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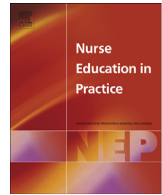

Building midwifery educator capacity using international partnerships: Findings from a qualitative study

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ABSTRACT

Midwifery educators play a critical role in strengthening the midwifery workforce globally, including in low and lower-middle income countries (LMIC) to ensure that midwives are adequately prepared to deliver quality midwifery care. The most effective approach to building midwifery educator capacity is not always clear. The aim of this study was to determine how one capacity building approach in Papua New Guinea (PNG) used international partnerships to improve teaching and learning. A qualitative exploratory case study design was used to explore the perspectives of 26 midwifery educators working in midwifery education institutions in PNG. Seven themes were identified which provide insights into the factors that enable and constrain midwifery educator capacity building. The study provides insights into strategies which may aid institutions and individuals better plan and implement international midwifery partnerships to strengthen context-specific knowledge and skills in teaching. Further research is necessary to assess how these findings can be transferred to other contexts.

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1. Introduction

High level evidence demonstrates that when the quality and quantity of the midwifery workforce is sufficient, maternal and newborn lives are saved (Frenk et al., 2010; Fullerton et al., 2011; Homer et al., 2014; Renfrew et al., 2014; ten Hoope-Bender et al., 2014; UNFPA et al., 2014). The International Confederation of Midwives has developed global standards to guide the development of a midwifery workforce to provide high-quality, evidence-based care for women. This involves strengthening what is known as the three pillars of midwifery which encompass professional association, regulation and education (International Confederation of Midwives, 2015; UNFPA et al., 2014; World Health Organization, 2014). Education, as one of these pillars, is the focus of this paper.

A learning environment that provides strong midwifery leadership, effective governance and adequate resourcing of teaching, clinical simulation and practice can produce quality midwifery graduates (Dawson et al., 2015; Frenk et al., 2010). However, in many low and middle income countries (LMIC), midwifery education institutions face many challenges to deliver quality teaching and learning (Frenk et al., 2010). Issues that prevent midwifery educators from maintaining their competency in teaching and clinical practice include staffing shortages that limit the time educators have for professional development (Fullerton et al., 2011). There are also a limited number of suitable professional development programs for midwives in rural areas (Dawson et al., 2015; Frenk et al., 2010; Lemay et al., 2012), inadequate access to the internet and poor computer literacy both of which can lead to the use of outdated or incomplete reference materials for teaching (Brodie, 2013).

Improving the capacity of midwifery educators is necessary to strengthen midwifery education and support the development of a quality midwifery workforce. Study abroad, the provision of externally-facilitated online training modules, regional collaboration and international consultants are some approaches that have been employed with varying levels of success to build educator capacity (Lasker, 2015; Forss and Maclean, 2007; West et al., 2015).

The literature shows that international partnerships to strengthen midwifery have been facilitated by education institutions, volunteers, faith based organisations, non-government and other international agencies who often work collaboratively with local partners to implement local government health policy and planning (Liberato et al., 2011; Yamey, 2012). Little is known about the key features of international partnerships that enable individuals and organisations to most effectively strengthen

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midwifery teaching in education institutions in LMIC.

One international partnership to build midwifery capacity was the Papua New Guinea (PNG) Maternal and Child Health Initiative (MCHI). The aim of this paper is to explore how the approach taken by the MCHI enabled international and national midwifery educators, working in a cross-cultural partnership, to strengthen midwifery teaching and learning in PNG.

1.1. The PNG Maternal and Child Health Initiative

PNG is a low-income country in the South Pacific (World Bank, 2014) with approximately 250,000 births a year (World Health Organization, 2015). The majority of the population reside in geographically isolated rural areas which contributes to the low rate of skilled attendance at birth of 44% and high maternal mortality ratio (MMR), estimated to be around 773 maternal deaths per 100, 000 live births (Papua New Guinea National Government, 2009; World Bank, 2011; World Health Organization, 2015). The PNG government developed strategies to address this high MMR, which included increasing the number and quality of midwives. A key component of the strategy was focused on strengthening midwifery education (UNFPA et al., 2014) which is also the focus of the MCHI.

The specific objectives of the PNG MCHI were to improve the standard of midwifery clinical teaching and practice in the four teaching sites (that expanded to five in mid-2015); and improve the quality of obstetrical care in two regions through the provision of clinical mentoring, supervision and teaching (World Health Organization Collaborating Centre for Nursing, Midwifery and Health Development, 2014).

An Australian university supported the PNG MCHI over a four year period. This support included: the recruitment of international midwives and obstetricians to work alongside midwifery educators in the midwifery teaching programs, facilitating three national education workshops a year to build the capacity of national educators, supporting the midwifery regulatory body to improve systems and processes, conducting monitoring and evaluation of the MCHI and making changes where required, and providing ongoing support to the international and national educators through regular teleconferences, face-to-face mentoring and clinical supervision. International midwifery educators (known as Clinical Midwifery Facilitators or CMFs) and the two obstetricians were provided with an orientation program before arriving in PNG. The program provided a background on the state of maternal and child health in PNG, cultural awareness training, and an opportunity to build relationships with other international educators and the coordinating team at UTS.

At the time this study was conducted (March 2015), Phase I of the PNG MCHI was ongoing.

During Phase I (2012–2013), eight CMFs worked as midwifery educators in partnership with PNG midwifery educators and clinicians in the four education institutions and clinical practicum sites. Education institutions were governed and administered either by the PNG government or private religious-affiliated organisations. The CMF provided pedagogical and clinical updates and mentoring to the national educators. The national educators provided valuable local context experience, skills, and cultural insights to the international educators. The midwifery education workshops provided opportunities for participation in simulated teaching and learning in a collaborative and multidisciplinary environment. The provision of teaching resources included clinical simulation equipment and mannequins, textbooks, hard copies of World Health Organization (WHO) midwifery education modules and other audio-visual resources. Teleconference, email and telephone support was provided to the international educators by a senior international midwifery mentor who had experience working in PNG.

The aim of this study therefore was to determine how this approach contributed to strengthening midwifery education in this low income context, in particular factors that enables or constrained these processes.

2. Methods

2.1. Design

A qualitative exploratory case study design was used. Qualitative case study research enables an in-depth understanding of phenomena in a real-life context when the boundaries between phenomenon and context are not always clear (Baxter and Jack, 2008; Creswell, 2013; Harder, 2010; Yin, 2012). In addition, a qualitative inquiry using a case study approach enabled an exploration of the perspectives of the international and national educators in the MCHI in order to ensure that all voices were represented in the study (Yin, 2009).

Case studies have been used extensively in social sciences, education and health (Yamey, 2012; Yin, 2009) and this method has contributed to knowledge of individual, social and organisational phenomena (Brideson et al., 2012; Fraser et al., 2013). A theoretical framework of behaviour change, called the Theory of Planned Behaviour (TPB) was used to inform the data collection and analysis in order to identify the factors that contributed to and influenced capacity building.

Capacity building is primarily concerned with enabling behaviour change to improve outcomes (Labonte and Laverack, 2001; Lavender et al., 2009; Liberato et al., 2011; West et al., 2015). In the context of this study, behaviour change is related to the international expatriate's adaptive behaviour to the environment and culture and the national host's reciprocal acceptance and utilization of the methods of teaching and facilitation of learning. The TPB is concerned with the factors which influence an individual's intention to perform (or not) a desired behaviour (Ajzen, 1991). Intentions and motivations are terms used interchangeably in behaviour change literature and thought to be key cognitive aspects determining whether an individual actually adopts a behaviour or not (Godin et al., 2008).

2.2. Setting and sample

Criterion sampling (Palinkas et al., 2015; Palys, 2008) was used to ensure the selection of rich insights from all midwifery educators working in the PNG Maternal and Child Health Initiative. Eighteen PNG national and 15 international educators who had been involved in the initiative from August 2012, up until the data collection period in March 2015 were invited via email to contribute to the research. Thirteen national and 13 international educators consented to participate and were interviewed. Two international midwifery educators and one national educator were not available for interview.

Participants were provided with an information sheet and a consent form a month prior to data collection and were informed that participation was voluntary. The date and time of data collection was negotiated with the participant.

2.3. Data collection

Twenty-six individual in-depth semi-structured interviews were conducted in March 2015. Nineteen participants were interviewed in person during a two and a half day midwifery education workshop at a conference venue for logistical and security reasons

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