Experiences of the graduates of the first baccalaureate midwifery programme in Pakistan: A descriptive exploratory study

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ABSTRACT

Background: in 2012 the Aga Khan University in Karachi, Pakistan opened the country's first bachelor's degree program in midwifery for women who held diplomas in nursing and midwifery. The principal aims were to prepare midwives who would be competent to provide full-scope practice. For quality assurance, the programme was continuously monitored and assessed. As part of this ongoing evaluation process we sought in-depth feedback from the first graduates about their student experiences.

Objective: this study aimed to explore the experiences of the first graduates of a Bachelor of Science in Midwifery (BScM) program to deepen our understanding of their views of the program's strengths and difficulties and to obtain their suggestions for change. Design and Methods: This qualitative descriptive exploratory study used universal sampling to collect data from all 21 of the first graduates of the BScM Program. Data collection involved focus group discussions using a semi structured interview guide and content analysis. The study was approved by Institutional Ethics Review Committee.

Findings: three main themes emerged from the data: (1) Competence acquisition, (2) Attitude transformation, and (3) Strengths and limitations of the program.

Conclusions: the study findings highlighted that the degree program in midwifery had a positive impact on graduates' perceptions of their knowledge, skills, attitudes and ability to implement evidence-based midwifery practice. The graduates regarded the university's environment, teaching-learning strategies, preceptorship model, self-directed learning and exposure to diverse clinical settings as major facilitators in achieving competence.

Introduction and background

In 2012 the Aga Khan University in Karachi, Pakistan opened the country's first bachelor's degree programme in midwifery for women who held diplomas in nursing and midwifery (Jan et al., 2016). It is essential to continuously evaluate an educational programme to assess its relevance, performance, and success in achieving its goals. As part of this ongoing evaluation process, we sought in-depth feedback from the first graduates about their student experiences. Their perceptions are vital for assessing the programme's strengths and areas for improvement. This paper briefly sets forth background information relevant to midwifery in Pakistan and goals of the new university programme since the context is important for understanding the graduates' feedback.

The Maternal Mortality Ratio (MMR) of Pakistan is 276/ 100,000 live births, a rate that remains high despite many interventions since the initiation of the Millennium Development Goals (NIPS - National Institute of Population Studies, Pakistan, Macro International Inc, 2008). The majority of these maternal deaths could be prevented by universal access to adequate reproductive health services. There is international consensus on the significant role of midwives in reducing maternal deaths. Current estimates are that, a 10% increase in skilled health workers leads to a 5% reduction in maternal deaths (UNFPA,

ICM, and WHO, 2014).

Hence, in order to improve perinatal outcomes, midwives needs to be educated, regulated and licensed (Renfrew et al., 2014). It is also endorsed by the WHO (2014), which states that, sufficient and competent health care providers specifically those with 'midwife or other midwifery skills' are essential without which all other strategies to reduce maternal, neonatal and child mortality will never be achieved.

Prior to 2012 there were three pathways to obtaining a midwifery qualification in Pakistan: become a Lady Health Visitor (LHV), or a nurse-midwife or a community midwife (CMW). The LHV pathway is a two year diploma programme, in which one year is public health nursing and one year is midwifery. The nurse-midwife pathway is a one year diploma programme following a three year nursing diploma. The CMW pathway of 18 months was launched by the government of Pakistan in 2007 for the improvement of primary maternity services in communities.

Studies have highlighted the shortcomings of midwifery education delivered through these diploma programmes (Rukanuddin et al., 2007; Sarfraz and Hamid, 2014). Most of the graduates successfully acquire the basic midwifery knowledge but due to limited clinical experience they do not acquire the necessary midwifery skills, hence, are unable to demonstrate confidence and competence in clinical practice (Sarfraz and Hamid, 2014).The midwives who work in a hospital setting are relegated to the role of the assisting doctor, and are unable to carry out the full scope of practice of a qualified midwife. Almost 90% of registered nurses are trained in midwifery but only a few actually practice midwifery (Rukanuddin et al., 2007).

Lack of development of the midwifery profession, the limited scope of practice and lack of career opportunities have fostered lack of acceptance and invisibility of midwives in Pakistan and in the larger South Asian region. This leads many young women to prefer the field of nursing rather than midwifery (Saleem et al., 2015; Jan et al., 2016).

These challenges highlighted the need to actively change midwifery education to ensure that it meets the education standards of the International Confederation of Midwives (ICM, 2013) and that the future workforce better meets the needs of the population. In our preceding article (Jan, et.al., 2016), the Bachelor's in midwifery programme is discussed in detail. The programme launched in 2012 after receiving feedback on the curriculum from the Education Committee of ICM. The ICM graciously agreed to review the document as it was the first undergraduate degree program for South Asia. This two year programme has a balance of 40% theory including midwifery, science and research courses and 60% clinical practice. Total 21 students were admitted in the first cohort, with a minimum of five from each province of Pakistan. The principal aims were to prepare midwives who would be competent to provide full-scope practice confidently and independently and who also would be clinical leaders in upgrading midwifery practice throughout the country (Jan et al., 2016). This strategy is aligned with the experiences of LMIC such as Burkina Faso, Cambodia, Indonesia, and Morocco, who have opted, for a rapid scale-up of their midwife workforce and deploy competent midwives (Van Lerberghe et al., 2014).

Our purpose in exploring the student experiences of the first cohort of graduates from the BScM Programme in Karachi, Pakistan was to deepen our understanding of their views of the programme's strengths and difficulties and to obtain their suggestions for change. As the first participants of the programme their views are very important in the ongoing assessment of its quality.

Methods

Study design and participants

We used a qualitative descriptive exploratory design for this study of student experiences. All 21 graduates were invited and agreed to participate in the study. This full participation provided a true representation of the sample and ensured that the different provinces were represented since the experiences could differ according to the province of origin.

Data collection procedure

Two Focus Group Discussions (FGDs) (n = 10 and 11 respectively) were conducted in November 2014. Krueger and Casey (1994) defined a focus group study as 'a carefully planned series of discussions designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment'. FGDs generate deeper and richer data through social interaction within the group as compared to individual interviews (Thomas et al., 1995). Group size was determined considering the suggested optimal group size for FGD 6–12 people (Tong et al., 2007; Polit and Beck, 2008). Researchers ensured equal representation of all provinces in each group. The interviews were conducted within one week of their graduation to avoid any recall bias among the participants. At this point students had not initiated their clinical work. In this way researchers controlled any contamination of their student experiences with their work experience.

Two educators from the same university who were not involved in direct teaching of these students were trained by the researchers to moderate the FGDs. Researchers developed a discussion guide (Box 1) for the moderators to ask and probe questions to increase the comprehensiveness of data collection (Wong, 2008). Each FGD lasted 60 to 90 minutes. The interviews were conducted in English language and were recorded in a digital voice recorder and field notes were obtained by the note taker accompanying each educator during FGDs. Notes were compared to the transcripts during analysis to increase data validity.

Data analysis

Data analysis was done manually and simultaneously along with data collection. After both the FGDs, the members of the research team did immediate debriefing with the observer who helped the researcher in taking notes and observing the non-verbal behaviors. The research team made debriefing notes; which included comments about the process of FGDs and the significance of data and its relationship to the phenomenon of interest. Then, the audio recordings were listened and data were transcribed on a MS word document with a pseudo file names. Moreover, the audio taped content were checked with the observer notes to take care of the non-verbal cues and behaviors. This helped the research team to understand the verbal statements better when incorporated with the non-verbal communication and gestures. The transcripts were distributed among three researchers who independently analyzed the data using Graneheim and Lundman (2004) analysis approach, which has three levels of coding the focus group data. In level one, the research team thoroughly read the transcripts line by line to look for meaning units (statements) that addressed the phenomenon of interest. In level two, data was compared for similarities and differences and were then coded accordingly. Similar data were clustered together into categories and data with differences were categorized separately. In level three, the clustered

Table 1
Example of three levels of coding of theme one.

Level 1 Meaning Unit	Level 2 Categories	Level 3 Theme
Variety of teaching-learning strategies	Theoretical learning	Competence Acquisition
Diverse learning styles		
Faculty-student relationships		
Constant guidance		
Hands-on practice	Clinical learning	
Self-directed learning		
Clinical facilitation		
Clinical portfolio		