Midwifery matters

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‘Midwifery matters more than ever’, states the landmark *Lancet* series on midwifery (Renfrew et al., 2014). *The State of the World’s Midwifery* 2014 estimates that midwives who are well educated, trained, licensed and regulated are capable of providing 87% of the essential sexual, reproductive, maternal and newborn healthcare services that improve pregnancy, birth and postpartum outcomes, and increase access to universal health coverage (United Nations Population Fund, 2014). Such a workforce can respond to the fundamental needs of women, babies and families that are, still too often, not met with skilled, compassionate care. Given the current emphasis on midwives as pivotal in strengthening health systems and service delivery throughout the world, Jhpiego, an organisation long supportive of nurses and midwives, has carefully examined the components of a sound approach to training and educating midwives. Midwifery education is the foundation supporting the development of midwives who can provide skilled care upon graduation, and are poised for careers in which they influence the availability and accessibility of high-quality care through example, leadership and advocacy.

In 2012, Jhpiego developed a conceptual model for organising its work in pre-service education (Johnson et al., 2013). The model, developed after an integrative review of the literature to determine the characteristics of high-quality pre-service education, depicts the essential inputs and influencing factors that determine an educational system’s ability to produce competent graduates. Although there are few studies of the impact of high-quality pre-service education on health and health systems outcomes, it is logical to assume that a skilled workforce contributes to the achievement of national and global health goals.

The overarching principle of any educational approach must be competence. Fig. 1 illustrates five essential inputs for an educational system to produce competent graduates: (a) curriculum; (b) infrastructure and management; (c) teachers, tutors and preceptors; (d) students; and (e) clinical practice sites. These inputs are buttressed by the supporting regulatory and licensing architecture of the governmental system, which, if weak, can undermine even the best efforts in education. The scope of this discussion will not permit an exhaustive examination of the supporting architecture of the profession, but the importance of regulation and licensing cannot be underestimated. The skilled midwifery workforce of the future will benefit from the recognition that each of these five factors is essential, and that the interplay between them creates a fully enabled learning environment for midwives.

Long thought to be the key that unlocks the kingdom of higher learning, it is now understood that a curriculum must be evidence based and, just as importantly, competency based. There is no clear evidence showing that one competency-based approach, such as problem-based learning, is superior to another, but it is known that didactic techniques that involve passive instruction, such as reading or listening to a lecture, have little or no impact on learning outcomes. Thus, active learning should be part of any midwifery education curriculum. In addition, the curriculum should reflect national health needs and priorities, and development of the curriculum must involve close collaboration with and between the ministries that oversee the education and practice of health providers. While countries should make a commitment to adhere to global guidelines for midwifery competencies, each country context determines the skills required to respond to national health needs and priorities.

The infrastructure of an educational institution is the second element meriting strong consideration. Infrastructure includes technology and simulation laboratories. Through technology, students have access to learning regardless of their location, so they can better balance family and work obligations. Digital learning improves students’ experience through, for example, up-to-date resources, materials that make it easier to understand challenging topics, and formats that are more engaging than traditional lectures. Students need access to elements of infrastructure and management of learning such as internet-enabled libraries, skills and simulation laboratories, and computer laboratories. Skills laboratories that are accessible and well managed are particularly important because they provide the opportunity for demonstration and simulated practice. Such facilities are essential to the process of shaping values and developing the decision-making and psychomotor skills that students need before they can move on to a clinical practice site.

Evidence from descriptive literature shows that the role of the clinical preceptor is as crucial as that of the classroom teacher. While there is limited evidence showing that a classroom teacher is as clinically proficient as a preceptor, the clinical and precepting skills of the clinical preceptor are crucial. In both roles, using a learner-centred teaching approach to identify students’ learning needs, assess students’ learning and manage time for exposure to clinical presentations supports students’ mastery of essential clinical decision-making processes.

In many countries, students gain admission to educational programmes based on their matriculation scores and proximity to centres of higher learning. These approaches to student selection do not take into account students’ expression of interest, nor do they adequately recruit students from diverse geographical locations. In some cases, student selection reflects questionable and arguably harmful criteria, such as eliminating older or married students from consideration. Multiple studies...
have demonstrated that targeted recruitment of qualified students from rural areas enhances retention in the communities in greatest need, a longstanding requirement for ensuring access. By valuing student interest in the profession during the selection process, and structuring student support accordingly after admission, programmes can significantly improve the likelihood that students will complete their education.

The final element of an education that produces competent graduates is integrating commencement of clinical skills and knowledge acquisition at the clinical practice site. In this setting, all of the key elements converge. Learner-centred collaborative support from the clinical preceptor and classroom teacher creates an environment where students develop the competency and confidence they need to provide direct patient care after graduation. Students repeat their practice at varying intervals and gradually increasing levels of complexity. Students, preceptors and teachers must all take part in assessing students’ progress in mastering skills and competencies. Programmes need creative solutions to challenges related to the number of students, competition among learners across cadres, overwhelmed clinicians, and insufficient space and supplies. Such solutions may include team-based practice, simulation and expansion of the clinical experience to a broader range of facilities. Student midwives, in particular, need an introduction to and sustained experiences with the midwifery model of care so that they truly understand all dimensions of the care model.

The reality in many settings is that the need is great and resources are limited. Research is needed on effective, sustainable and culturally appropriate combinations of the five essential inputs in this educational model. However, while evidence tells us much of what is most valuable for learning, the real constraints that many countries face demand careful prioritization and a strategy to move towards an educational system that prudently incorporates, step by step, the foundations of high-quality clinical learning. The World Health Organization’s Global Strategy on Human Resources for Health: Workforce 2030 calls us to scale up transformative, high-quality education as the United Nations High-Level Commission on Health Employment and Economic Growth estimates a staggering deficit of 18 million health workers by 2030 (Horton et al., 2016; World Health Organization, 2016). It is imperative that we advance rapidly from evidence to action.

References