Midwifery ■ (■■■■) ■■■–■■■

Contents lists available at SciVerse ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

Competency-based education: The essential basis of pre-service education for the professional midwifery workforce

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ARTICLE INFO

Article history:
Received 31 January 2013
Received in revised form
29 June 2013
Accepted 1 July 2013

Keywords:
Midwifery education
Competency-based education
Midwifery workforce

ABSTRACT

Background: many articles published in the decade since promulgation of the Millennium Development Goals have acknowledged the distinct advantages to maternal and newborn health outcomes that can be achieved as a result of expanding access to skilled birth attendant (including midwifery) services. However, these advantages are often predicated on the assumption that the midwifery workforce shares a common definition and identity. Regrettably, a clear delineation of midwifery competencies is rarely addressed. A core set of midwifery competencies is essential to providing the high quality services that lead to the desirable health outcomes described in that body of research. Attribution of improved outcomes to access to midwifery cannot be made without a common understanding of a defined set of services provided to standard by the midwifery workforce across the inter-conceptional and childbearing time frame. The International Confederation of Midwives (ICM) has developed a clear list of competencies that delineate the domains of practice for the fully qualified, professional midwife. These domains frame the educational outcomes that must be conveyed within competency-based education programmes.

Purpose: this article explores the concept of competency-based education for midwives; first exploring the concept of competency itself, then providing examples of what is already known about competency-based approaches to curriculum design, teacher preparation, teacher support and assessment of student learning. These concepts are linked to the ICM competencies as the unifying construct for education of individuals who share a common definition and identity as midwives.

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Introduction

According to Ban Ki-moon, secretary general of the United Nations, 'of the eight millennium development goals, the two specifically concerned with improving the health of women and children are the furthest from being achieved (United Nations Population Fund (UNFPA), 2011).' In spite of significant global efforts to reduce maternal and infant mortality, millions of marginalised women and children die each year, many from preventable causes.

Access to a qualified competent midwife during pregnancy and the day of birth would prevent many of the 350,000 maternal deaths each year from pregnancy related complications and the high burden of newborn morbidity and mortality (World Health Organization (WHO), 2011, 2012). Regrettably, there are profound shortages of fully qualified midwives (International Confederation of Midwives (ICM), 2010a) where they are needed most. In Ethiopia, for example the government projects a need for almost 10,000 midwives to care for its population of 91 million (World Health Organization (WHO), 2010). As of 2012, Ethiopia had fewer than 3000 midwives; and many of these individuals are not fully qualified according to the ICM definition (personal correspondence, Tegbar Yigzaw, 2012).

A body of research details the distinct advantages to maternal and newborn health outcomes that can be achieved as a result of expanding access to skilled birth attendant (including midwifery) services (Högberg, 2010; Liljestrand and Sambath, 2012). However, these advantages are often predicated on the assumption that the midwifery workforce shares a common definition and identity. Regrettably, a clear delineation of midwifery competencies is rarely addressed (Viera et al., 2012; Rosskam et al., 2013). A core set of midwifery competencies is essential to providing the high

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0266-6138/$ - see front matter © 2013 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.midw.2013.07.006

quality services that lead to the desirable health outcomes described in those articles.

The International Confederation of Midwives (ICM) developed its first list of midwifery competencies in 2002, with evidence-based updates in 2010 and 2013 (International Confederation of Midwives (ICM), 2010a, 2013a). The competency list defines the basic content of a pre-service midwifery education programme for the fully qualified midwife. Graduates of these programmes would be prepared to meet the expected scope of midwifery practice as defined by the International Confederation of Midwives (2011a). We now know what midwives need to be able to do upon entry into the profession. However, other organisations or governments have crafted their own, often competing, and often more limited, delineations of midwifery competencies and scope of practice. Attribution of improved outcomes to access to midwifery services cannot be made without a common understanding of a common set of services provided by the midwifery workforce across the inter-conceptional and childbearing time frame.

The identified need for midwives has resulted in recent efforts in both developed (e.g., Canada, Japan, Australia, New Zealand) and developing nations to increase the supply of midwives entering their workforce. Unfortunately, these efforts have at times resulted in a focus on quantity over quality. This has led, in some instances, to the scaling up of various cadres of multipurpose workers who typically lack the full range of midwifery competencies needed to provide essential services and may have limited authority (Fauveau et al., 2008; Adegoke et al., 2012), a phenomenon that is particularly notable in low resource countries. In addition, the global focus on providing a skilled birth attendant for the time of labour, birth and immediately post partum to attend to potential life-threatening complications during this time frame negates the importance of having the midwifery competencies needed prior to and during pregnancy that can prevent many complications from occurring.

A fully qualified midwife (International Confederation of Midwives (ICM), 2011a, 2013a) is the vital link between all levels of care needed by women during the reproductive years and the childbearing cycle. Among the most important attributes of the fully qualified midwife is the ability to promote health and prevent complications before they occur, referring those women needing medical attention early enough to prevent adverse outcomes for the woman or her newborn.

There are currently many pathways to midwifery (Fig. 1) (United Nations Population Fund (UNFPA), 2011). Midwifery education can be a stand-alone direct entry curriculum, post-registration (nursing), or threaded within a nursing curriculum. Programmes that combine nursing and midwifery education are not supported by ICM as they necessarily limit the focus on the entire set of competencies needed for either profession.

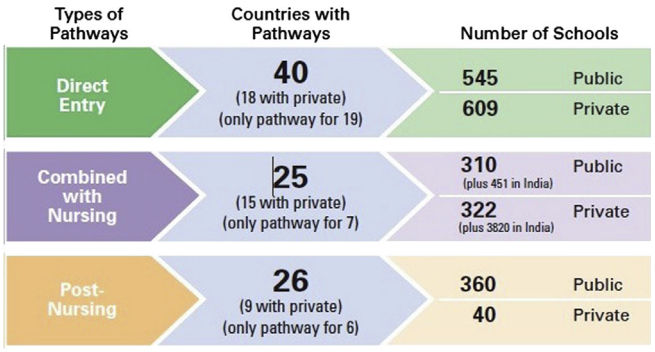

Fig. 1. Pathways to midwifery. Reproduced by kind permission of the UNFPA from www.stateoftheworldsmidwifery.com.

Length of programmes can also vary widely. Midwifery content may be taught at a variety of levels ranging from hospital or Ministry of Health programmes to university undergraduate or graduate study. The International Confederation of Midwives takes no stance on degree requirements for midwives but has set a consensus standard duration of education of 18 months (post-registration) to three years (direct entry) depending on programme pathway (International Confederation of Midwives (ICM), 2010b, 2013b). The World Health Organization (WHO) has recommended a minimum of a baccalaureate degree (World Health Organization (WHO), 2009). The ICM essential competencies are the same regardless of programme level or duration.

Midwifery education in many countries currently follows a didactic curricular model where students learn through classroom lecture with little opportunity for skills practice, simulation and role play needed to develop critical thinking, values and the clinical decision making abilities needed for effective practice. Many midwifery students graduate having attended a limited number of women in labour (Fullerton et al., 2010) and some with minimal clinical experience in antepartum, family planning or newborn care. In addition, the assessment of student progress and readiness for practice may not be linked to the intended outcomes of learning and targeted clinical competencies (Lurie, 2012).

Frenk et al. (2010) and the Lancet Commission have proposed what they term a 'third generation' of educational reform, in which health professions education is linked to the specific context of the health system in any global setting. Competencies are proposed as the objective criterion for the classification of health professionals; underpinned by a common set of attitudes, values and behaviours that define every health worker as an accountable practitioner (i.e., competency-based education). The purpose of this article is to explore the concept of competency-based education for midwives; first exploring the concept of competency itself, then providing examples of what is already known about competency-based approaches to curriculum design, teacher preparation, teacher support, and assessment of student learning.

The core constructs of competence and competency

A very complex body of literature has generated a certain consensus about the components of both competence and competency; but no common definition of either construct has been uniformly favored (Fernandez et al., 2012). In general, competence is discussed in relationship to behavioural tasks, and competency in relationship to the personal characteristics that underpin the performance of those tasks (Fullerton et al., 2011; International Confederation of Midwives, 2011b).

Competence is sometimes defined through a description of actions that can be demonstrated or observed and assessed (the *behavioural or performance approach*). Successful performance is only possible in this approach when the necessary and underlying knowledge and understanding are present. A second perspective (the *generic approach*) defines competence as broad clusters of abilities such as knowledge or capacity for critical thinking that act together to promote expert performance. This approach ignores the context, assuming that these abilities will serve as well in a variety of circumstances. These two frameworks are sometimes interwoven (the *holistic approach*) by combining the general underlying attributes of the practitioner with the context in which they are applied, and allows the incorporation of ethics and values as elements in competent performance (McMullan et al., 2003). The intertwined set of specific task statements, and the explicit

Please cite this article as: Fullerton, J.T., et al., Competency-based education: The essential basis of pre-service education for the professional midwifery workforce. Midwifery (2013), http://dx.doi.org/10.1016/j.midw.2013.07.006

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