Nurse Education in Practice 31 (2018) 143–150

Contents lists available at ScienceDirect

Nurse Education in Practice

journal homepage: www.elsevier.com/locate/nepr

Midwifery Education in Practice

‘Living the rural experience-preparation for practice’: The future proofing of sustainable rural midwifery practice through midwifery education

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ARTICLE INFO

Keywords:
Midwifery education
Pre-registration
Rural placements
Sustainability
Rural practice

ABSTRACT

Rural practice presents unique challenges and skill requirements for midwives. New Zealand and Scotland face similar challenges in sustaining a rural midwifery workforce. This paper draws from an international multi-centre study exploring rural midwifery to focus on the education needs of student midwives within pre-registration midwifery programmes in order to determine appropriate preparation for rural practice.

The mixed-methods study was conducted with 222 midwives working in rural areas in New Zealand (n = 145) and Scotland (n = 77). Midwives’ views were gathered through an anonymous online survey and online discussion forums. Descriptive analysis was used for quantitative data and thematic analysis was conducted with qualitative data.

‘Future proofing rural midwifery practice’ using education was identified as the overarching central theme in ensuring the sustainability of rural midwives, with two associated principle themes emerging (i) ‘preparation for rural practice’ and (ii) ‘living the experience and seeing the reality’.

The majority of participants agreed that pre-registration midwifery programmes should include a rural placement for students and rural-specific education with educational input from rural midwives. This study provides insight into how best to prepare midwives for rural practice within pre-registration midwifery education, in order to meet the needs of midwives and families in the rural context.

1. Introduction

The provision of maternity care in rural areas needs to ensure that women and babies, irrespective of remoteness, have equitable access to health care and receive safe care. This is now vital as research evidence suggests that pregnant women travelling long distances to access maternity care services are at a greater risk of experiencing adverse pregnancy outcomes (Grzybowski et al., 2011). Providing and maintaining health services in rural areas can be challenging for all health professionals and the difficulties faced impact on attracting and retaining qualified maternity care staff (Kornelsen, 2009; Tucker et al., 2005). This is particularly pertinent in relation to the recruitment and retention of rural midwives as the primary care providers in the integrated maternity care systems in both New Zealand (NZ) and Scotland.

This paper draws from a larger, multi-centred study exploring ‘rural midwifery’ in NZ and Scotland. The study aimed to contribute to the knowledge base informing equitable and sustainable maternity care for rural communities. Whilst there is no internationally recognised definition of a ‘rural’ area (Statistics NZ, nd), the overarching term ‘rural’ within the context of this study encompasses the classification of rurality in both countries (Table 1). The purpose of this paper is to focus on the educational needs of pre-registration student midwives regarding preparation for rural practice to inform and support sustainable and equitable rural maternity care.

2. Literature review

It is critical for a midwife to be ready for each moment of practice regardless of geographic or practice setting (Calvert, 2015). However,

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https://doi.org/10.1016/j.nepr.2018.06.001
Received 30 November 2017; Received in revised form 5 June 2018; Accepted 5 June 2018

Table 1
Classification of urban/rural areas in New Zealand and Scotland.

Classification	New Zealand (www.stats.govt.nz)	Scotland [settlements] (Scottish Government, 2014)
Urban	1. Main urban areas.	1. Large Urban Areas (≥125,000 people).
	2. Smaller urban communities.	2. Other Urban Areas (10,000 to 124,999 people).
	3. Independent urban communities.	3. Accessible Small Towns (3000 to 9999 people, and within a 30 min drive time of a Settlement of ≥10,000.
Rural	4. Rural areas with a high urban influence.	4. Remote Small Towns (3000 to 9999 people, and with a drive time of over 30 min to a Settlement of ≥10,000).
	5. Rural areas with moderate urban influences.	
	6. Rural areas with low urban influence.	5. Accessible Rural Areas (< 3000 people, and within a 30 min drive time of a Settlement of ≥10,000).
	7. Highly rural/remote areas.	6. Remote Rural Areas (< 3000 people, and with a drive time of over 30 min of a Settlement of ≥10,000).

the need to be ready to expect the unexpected and the expectancy of challenge form the lived reality of rural midwifery practice. These challenges include: providing a service to a small but widely dispersed population (National Health Committee (NHC), 2010); issues related to remuneration (Crowther, 2016); engaging in continuing education (Tucker et al., 2005); and the distance of interface services impacting on transfer decisions such as GP and tertiary facilities (Munro et al., 2013; Tucker et al., 2005). Furthermore, travel demands have a significant impact on time availability, which has a bearing on realistic caseload size (Redshaw et al., 2012). There is emergent evidence that rural midwives are more relationally connected to their community, making their work more meaningful (Crowther and Smythe, 2016; Patterson, 2007) but this may encroach on the personal lives of the midwives (Crowther et al., 2017; Kyle and Aileone, 2013; Patterson, 2007). Further professional challenges facing rural midwives include: living and practising in relative isolation, often with lack of collegial support (Kyle and Aileone, 2013); limited access to information technology (Crowther, 2016; Ireland et al., 2007); access to funding for education; being released and replaced for professional development (Crowther, 2016; Kornelsen, 2009; Ireland et al., 2007; Hundley et al., 2007) and fewer opportunities to engage in essential inter-professional education (Ireland et al., 2007).

Specific skills identified for rural practice include: sound decision-making skills, especially in relation to transfer (Cheyne et al., 2012; Patterson et al., 2011); knowing when to call for back up (Kyle and Aileone, 2013; Tucker et al., 2005); and fostering an ability to work in collaboration with other midwives and health professionals (Miller et al., 2012; Harris et al., 2011; Hundley et al., 2007; Ireland et al., 2007). Our wider study found that rural midwives in NZ and Scotland develop what is described as an "attitude of courage and fortitude" (Gilkison et al., 2017) as a unique skill set which underpins their practice. This description also refers to the fostering of skills such as preparedness and resourcefulness. In another publication, we further describe the significance of developing meaningful relationships to safeguard rural birth (Crowther et al., 2018).

Literature indicates that recruitment, retention and preparation of professionals to work in rural areas can be enhanced through: improved financial incentives; stable rural group practices with appropriate facilities; healthcare teams; community support; increasing student numbers; and increasing rural specific training (Kyle and Aileone, 2013; Adair et al., 2012; Robertson, 2008; Steed, 2008; Hendry, 2003). Research in medicine also indicates that rural undergraduate placements have a lasting positive impact on students' attitudes towards rural practice (Williamson et al., 2012; Orpin and Gabriel, 2005), although it remains unclear whether this translates into increased numbers of graduates wanting to work and live in rural areas.

3. Midwifery in NZ and Scotland

As educational approaches tend to be embedded in the midwifery and maternity care system of each country, Table 2 provides an overview of midwifery in NZ and Scotland. Similarities between the countries include the population size, landscape and birth numbers (National Records of Scotland, 2016; Statistics New Zealand, 2016) and an approach to midwifery practice, education and regulation. This approach is based on midwives working in collaboration and partnership with women to provide individualised woman centred care (Scottish Government, 2017, 2010; McAra-Couper et al., 2014).

The challenges and requisite skills needed to sustain rural and remote midwifery practice, as identified in the literature review, would suggest that is it imperative that midwifery students in both Scotland and New Zealand are adequately prepared and have a clear understanding of the uniqueness of the rural practice setting. This paper reports on the realities of practice from both countries that inform educational needs. The data are additionally used to consider future educational strategies to both prepare students for the realities of rural practice and to encourage recruitment and retention in rural and remote regions.

4. Methods

A mixed methods study design incorporating both quantitative and qualitative approaches was adopted to address the research aims and objectives. The study was conducted in two consecutive parts.

The New Zealand College of Midwives (NZCOM) and Lead Midwives in Scotland provided access and supported recruitment of participants. Inclusion criteria in NZ included midwives who self-designated as rural midwives. Lead Midwives in Scotland, recommended that community midwives working in rural areas in each of the 14 Health Boards would self-select for the study. In Scotland, the census 'Urban rural classification and definition of rural areas in Scotland' was used (Scottish Government, 2014).

Ethical approval was obtained from the ethics committees in Higher Education Institutions (RGU and UWS in Scotland and in NZ at AUT Research Ethics committee (AUTEC) and endorsed at Ara Human Research Ethics committee). Access was approved through the National Research and Development Centre in Scotland and by the professional body in NZ (NZ College of Midwives).

Part One: An online survey was designed to include key issues on rural midwifery practice identified from the literature. In relation to education, participants were asked if they had a rural placement during their programme and if the placement prepared them for rural practice. Open textboxes offered participants an opportunity to provide further information and viewpoints on their educational preparation for rural practice and any improvements (See Table 3). Following a pilot and update, the online survey was circulated via SurveyMonkey® to approximately 2500 midwives in NZ (representing all midwife members of NZCOM) and to approximately 270 community midwives (involved in providing rural practice) in Scotland. Two rounds of email reminders were circulated by NZCOM and Lead Midwives (Scotland) to prompt midwives to complete the online survey.

In NZ, 145 midwives responded to the survey, of whom 103 (71%) had a caseload that was comprised of 50% or more of women residing in a rural area. In Scotland, 77 community midwives participated from 13 of 14 Health Boards. It was not possible to determine the response rate as both countries did not maintain a specific database for rural midwives.

Part Two: Online discussion forums were chosen to provide