissions.

To structure the discussions, a semi-structured discussion guide was composed [21], based on five topics that had emerged from the literature when developing the different work packages of the HEALCARe project, specifically addressing health literacy **(HL)** and respectful compassionate care **(RCC)** competencies [3]. These topics were: **(1)** general communication skills of nurses and midwives; **(2)** health literacy (knowledge, skills, and attitude) of nurses and midwives; **(3)** respectful compassionate care competencies; **(4)** teaching methods; and **(5)** suggestions for teaching and training improvements. All topics included open-ended questions inviting participants to explain their perceptions and share their opinions. The discussion guide was first developed in English by the project members through international collaboration in the HEALCARe project, after which it was translated into Kiswahili by bilingual researchers and pilot-tested by the study team. The discussion guide questions were refined during the data collection among the different institutions to ensure that in-depth information would be provided [20].

All FGDs were conducted in Kiswahili to create a comfortable atmosphere for the participants and to guarantee consistency between all of the nine discussions. The discussions were held in private rooms in the faculty buildings and lasted between 45 to 70 minutes. After nine group discussions, no new information was collected, which was agreed upon by all three institutions. Therefore, data saturation could be determined [21].

Data Analysis

The data from the questionnaires were analyzed using descriptive statistics. The recordings of all FGDs were transcribed verbatim, maintaining the Kiswahili language to ensure consistency. Afterwards, they were validated and translated from Kiswahili into English by Tanzanian bilingual research assistants. Consequently, thematic analysis was accomplished through deductive as well as inductive reasoning [20,22]. First, deductive codes concerning the concepts of health literacy **(HL)** and respectful compassionate care **(RCC)** competencies were applied to text fragments. In addition, inductive codes were identified through open coding and multiple interpretation rounds. Each institution started with the coding of one transcript, and the total of three transcripts were discussed among the study team.

The preliminary findings were discussed among the three institutions. A codebook was iteratively developed throughout the coding process [22], using a spreadsheet to facilitate collaboration and communication amongst all members of the study group. Codes were merged into code groups and categories, after which categories were merged into themes, according to the principles of inductive coding [20,22]. In all interpretation rounds of this iterative process, consensus among the members of the study group from all three institutions in Tanzania and participating European partners was achieved. In-person meetings took place during HEALCARe project meetings in Tanzania as well as in the Netherlands. In addition, progress in the analysis was discussed among all partners in monthly online meetings. Through detailed exchanges of interpretations, the validation of the results was ensured. After the final interpretation round, consensus was reached, with five inductive themes identified.

Trustworthiness

Trustworthiness was enhanced by continuous reflection on the data collection and analysis process [23]. The moderators, assistant moderators, and members of the study group involved in the analysis process remained reflective throughout. Credibility was obtained by repeatedly checking the accuracy of the data. The majority of the authors involved in the interpretation of data are fluent in both languages (Kiswahili and English), which reduced translation bias and confirmed the truthfulness of the interpretation of participants' responses.

Dependability was addressed by checking the congruency of the entire study process [23], which also contributed to the scientific rigor of the overall study [20]. The study team followed the consolidated criteria for reporting qualitative research **(COREQ)** guidelines [24].

Ethics Approval and Consent to Participate

Ethical approval was obtained from the College Research and Ethics Review Committee (CRERC) of the Kilimanjaro Christian Medical University College (KCMUCo), with ethical clearance certificate no. 2529, and the National Institute for Medical Research (NIMR), ref. no. NIMR/HQ/R.8a/Vol.IX/4003. A written informed consent was obtained from all participants in the focus group discussions.

Results

Number of focus groups

The nine focus groups had between five and eight participants, with a total of 65 participants, of which 30 were lecturers and 35 were clinical instructors (Table 1).

Institution	focus groups	participants	lecturers	clinical instructors
MUHAS	3	8	3	5
		8	4	4
		5	3	2
CUHAS	3	8	4	4
		8	4	4
		8	4	4
KCMUCo	3	7	3	4
		7	3	4
		6	2	4
Total	3	65	30	35

Table 1: Number of focus groups and participants in each institution.

Participants' Characteristics

Table 2 represents the descriptive statistics from the questionnaire. The focus group members with primary expertise in lecturing identified themselves as lecturers, assistant lecturers, or teaching assistants. Those with primary expertise in clinical practice and supervising students during their internship identified themselves as clinical instructors, nursing officers, or assistant nursing officers. All but one of the participants were registered nurses; one participant was an advanced midwifery practitioner.

Total number of participants		N=65
Gender	Female	38 (58%)
	Male	27 (42%)
Age in years	Mean	40 (sd=9.1)
Job title	Lecturer	30 (46.2%)
	Clinical instructor	35 (53.8%)
Education level	BSc	29 (44.6%)
	MSc	26 (40%)
	Diploma	6 (9.2%)
	PhD	4 (6.2%)
Years experience in lecturing	Mean	7.2 (sd=5.9)
Years experience in clinical Instruction	Mean	13.7 (sd=9.7)

Table 2: Participants' characteristics.

Themes Identified

The analysis of the transcripts generated seven themes, including two deductive and five inductive themes. The deductive themes are: **(1)** knowledge of HL, and **(2)** knowledge of RCC. Using inductive reasoning, five additional themes were identified: **(1)** modules with clear key components in the curriculum, **(2)** expert teaching in the faculty classroom, **(3)** priority of supervision in the clinical setting, **(4)** learning methods, materials and resources, and **(5)** evaluation tools and monitoring the transfer from theory to practice. The themes are represented in the model in Figure 1.

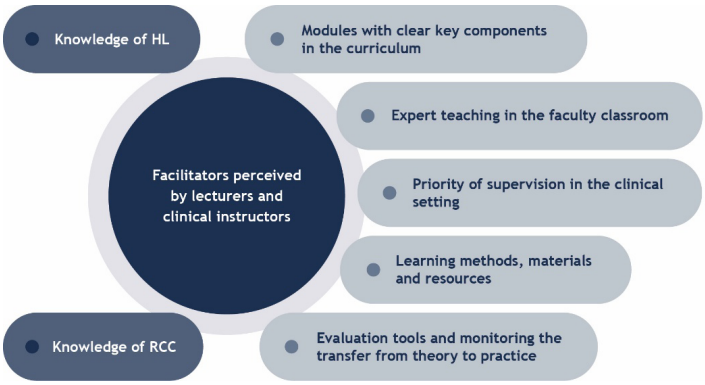

Figure 1: Two deductive and five inductive themes.

Below, the deductive and inductive themes are presented, illustrated with anonymized quotes. The representative focus group is indicated in brackets.

Deductive Themes

Knowledge of HL

All participants in the focus groups were, to some extent, familiar with the concept of health literacy **(HL),** which refers to whether health and health information are understood and accessible for patients or clients. It was perceived that HL concerns not only patients but also care providers: "Health literacy is the self-awareness of what health is, the ability to seek help and understanding broadly, mentally and physically, it is for both care provider and the client" **(B2).**

Some participants specifically explained that HL refers to providing health education using different types of media. One participant stated that it is important for students to have access to the correct information: "They really need to know how to assess patients' needs or information, and they also need to know where they themselves can access health information because for them to provide information they need to have the right information" **(A1).**

Most of all, HL was perceived as the capacity to interact with patients with different levels of HL or limited health literacy. It was mentioned that it should be within the nurse's expertise to be aware of the HL of the patients and respond appropriately. One participant explained in detail how limited health literacy in patients is not just limited understanding, but may be connected to feelings of worry, which could further reduce the likelihood of patients asking questions about their health: "When I meet with patients having limited health literacy, first of all, as a nurse I'm supposed to be very competent, respectful to my clients […] So, I have to use simple language, to transform my communication, which I was taught in class, to handle my patient. Therefore, me as a nurse and what I perceive, that is what I'm supposed to be so that my patient understands. Because another thing about the patients whom we meet is that they have worries. Therefore, that limited literacy emerges from worries; they are not able to question certain things. Therefore, you may provide simple information and they say they understand; they just say they understand, but in reality, they have some questions" **(A1).**

Knowledge of RCC

All participants were familiar with the concept of respectful compassionate care **(RCC).** Important conditions for providing RCC that were mentioned included respect, equality, confidentiality, and privacy: "It is the service you provide to the patient regardless of their economic situation, without discrimination, to keep the patients in a place where they will be satisfied, respect their personality, avoid defamatory words, and the care should be equal for all" **(B3).**

"Confidentiality and privacy are important because the midwife will be in a situation with sensitive issues with a patient and patient information, and in most cases, I will be able to be confidential there, but also trying to have privacy, especially when I want to discuss sensitive issues with a patient" **(A1).**

Inductive Themes

Modules with Clear Key Components in the Curriculum

In all focus groups, participants discussed whether communication skills, health literacy **(HL),** or respectful, compassionate care **(RCC)** components are present in the modules of the bachelor curriculum. Only communication skills components appear to be addressed appropriately in some modules during the first year in all faculties, and those modules are clear. However, this does not apply to HL and RCC: "The current curriculum has specific modules for communication skills, and students are taught based on that module" **(C1).**

"Students have not received health literacy and respectful, compassionate care training; it should be in the curriculum to avoid nurses working only with experience and not formal education" **(B3).**

One participant, however, explained that even in the communication skills module, the key components are not clear, which is partly due to inadequate time allocation: "The way general communication is organized in the current curriculum, I perceive it to be unsatisfactory because some of the key components are not very clear, particularly in the new bachelor curriculum. I might think maybe because of the time, skills on communication are not allocated more time" **(A1).**

While discussing their perceptions, some participants gave suggestions for the key components of the modules in the curriculum, such as skills for providing culturally appropriate care and health literacy to be incorporated in the upcoming curriculum revisions: "Various skills should be incorporated, that includes the provision of culturally appropriate care to avoid complaints from our clients, also it must consider the diverse majority of the people" **(B1).** "[…] health literacy should be included in the curriculum in the first semester before students go to the wards and also during follow-up of those students in the clinical" **(C1).**

Expert Teaching in the Faculty Classroom

When discussing teaching in the faculty, many participants perceived that the expertise of some lecturers is insufficient or at least not up to date: "For those who are teaching, have they received any training to enable them to conduct teaching on health literacy and respectful compassionate care? I can say no, I have never. It's just from what I did during my bachelor's degree that is what I am applying" **(A3).**

One participant who is a lecturer was quite honest in explaining their lack of confidence in addressing RCC competencies in the classroom. When discussing lecturers' competencies, all participants emphasized the need for more training for lecturers to facilitate expertise in teaching specifically in the area of RCC: "I want to contribute that there should be special training because teachers who implement a nursing curriculum were taught in general, but specifically on respectful and compassionate care it's not there, so I think there should be a special program to be trained on how to emphasize this area of respectful and compassionate care to students to continue improving students" **(C3).** Another facilitator perceived was the lecturers' expertise to address not only students' knowledge but also their skills and attitudes:

"My opinion is, that based on when the students come they have knowledge, but skills are a challenge to students. In class, they are taught the knowledge, but when they come to practice, they don't have the skills and their attitude is limited. Having knowledge without skills, and even attitude will be low"**(C3).**

Priority of Supervision in the Clinical Setting

All participants agreed that the availability of competent staff for clinical instruction is a crucial facilitator for adequate supervision of students in the clinical setting. Availability and time allocation, coupled with a heavy workload and inadequate expertise, were perceived as the two main challenges. Facilitators mentioned by the participants included harmonizing timetables and ongoing training of clinical instructors, including new staff:

"What I think the biggest challenge for clinical instructors is the workload in the wards; they often don't have enough time. The students and sometimes working hours for clinical instructors are contrary to students' clinical timetables. I think we try to find a way to harmonize the timetable" **(B2).** "Staff is not that good; for students we expect that after the theory, they go to the ward to get people to direct them. So if the clinical areas' staff are not good, what will they learn? […] Once we develop a curriculum we are supposed to train teachers as well on those topics, but also once we get new staff, also has to be involved in those topics that we expect to deliver to students" **(C1).** Participants also perceived that clinical instructors should be more aware of their role as models for others:

"Ward teachers should do the needful so that students can model good behaviour. Application of professionalism, ethics and scientific reasoning is important for daily modelling and training" **(B1).**

Learning Methods, Materials and Resources

All participants exchanged their experiences and ideas on applying learning methods and materials in both the classroom and the clinical setting. Most perceived a lack of training materials, with specific references to RCC materials: "It is important that our students and teachers understand how to be compassionate and respectful to our clients. It's important and the sole core of our personnel; the main problem is the lack of training and training materials" **(B1).**

Learning methods and materials that were mentioned as facilitators included group discussions, role plays, simulations, case studies, and observations: "It is better if we use lectures, discussions, group work, bedside teaching and illustrations, and role plays so that students can practice, it is better if they practice at the same time rather than focusing on another subject" **(B3).** "The other method of 'when I see, I remember; when I hear, I can forget', I think also practical skills have to be done. You teach while you do, this is how it has to be done. Many forget by hearing, but if you do, they will remember. He or she [the lecturer] touched and did this, so, I think the mixture of the practical and theory**" (C2).**

When discussing the availability of training materials and resources, some participants stated that the resources are sufficient, as the students themselves, as well as the patients, can act in role plays and thus are the 'human resources': "We have many resources in our settings, teachers are there in wards and classrooms, patients, and the hospital is here in its fullness, etcetera. We have classes, different wards, and many other departments, and more importantly, we have students. Those are part and parcel of our education system as far as I know**" (B1).**

In response, one participant stated that although the human and material resources are both available, it does not necessarily imply

that they are used effectively for teaching HL and RCC: "As the previous colleague said, human and material resources are there but we don't actually use them effectively. We have various teaching materials and techniques, but the question is how often do we use them to foster knowledge on customer care, health literacy, and respectful compassionate care? It's time now to use our resources properly for the betterment of our students and our profession in general" **(B1).**

Evaluation Tools and Monitoring the Transfer from Theory to Practice

All participants stated that there is a lack of evaluation tools in classroom teaching and in the clinical setting, such as a clear checklist or monitoring tool to assess progress in students' skills: "There is no specific content for these modules, so even monitoring is a challenge, there is no evaluation tool that can help a teacher know how much they have covered the content of respectful and compassionate care, so it's hard to measure" **(C3).** "Apart from classroom teaching this should go hand in hand with clinical teaching, and follow-up assessment should go with it, because now when it comes to clinical teaching and evaluation, we want to see: is the student really applying what they were taught in class? So there should be tools when it comes to assessing certain skills of a student" **(A3).**

The main concern of the participants was whether evaluation and monitoring were adequate to assess whether theory was transferred into practice. All participants addressed the problem of the lack of connection between theory and practice. Again, the shortage of staff to perform the follow-up was seen as a challenge: "There is a gap between theory and practice; a big gap" **(A2).** "There is a weakness in that they have been taught in class, but they are supposed to practice in the ward, and nobody is monitoring, no one is following up**" (C1).**

In all focus groups, the challenges of transferring theory into practice were discussed. Monitoring students' performance in practice will be facilitated by observations and by providing correct feedback, which will be the responsibility of both lecturers and students: "I think we can test the students if they care about dignity, respect, etcetera, when they practice in the ward, right? For example, observing when enrolling the patient, does the student follow the methods of communication and care?" **(B1).** "After the student has been taught in class, he/she understands well, but going to transfer knowledge to practice is not his/her responsibility alone. For example, a student can give an injection to the patient without providing proper information about the drug and the procedure. Therefore, it is the responsibility of both teachers and students to ensure that correct feedback is provided" **(B2).**

Discussion

The aim of this qualitative study was to explore what facilitates health literacy and respectful compassionate care competencies for nursing and midwifery bachelor students in Tanzania from the perspectives of lecturers and clinical instructors, in order to contribute to the quality development of the curriculum.

The two deductive themes identified show that the participants were relatively familiar with the concepts of HL and RCC and recognized their importance for future graduates' provision of quality care. They reported their perceived picture of well-equipped graduate professionals after a modified training curriculum.

The five inductive themes identified represent the participants' perceptions of the facilitators for developing HL and RCC competencies, including their own roles in the training of these competencies. The participants emphasized the shortcomings of the current students' competencies; hence, at the same time, they were able to identify potential facilitators, which were discussed and acknowledged across the groups. These include the importance of appropriate expertise of lecturers and the availability of adequate training materials. This finding is supported by an explorative study on the experiences of clinical teaching and learning among medical and nursing graduates in Tanzania [14]. The latter study describes a lack of tools for clinical teaching and learning, such as clear guidelines, and reports limited bedside teaching, which inhibits graduates' clinical competence development [14].

An illustrative part of the discussion about the availability of learning methods, materials, and resources was the explicit comment on 'human learning material,' referring to the students themselves, patients in the wards, or other role models. It was discussed whether the availability of this 'human material' could be considered a facilitator and contribute to existing training materials. Other studies indicate that health literacy training using human material generated improvements in HL competencies in students [25].

Our results show that the participants in our study are capable of formulating appropriate recommendations on how to incorporate HL and RCC topics as key components in the nursing and midwifery bachelor's degree curriculum of Tanzanian universities. One recommendation was that lecturers and clinical instructors should be educated first, before they start teaching students. Hence, this study suggests the importance of capacity building for lecturers for expert teaching in the classroom and for clinical instructors for supervising in the clinical setting. These results are confirmed by other studies reporting limited teaching expertise among most of the educators, whether university lecturers or clinical instructors, which requires reconsideration of the approaches on how students are prepared during their studies [26]. Most lecturers have been educated themselves in knowledge-based frontal classroom

education, and their understanding of competence-based education is limited, which has also been reported by others [27]. While, in theory, the curriculum in professional training is now competence-based, in practice, some training modules are still focusing on knowledge acquisition only [3].

A discrepancy between theory and practice had been perceived by all participants in our study, and it was reported that the transfer of theory taught in the classroom to practice in the clinical setting cannot be the responsibility of students alone. This transfer needs support from the practicum sites' resources in terms of available allocated time and supervision. Practical learning in the clinical setting takes place within the context of the nurse-patient relationship. This is challenging for both students and supervisors, as the nurse-patient relationship is context-specific [28], and in this relational context, the students need to perform and learn at the same time. To be able to develop HL and RCC competencies, students need to experience a 'context of performance' and a 'context of learning' concurrently. It requires optimal conditions for adequate guidance to interconnect performance and learning.

Our participants suggested intensifying bedside teaching, which was also confirmed by others [14]. However, if this type of learning in practice takes place only during internships, it was considered rather too late. The transfer of theoretical knowledge to practical clinical skills should also take place prior to the internship, during the faculty classroom teaching. This could be realized by a variety of didactic methods and learning resources to facilitate the transfer of knowledge to skills [29].

Our findings confirm the need for modification of the curriculum through quality development of teaching and supervision expertise, as well as learning materials, to address the current gaps in knowledge, skills, and attitudes. Health literacy as a concept is helpful to contribute to these challenges because of the distinct domains such as knowledge, skills, and attitudes. Particularly, the discrepancy between the domains of knowledge and skills represents the disconnection between theory and practice. Our findings show that even when the theoretical knowledge is adequate, the transfer to skills and attitudes in practice is not guaranteed, as was confirmed by other studies, showing that adequate knowledge in nurses and midwives does not necessarily generate adequate skills [30]. Even though our participants did not particularly mention the separate domains of HL, they appeared to be fully aware of the challenges of the transfer between these and made suggestions for facilitating the transfer from theory to practice, and therefore from knowledge to skills. All participants perceived this as an urgent element of development.

Our findings correspond with global perspectives on undertaking interventions for improving respectful compassionate care for patients, specifically for vulnerable groups such as women in labour and delivery, both on a global scale and specifically in the Eastern part of Africa [31]. By improving health literacy in nurses and midwives, as well as in patients, all partners will benefit, including the most vulnerable target groups such as women and patients in rural areas, ultimately improving the quality of person-centered care for the entire population in Tanzania.

Strengths and Limitations

The strength of this multicenter study is the interaction between the representatives of the three universities, which had been initiated from 2020 onwards since all three universities adopted the same competence-based curriculum approach [14]. This interaction has been encouraged even more by the choice of focus group discussions as the data collection method. The high level of interaction yielded rich data, showing that the participants felt free to speak and felt invited to identify specific areas for facilitating the quality development of the curriculum.

Another strength of the study is the international collaboration. Particularly in the different stages of the analysis, interpretations of the data were exchanged and discussed in detail in meetings among professionals engaged in the HEALCARe project, with different professional and cultural backgrounds [3]. This exchange was challenging and encouraged a high level of reflection to achieve consensus among all members of the study group during the entire coding procedure, from open coding to selecting codes in subsequent interpretation rounds for identifying the themes. Since the meetings in person took place in Tanzania as well as in the Netherlands, all contributors were able to reflect on the meaning of the data from their own cultural and environmental perspectives, as well as situating those within the host culture and environment. Additional online meetings were arranged with different compositions of members of the study group. The above contributed considerably to the validation of the study.

Limitations of the study include the uncertainty about hidden hierarchical differences between the university lecturers and the clinical instructors. The process could have forced consensus even when it had not been achieved. However, as professionals, the moderators recognized the potential impact of the different roles of the participants interviewed, and they managed to maintain the dialogue between the participants, stressing the freedom of speech for everyone.

Another limitation is that this study reflects the perceptions of participants, about whom we cannot be certain of their outset concerning the theoretical framework and their reflective skills. However, these lecturers and clinical instructors are the same professionals who will be responsible for the achievement, that is, modification of the curriculum through quality development.

It is specifically this combination of collecting data among the professionals who will contribute to the curriculum development at the same time, which demonstrates the value of national and international collaboration, enabling professionals to contribute to quality development in the sector in which they are engaged themselves.

Conclusion

By conducting nine focus group discussions among university lecturers and clinical instructors in nursing and midwifery, we identified that health literacy and respectful compassionate care competencies need to be addressed in nursing education. The quality development of a modified nursing and midwifery bachelor curriculum will be facilitated by optimizing modules with clear key components in the curriculum, by expert teaching in the faculty classroom, by prioritizing supervision in the clinical setting, by appropriate teaching methods, materials, and resources, and by evaluation tools and monitoring the transfer of theory to practice. Using the concept of health literacy, including its domains such as knowledge, skills, and attitudes, adds to the awareness that progress in learning should address the challenge of transferring theoretical knowledge to practical skills in the clinical setting. This will enhance the respectful compassionate care competencies in current undergraduate and future nurses and midwives, reinforcing the quality of person-centered care, and contributing to universal health coverage in Tanzania.

Declarations

Consent for Publication

Not applicable.

Data Availability

The interviews used in the study were developed for this study and have not been published elsewhere. They are not publicly available, to protect study participants' privacy. They are available from the corresponding author on reasonable request.

Competing Interests

The authors declare that they have no competing interests.

Authors' Contributions

C.M. = Chuck Mtuya

A.O. = Alberta Oosterhoff

W.P. = Wolter Paans

S.M. = Stella Mushy

L.N. = Lemi Nyanda

V.S. = Vivian Saria

E.T. = Edith Tarimo

R.L. = Rose Laisser

E.T., R.L., V.S. and C.M. contributed to data collection, transcribing, validation and translating. S.M., C.M. and L.N. contributed to collecting participant demographics. All authors were engaged in data analysis and writing. All authors read and approved the final manuscript.

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