OUR EXTRAORDINARY JOURNEY to TRANSFORM MIDWIFERY EDUCATION

An appreciation of our role as midwife educators

DISCOVERY

"Saving women's lives with cost-quality effective midwifery care is based on sound pre-service and ongoing education. Effective midwifery education requires competent, caring, and compassionate teachers. The competencies are based on the midwifery philosophy, values and model of care" (Thompson, 2002:256).

CONVERSATIONS IN PAIRS

Thank you for taking part in an exciting process. The questions being asked are called **Appreciative Questions**. You are going to ask one another questions about times when you observed or had the best possible experience of midwifery educators' competencies. Often we try to ask about things that are not working well - the problems – so that we can fix them. In this case, however, we will try to ask about things that are working well – the successes – so that we can do more of it.

So the best thing that you can do in this conversation is to think about, remember, and tell your colleague in detail about the positive things you have seen, heard, experienced or imagined in your practice or education that reflected midwifery educators' competence.

SUGGESTED TIME LIMIT: 60 min.

1) Tell me about a peak experience, or high point, in your current practice as educator or witnessed in education – a time that you felt alive, most engaged, or really proud of what you did or experienced.

……

……

……

……

……

……

2) What was it about you, the situation, and/or the midwifery educator's competence that created the space for that peak experience to emerge?

……

……

……

……

……

……

……

……

……

3) What do you value most about yourself as a midwife educator or stakeholder in education regarding midwifery educator's competence?

……

……

……

……

……

……

4) What is the one thing that gives life to your practice without which it just would not be the same?

……

……

……

……

……

……

……

……

……

INVITING THE EXTRAORDINARY

Background

In today's rapidly changing environment, midwifery educator's competence to ensure quality midwifery education depends on the collective capacity to invite the extraordinary. The International Confederation of Midwives (ICM), as a collective of midwives world-wide, formulated a philosophy and model of care that apart from the importance of safe motherhood describes elements of how midwives think about midwifery and how their subsequent care will be. Concepts within the ICM Philosophy and model include partnership with women, respect for human dignity, compassion and the promotion of human rights for all persons. (International Confederation of Midwives, 2014:1–3).

To reach universal health coverage and ending preventable maternal mortality we need more competent midwives. The gaps identified should be covered and the midwifery workforce should be available, accessible, with quality and acceptable care given. These midwives will be the product of a midwifery education programme based on a sound philosophy and according to global standards and should be implemented and delivered by competent educators.

The need for adequately prepared midwife educators who have access to resources, such as technology, laboratories for skills training, as well as adequate resources and capacity within the educational institution is crucial. With a very high faculty to student ratio (1:45) in developing countries like SA and in areas only 6.6% of midwife educators with qualifications or preparation as educators there is a need to capacitate midwife educators, especially in the developing countries (World Health Organisation, 2013:9).

As midwifery is a profession working with women and mostly but not exclusively practiced by female midwives, the issue of gender inequality is significant. "Autonomous midwifery practice enables midwives to fulfil their contract with society by providing up-to-date, evidence-based, high quality and ethical care for childbearing women and their families, as set out in the ICM Definition of the Midwife 2011. However, in significant areas of the world, midwifery education and practice are being defined by those without midwifery knowledge and skills. In other places, even though midwifery education and practice are defined by midwives, the regulation of midwifery practice rests in the hands of other health professionals or government agents who seek to control and limit the scope of midwifery practice (International Confederation of Midwives (ICM), 2011b:1)

Extraordinary steps

When we are at our best, we invite the extraordinary by creating new ways of doing things and by utilizing communication strategies to find new and different solutions. We invite the extraordinary by exploring and taking risk by being inquisitive and by

looking at things in new and different ways. We invite the extraordinary by serving as a conduit for new ideas and by boldly inventing new ways of engagement that establish new standards for excellence in our midwifery educators' competence and midwifery education.

5) Tell me about the best example of midwifery education competence that you experienced in midwifery education. What was it about that incident that made it so memorable?

……

……

……

……

……

……

……

……

……

6) Tell me what you do when you feel highly relaxed, most secure, or most cherished as midwife educator – when it is simply great to be a midwife educator?

……

……

……

……

……

……

7) What do you regard to be the best aspect of the midwifery educators' competence to igniting change in an environment of gender inequality?

……

……

……

……

……

……

IN CLOSING

8) Imagine that you have a magic wand, and you would have any three wishes granted in order to create ideal midwifery education. What would those wishes be? (Please – THINK BIG)

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

INTERVIEW SUMMARY SHEET Individual exercise

What were the best stories/quotes that you heard in the interview? Summarise your thoughts below.

1. .....
   .....
   .....
   .....
   .....
2. .....
   .....
   .....
   .....
   .....
3. .....
   .....
   .....
   .....
   .....
4. .....
   .....
   .....
   .....
   .....
5. .....
   .....
   .....
   .....
   .....

POSITIVE THEMES OF OUR MIDWIFERY EDUCATORS COMPETENCE

Voting with five stickers per person.

The themes that represent the core of our midwifery educators' competence.

1. ……

2. ……

3. ……

4. ……

5. ……

6. ……

7. ……

8. ……

DREAM

DREAM EXERCISE

It is four years from now. You are a member of a dynamic midwifery education team. What is the most extraordinary thing that **you** would personally have liked to accomplish as a member of the team within the next four years?

……

……

……

……

……

……

VISUAL IMAGE OF AN EXTRAORDINARY MIDWIFERY TEAM

PRODUCE A COLLAGE

OR

WRITE A POEM

DESIGN

Midwifery educators' competence: provocative proposition

Write down a single line statement that describes your midwifery educators competence in an optimal way. Such a statement can also be called a provocative proposition or possibility statement.

To write a good provocative proposition, capitalize on the opportunities discussed previously, and ask yourself the following questions:

→ Is it provocative? Does it stretch and challenge? Is it desired?

Do we want it as a preferred future?

→ Is it stated in affirmative bold terms? Perhaps a catchphrase?

Creating and sustaining our dream: SOCIAL ARCHITECTURE

What are the desired resources/frameworks for meeting the opportunities identified in the dream exercise?

……
……
……
……
……
……
……
……
……

DESTINY

Framework elements to operationalise the themes in our midwifery educators' competence.

Please state those elements that you consider crucial to strengthen midwifery educators' competencies in South Africa. To ensure Competence can grow from novice to expert. To educate midwives complying with the ICM Philosophy and Model of care within the environment of gender inequality.

EvaSys	World Health Organisation **Midwifery Educators Core Competencies** gap analysis self-	Electric Paper

Mark as shown: ☐ ☒ ☐ ☐ ☐ Please use a ball-point pen or a thin felt tip. This form will be processed automatically.

Correction: ☐ ■ ☐ ☒ ☐ Please follow the examples shown on the left hand side to help optimize the reading results.

1. Informed consent and demographic information

Dear midwife educator

I am a PhD student I am engaging in research with the aim of developing a transformative framework to strengthen Midwifery Educators Competencies (MEC) in South Africa.

Invitation to participate: I am inviting you to be part of this co-creative process to ultimately have a transformative framework, by participating in the quantitative phase of the research:

What is involved in this phase of the study?

Midwife educators fro across South Africa will be completing the self-assessment of midwife educators competencies.

Risks of being involved in the study were not identified.

Benefits of being in the study is that you are part of the strengthening of midwifery education through co-creating a transformative framework for MEC in SA.

Participation is voluntary, and refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

Confidentiality: Efforts will be made to keep personal information confidential.The Evasys system will not have a way of identifying you in this questionnaire. Absolute confidentiality cannot be guaranteed. Personal information may be disclosed if required by law. Organisations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the Health Sciences Research Ethics Committee. If results are published, this may lead to individual/cohort identification.

Contact details of researcher E. Bekker bekkeree@ufs.ac.za/ 082 890 6824– for further information/reporting of study-related adverse events.

Contact details of HSREC Secretariat: **Mrs Maré Marais (Head of Ethics Administration) T: +27 51 401 7795**

Your participation in this research is voluntary, and you will not be penalised or lose benefits if you refuse to participate or decide to terminate participation. If you agree to participate, your completion of this self-assessment questionnaire and submission is seen as your consent.

I understand what my involvement in the study means and I voluntarily agree to participate.

1. Informed consent and demographic information [Continue]

1.1 Please select your qualifications from the options below :(Please tick more than one if applicable)

- ☐ Diploma in midwifery
- ☐ Diploma in advanced midwifery
- ☐ Nursing education
- ☐ Nursing Management
- ☐ Bachelors degree
- ☐ Masters degree
- ☐ PhD

1.2 List any qualifications not captured in Question 1.1.

1.3 Indicate your professional registration with SANC. Indicate all that apply.

- ☐ General Nurse
- ☐ Midwife
- ☐ Community Nurse
- ☐ Psychiatric nurse
- ☐ Nurse educator
- ☐ Nursing administration or management
- ☐ Advanced midwife
- ☐ Moderator
- ☐ Assessor

1.4 List any SANC registrations not selected in 1.3

1.5 What is your age in years?

1.6 Your gender

1.7 Please indicate in which of the following midwifery programmes are you involved as educator

- ☐ One year midwifery diploma
- ☐ Comprehensive diploma
- ☐ Advanced midwife diploma
- ☐ Bachelors programme
- ☐ Masters degree
- ☐ PhD

1.8 Indicate all your responsibilities in the programmes listed in 1.7 (please tick all applicable options).

- ☐ Clinical accompaniment
- ☐ Lecturer Theory
- ☐ Lecturer Practical
- ☐ Coordinator
- ☐ Research supervision

1.9 How many years of clinical midwifery experience did you have before entering into education?

1.10 How many years experience do you have as an educator?

1. Informed consent and demographic information [Continue]

1.11 Amount of hours per week spent in clinical practice settings

1.12 Please write in short what is giving you energy in your task as midwife educator?

1.13 What component that you teach in midwifery excites you, and why?

2. The questions in the following section are focused on the impact of issues like gender, race and class on midwifery and midwifery educators. The majority, **but not all,** educators are women and our profession is also involving the mother as partner in her care. Universal health coverage and reproductive health issues are embedded within a human rights perspective that in practice is underpinned by elements, such as gender.

2.1	Does the unequal social position of women negatively affect their maternal health needs?	Yes ☐	☐ No
2.2	Do you as midwife educator consider yourself to have the ability to make choices and act on those choices with regard to Midwife Educators' Competencies?	Yes ☐	☐ No
2.3	Do you consider the profession of midwifery as an autonomous profession in your context in SA?	Yes ☐	☐ No
2.4	Is the autonomy of the midwifery profession linked to the fact that midwives work with women?	Yes ☐	☐ No
2.5	Do midwife educators experience disadvantage or discrimination in any way?	Yes ☐	☐ No

2.6 Please motivate your answer in 2.5

2.7 What in your opinion can transform midwifery educators' competence to ensure that maternal and child health goals and universal health coverage are reached?

3. The next section is using the World Health Organization set of competencies of Midwife educators. This is a self-assessment. Please read the instructions and for each question answer two components. Although there are many the completion format of clicking would save time. Please use this anonymous platform to ensure that midwife educators as a group of faculty can be strengthened.

4. Competency 1

Midwifery educators behave in ways that reflect the ethical standards of teaching and the midwifery profession.

4. Competency 1

Midwifery educators behave in ways that reflect the ethical standards of teaching and the midwifery profession. [Continue]

There is a number of questions following regarding different competencies.

For each you please need to **select two answers**, one for competence and one of confidence.

In your self-assessment, kindly rate the options for ***competence*** (the options in blue) as follows:

Not have competency- this implies that you do not currently have either the knowledge, skill or attitude relating to the statement.

Did at least one- this implies that you performed this competency at least once in the past year.

Competent- this implies that you are current in your knowledge or can perform the skill effectively and repeatedly or have the expected attitude.

In choosing the options to rate your self-assessment kindly rate your ***confidence*** (options in green) using the following description. If it says:

Not confident- this implies that you have little or no confidence in this knowledge/skill or attitude.

Confident- this implies that you are confident in this knowledge/skill or attitude.

So for each question, please select two choices, one from the COMPETENCE (Text in blue) section as well as one from the CONFIDENCE (Text in green) .

Basic knowledge required to demonstrate skills/abilities& behaviours/attitudes:

4.1 International ethical responsibilities and obligations related to teaching and {midwifery} practice

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

4.2 Local ethical responsibilities and obligations related to teaching and {midwifery} practice

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Skills/abilities

Use knowledge of ethical issues as basis for influencing, designing, implementing, and evaluating policies and procedures related to:

4.3 **a. Students**

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

4.4 **c. Clinical environment**

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Behaviours/attitudes

4.5 Display ethical intent incorporating fundamental ethical principle of respect and responsibility

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

4.6 Protect the rights of women when teaching or delivering midwifery care:

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

4. Competency 1

Midwifery educators behave in ways that reflect the ethical standards of teaching and the midwifery profession. [Continue]

4.7 Recognize potential ethical issues and dilemmas in the workplace:
☐ Do not feel competent ☐ Did at least one ☐ Do feel competent
☐ Not confident ☐ Confident

4.8 Discuss ethical issues and dilemmas with students and other appropriate persons:
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

5. Competency #2: Midwifery educators demonstrate understanding of legal and regulatory statutes relevant to midwifery teaching and practice.

Basic knowledge required to demonstrate skills/abilities and behaviours/attitudes:

5.1 Law and regulation related to midwifery practice
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

5.2 Law and regulation relating to teaching and in health professions
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Skills and abilities

Incorporate legal and regulatory requirements to into midwifery education during:

5.3 a. Implementation of teaching and learning
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

5.4 b. Assessment of teaching and learning
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Behaviours/attitudes

5.5 Comply with legal and regulatory statutes
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

5.6 Ensure students comply with legal and regulatory statutes
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

6. **Competency #3: Midwifery educators maintain competency in midwifery practice.**

6.1 All areas of the theoretical component of the midwifery curriculum
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

6.2 All areas of best practice in the clinical practice of midwifery
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

6.3 Evidence-based and up-to-date midwifery content and related subjects
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Skills/abilities

6.4 Provide a safe, competent and effective midwifery care to women and their newborns
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

6.5 Apply research findings in practice
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

6. Competency #3: Midwifery educators maintain competency in midwifery practice. [Continue]

6.6 Fulfil the requirements of the midwifery regulating body
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Behaviours/attitudes

6.7 Participate in professional development activities in order to increase effectiveness
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

6.8 Participate in accord with a code of ethics
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

6.9 Provide high quality [midwifery] care
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

6.10 Demonstrate and value lifelong learning to maintain own competence
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

7. Competency #4: Midwifery educators practice midwifery in ways that reflect evidence-based and up-to-date knowledge.

Knowledge required to demonstrate skills/abilities and behaviors/attitudes

7.1 Research processes
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

7.2 Locally relevant epidemiology
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

7.3 Locally relevant community health issues
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

7.4 Locally relevant health issues [sexual and reproductive health]
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

7.5 Locally relevant provision of [SSRH] health services
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Skills/abilities

7.6 Access research findings
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

7.7 Review literature for evidence related to practice
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

7.8 Implement research findings
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Behaviours/attitudes

7.9 Willingness to adjust to practice in the light of evidence
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

8. Competency #5: Midwifery educators incorporate educational strategies to promote active learning.

Knowledge required to demostrate skills/abilities and behaviour/attitudes

8.1 Theories of learning that result in development of clinical competence
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

8.2 Competency-based education (CBE)
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Skills/abilities

8.3 Acknowledge students as adult learners
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not Confident ☐ Confident

8.4 Ground teaching strategies in educational theory and evidence-based teaching
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Use educational approaches reflecting contemporary educational theory and practice of midwifery including:

8.5 a. Problem-based learning
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

8.6 b. Case-study or narrative based learning
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

8.7 c. Discussion and group work
☐ Do feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

8.8 d. Seminar presentations
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

8.9 e. Experimental learning(e.g., role-play, simulation, simulated patient/woman)
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

8.10 f. Workshops
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

8.11 g. Projects
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

8.12 h. Active/participatory lectures
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

8.13 i. Effective use of audio visual materials
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

8.14 j. E-learning
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Behaviours/attitudes

8.15 Model critical and reflective thinking
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

8.16 Show enthusiasm for teaching, learning and midwifery that inspires and motivates students
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

8. Competency #5: Midwifery educators incorporate educational strategies to promote active learning. [Continue]

8.17 Foster a relationship of mutual trust and respect

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

9. Competency #6: Midwifery educators select and use effective teaching and learning

Basic knowledge required to demonstrate skills/abilities and behaviours/attitudes

9.1 Educational and learning resources and materials based on best available evidence

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Skills/abilities

9.2 Evaluate and choose appropriate teaching and learning materials and resources

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

9.3 Develop appropriate educational materials that are matched to the learning domain [psychomotor, cognitive, affective]

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

9.4 Use information technologies skilfully to support the teaching-learning process

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

9.5 Ensure safe and appropriate physical learning environments including: classroom conditions such as light, temperature, desk arrangement

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

9.6 Ensure safe and appropriate physical learning environments including: classroom size and amount of students

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

9.7 Advocate for change when the learning environment not provided

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

10. Competency #7: Midwifery educators recognize and support different learning styles and the unique needs

Basic knowledge required to demonstrate skills/abilities and behaviours/attitudes

10.1 Theory and methodology of educational needs assessment [of individual learners]

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

10.2 Social and human relationships and the conditions for learning

☐ Do not feel competent ☐ Did at least once ☐ Do feel confident
☐ Not confident ☐ Confident

10.3 Interaction between educator and learner

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

10.4 Principles of counselling

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Skills/abilities

10.5 Provide resources to diverse learners that help meet their individual learning needs

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

10. **Competency #7: Midwifery educators recognize and support different learning styles and the unique needs** [Continue]

10.6 Engage in effective advice and counselling strategies that help learners meet their learning goals
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

10.7 Create effective learning environments that are focused on socialisation of the role of the midwife
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

10.8 Create effective learning environments that facilitate learners' self-reflection and personal goal setting
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

10.9 Recognise the influence of teaching styles and interpersonal interactions on learner outcomes
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

10.10 Foster the cognitive, psychomotor and affective development of learners
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Behaviours/attitudes

10.11 Demonstrate interest in and respect for learners
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

10.12 Support learner's continuous lifelong learning as a professional midwife
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

10.13 Use personal attributes (e.g., caring, confidence, patience, integrity and flexibility) that facilitate learning
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11. **Competency #8: Midwifery educators contribute to or facilitate a safe and effective learning environment in the clinical setting**

Basic knowledge required to demonstrate skills/abilities & behaviours/attitudes

11.1 The clinical environment and governing structures
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.2 Competency-based clinical learning
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.3 How students integrate into a new practice setting
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.4 Evidence informed practice
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.5 Ethical expectations of midwifery practice including supporting informed choice
☐ Do not feel competent ☐ Did a least once ☐ Do feel competent
☐ Not confident ☐ Confident

Skills/abilities

Facilitate effective learning and the development of competence within an area of practice by correctly teaching students the process of:

11.6 a. assessment
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.7 b. planning
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11. **Competency #8: Midwifery educators contribute to or facilitate a safe and effective learning environment in the clinical setting** [Continue]

11.8 c. implementation
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.9 d. evaluation
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.10 e. documentation of midwifery care
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.11 Create an environment in which practice development is fostered, evaluated and disseminated
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.12 Demonstrate effective midwifery relationships with patients/women
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.13 Obtain free and informed consent for student involvement in care
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Competent

11.14 Protect the woman and her baby from harm
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.15 Enable students to relate theory to practice encouraging reflective learning
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.16 Build and maintain collegial relationships with staff in the clinical environment
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.17 Demonstrate to students principles of effective delegation and supervision
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Behaviours/attitudes

11.18 Demonstrate effective interpersonal skills
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.19 Seek clarification or assistance from staff as needed
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.20 Set effective professional boundaries whilst creating a dynamic, constructive teacher- student professional relationship
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.21 Foster professional growth and personal development by use of effective communication
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.22 Facilitate and develop the ethos of interprofessional learning and working
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.23 Identify teaching opportunities in the clinical setting
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

11.24 Set boundaries of safe practice
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

12. **Competency #9: Midwifery educators foster individualized experiential learning**

Basic knowledge required to demonstrate skills/abilities & behaviours/attitudes

12. **Competency #9: Midwifery educators foster individualized experiential learning** [Continue]

12.1 Experiential learning
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

12.2 Diversity of learning processes
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Skills/abilities

12.3 Design and deliver programmes of learning in practice settings supporting a range of students in their area of practice
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

12.4 Assess programmes of learning in practice settings
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

12.5 Assess, create and develop opportunities for students to identify and undertake experiences to meet their learning needs
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

12.6 Provide advice and support to identify changes required [to demonstrate competency]
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Behaviours/attitudes

12.7 Assess students' ability to integrate their professional role, their capacity to undertake that role and the knowledge based with which that professional identify and performance are intermeshed.
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

12.8 Act with respect and interest in the students
☐ Do no feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

12.9 Demonstrate patience with individual students to foster experiencial learning
☐ Do not feel competent ☐ Did at least once ☐ Do feel confident
☐ Not confident ☐ Confident

13. **Competency #10: Midwifery educators continuously monitor, assess and evaluate the effectiveness of the educational programme.**

Basic knowledge required to demonstrate skills/abilities & behaviours/attitudes
Theory and methodology of learning outcomes assessment and evaluation including:

13.1 a. examination [paper/pencil test]
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

13.2 b. essay
☐ Do not feel competent ☐ Did a least once ☐ Do feel competent
☐ Not confident ☐ Confident

13.3 c. seminar presentation
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

13.4 d. midwifery case study
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

13.5 e. project
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

13.6 f. Objective Structured Clinical Examination (OSCE)
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Skills/abilities

13. Competency #10: Midwifery educators continuously monitor, assess and evaluate the effectiveness of the educational programme. [Continue]

13.7 Use methods of assessment and evaluation of learning that are linked to learning goals

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Use a variety of strategies and tools to assess and evaluate learning in the cognitive, psychomotor and affective domains for:

13.8 a. Formative evaluation

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

13.9 b. Summative evaluation

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

13.10 Participate in selection of the key elements of assessment tools (e.g., examination blueprinting, examination item writing, validity, reliability)

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

13.11 Construct tests and appropriate evaluation tools

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

13.12 Participate in setting pass or fail standards and assessment criteria

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

13.13 Provide timely, constructive and thoughtful feedback to learners

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

13.14 Use assessment and evaluation data to enhance the teaching-learning process

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

13.15 Maintain accurate records of student progress and achievement

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

13.16 Participate in programme evaluation

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Behaviour/attitudes

13.17 Display ethical intent and objectivity in all evaluation processes

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

14. Competency # 11: Midwifery educators assess student competence

Basic knowledge required to demonstrate skills/abilities & behaviours/attitudes

14.1 Assessment procedures

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Skills/abilities

14.2 Adapt, design and use of tools for assessing and documenting clinical practice

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

14.3 In partnership with other members of teaching team, use knowledge and experience to design and implement assessment frameworks

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

14.4 Assess progress in order to plan for the students' increasing level of skill acquisition

☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

14. Competency # 11: Midwifery educators assess student competence [Continue]

14.5 Make accurate judgments about the competency/proficiency of students including cultural and respectful care competency
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

14.6 Provide constructive feedback to students and assist in identifying future learning needs and actions
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

14.7 Manage unsuccessful students so that they may enhance their performance and capabilities for safe and effective practice
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

14.8 Manage unsuccessful students so that they are able to understand their failure and the implications of this for their future
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

14.9 Be accountable for confirming that students have met, or have not met, agreed standards of competency and are capable of safe and effective practice
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Behaviours/attitudes

14.10 Act as a role model
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

14.11 Display ethical intent and objectivity in all competence assessments
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

15. Competency #12: Midwifery educators actively participate in organizing and implementing a midwifery curriculum

Basic knowledge required to demonstrate skills/abilities & behaviours/attitudes

15.1 Educational management theories
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Skills/abilities

Participate in developing midwifery curriculum including:

15.2 a. Identifying programmatic and student outcomes
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

15.3 b. Developing competency statements
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

15.4 c. Writing learning objectives
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

15.5 d. Selecting appropriate learning activities
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

15.6 e. Selecting appropriate evaluation methods
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

15.7 Participate in the design of midwifery curriculum based on educational decision, principles, theory and research
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

15.8 Participate in the development of syllabi, and class/course outlines including learning objectives, target audience, contents of subject, teaching materials and evaluation methods
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Ensure the curriculum reflects:

15. **Competency #12: Midwifery educators actively participate in organizing and implementing a midwifery curriculum** [Continue]

15.9 a. the institutional philosophy and mission
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

15.10 b. current midwifery and health care trends, and
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

15.11 c. community and societal needs so as to prepare graduates for practice in a complex, dynamic, multicultural health care environment
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

15.12 Incorporate strategies for efficient management of time and resources
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

15.13 Work in multidisciplinary, interdisciplinary teams
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Behaviours/attitudes

15.14 Make inclusive and collaborative decisions
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

15.15 Participate as an effective team members
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

16. **Competency #13: Midwifery educators implement and revise midwifery educational courses/programmes**

Basic knowledge required to demonstrate skills/abilities & behaviours/attitudes

Skills/abilities

16.1 Curriculum monitoring and evaluation
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

16.2 Curriculum revision
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

16.3 Organisational management including organisational monitoring and evaluation
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

16.4 Quality assurance of organisational performance
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Skills/abilities

Revise curriculum based on:

16.5 a. systematic monitoring and evaluation of programme outcomes
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

16.6 b. learner needs
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

16.7 c. health care trends
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

16.8 d. midwifery trends
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

16. **Competency #13: Midwifery educators implement and revise midwifery educational courses/programmes** [Continue]

16.9 e. evolving community and societal needs
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

16.10 Implement curriculum revisions using appropriate change theories and strategies
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

16.11 Collaborate with external constituencies throughout the process of curriculum design, implementation and revision
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Design and implement programme assessment models that promote continuous quality improvement of all aspects of the programme including:

16.12 a. student performance
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

16.13 b. student evaluations
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

16.14 c. peer observations
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

16.15 d. graduation rates
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

16.16 e. qualification or registration success
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

16.17 Monitor and review midwifery programmes to ensure congruence with international and regional goals and national standards
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

16.18 Contribute to the quality assurance processes of the organization
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

16.19 Participate in the evaluation of organizational effectiveness in midwifery education
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Behaviours/attitudes

16.20 Keep thorough and accurate records
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

16.21 Display integrity in undertaking monitoring processes
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

17. **Competency #14: Midwifery educators communicate effectively using a variety of methods in diverse settings**

Basic knowledge required to demonstrate skills/abilities & behaviours/attitudes

17.1 Communication techniques
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

17.2 Presentation methodologies
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

17.3 Report writing
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Skills/abilities

17. **Competency #14: Midwifery educators communicate effectively using a variety of methods in diverse settings** [Continue]

17.4 Communication effectively using oral, written and electronic communication in order to achieve learner outcomes
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

17.5 Write clearly, produce concise reports and present effectively
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel confident
- ☐ Not confident
- ☐ Confident

17.6 Demonstrate effective communication skills in working with women, learners and other members of the health care team in clinical settings
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

17.7 Teach students how to engage in education of the childbearing women and the family
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

17.8 Document effective feedback
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

17.9 Maintain accurate records
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

17.10 Engage in conflict resolution as necessary
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel confident
- ☐ Not confident
- ☐ Confident

17.11 Demonstrate public speaking and active listening skills
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

17.12 Demonstrate excellent interpersonal and communication skills
- ☐ Do not feel confident
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

Behaviours/attitudes

17.13 Demonstrate an awareness of self and others
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

18. **Competency #15: Midwifery educators demonstrate cultural competence in course design and development, teaching and midwifery practice**

Basic knowledge required to demonstrate skills/abilities & behaviours/attitudes

18.1 Cultural diversity and identity
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

18.2 Human rights
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

18.3 Impact of power relations, racism and sexism
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

Skills/abilities

18.4 Recognise and describe multicultural, gender and experiential influences on teaching and learning
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

18.5 Facilitate the provision of culturally appropriate care
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

18.6 Encourage the expression and exchange of multicultural views
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

18. Competency #15: Midwifery educators demonstrate cultural competence in course design and development, teaching and midwifery practice [Continue]

18.7 Respect and protect human rights
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

18.8 Foster in students the ability to act and speak up when there are violations of human rights
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Behaviours/attitudes

18.9 Demonstrate cultural sensitivity
☐ Do not feel confident ☐ Did at least once ☐ Do feel confident
☐ Not confident ☐ Confident

18.10 Model cultural sensitivity when advocating for change
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

18.11 Be accountable for own actions and inactions in safeguarding human rights
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

19. Competency #16: Midwifery educators function as change agents and leaders in order to improve both midwifery practice and midwifery education

Basic knowledge required to demonstrate skills/abilities & behaviours/attitudes

19.1 Change management
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

19.2 Leadership theory
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

19.3 Interdisciplinary collaboration
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Skills/abilities

19.4 Act as a guardian of safe, competent, respectful midwifery care
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

19.5 Create and maintain community and clinical partnerships that support educational goals
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

19.6 Integrate a long-term, innovative and creative perspective into the midwifery educator role
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

19.7 Participate in interdisciplinary efforts to address health care and educational needs
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

19.8 Implement strategies for organizational change
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

19.9 Provide organizational leadership in different disciplines as well as in the midwifery programme to enhance the visibility of midwifery identify and its contributions to the academic community
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

19.10 Assume a leadership role in various levels of institutional governance as appropriate
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

19.11 Use feedback gained from self, peer, student and administrative evaluation to improve role effectiveness
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

19. Competency #16: Midwifery educators function as change agents and leaders in order to improve both midwifery practice and midwifery education [Continue]

19.12 Mentor and support colleagues
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Behaviour/attitudes

19.13 Integrate interpersonal values of respect, collegiality, professionalism, and caring to build an organizational climate that fosters the develop of students and educators
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

19.14 Demonstrate integrity, courage, perseverance, vitality and creativity
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

19.15 Develop collegial working relationships with students, faculty colleagues and clinical agency personnel to promote positive learning environments
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

19.16 Engage in self-reflection and continued learning to improve teaching practices that facilitate learning
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

20. Competency # 17: Midwifery educators used a variety of advocacy strategies to promote midwifery education and practice including professional, community, human rights and structural advocacy

Basic knowledge required to demonstrate skills/abilities & behaviours/attitudes

20.1 Advocacy strategies
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

20.2 Organizational functioning
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Skills/attitudes

20.3 Demonstrate a leadership role outside of the institutions; e.g., with government and professional associations
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Behaviours/attitudes

20.4 Display confidence in presentation and argument
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

20.5 Communicate effectively and professionally
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

21. Competency #18: Midwifery educators use research to inform teaching and practice

Basic knowledge required to demonstrate skills/abilities & behaviours/attitudes

21.1 Evidence-based practice and levels of evidence
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

21.2 Available research resources
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

21.3 Qualitative and quantitative approaches
☐ Do not feel competent ☐ Did at least once ☐ Do feel competent
☐ Not confident ☐ Confident

Skills/abilities

21. **Competency #18: Midwifery educators use research to inform teaching and practice** [Continue]

21.4 Use online resources to locate research and clinical guidelines relevant to an issues
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

21.5 Interpret the quality and applicability of research papers and reports
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

21.6 Use research in teaching and in practice
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

Behaviours/attitudes

21.7 Demonstrate and encourage inquiry
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

22. **Competency #19: Midwifery educators cultivate a culture that supports critical inquiry and evidence-based practice**

Basic knowledge required to demonstrate skills/abilities & behaviours/attitudes

22.1 Evidence-based practice and levels of evidence
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

22.2 Critical inquiry
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

Skills/abilities

22.3 Create a climate where inquiring minds can be actively involved in incorporating research into practice
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

22.4 Provide positive feedback for research endeavours
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

Behaviours/attitudes

22.5 Role model critical thinking in all areas of teaching
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

22.6 Prioritize questions and reflection
- ☐ Do not feel competent
- ☐ Did at least once
- ☐ Do feel competent
- ☐ Not confident
- ☐ Confident

23. Thank you for completing the questionnaire. Your answers will contribute to shape a transformative framework for midwifery education. I appreciate your time and contribution.

23.1 If there is any comments that you would till like to add, please share that

Competencies of South African midwifery educators: A transformative framework[1]

Information to expert

Dear Expert Member

I have conducted research with the aim of developing a transformative framework to strengthen Midwifery Educators' Competencies (MEC) in South Africa (SA). Mixed method research was followed from which a transformative framework was drafted.

Invitation to participate: You are invited to participate in the final phase of the research where the transformative framework will be refined to ensure that it addresses contextual needs.

Background: Globally, the need to ensure quality midwifery education is recognized as a key element to improve quality of care; end preventable maternal and neonatal deaths. A midwife educated according to international standards can provide care within an enabling environment that covers a continuum of care and intervention packages that will strengthen the agenda for universal health coverage (WHO, 2019:1).

There are a number of important guiding developments in midwifery education. These include the Global Standards on Midwifery Education developed by ICM (2011); the Essential Competencies for Basic Midwifery Education (revised 2011 and 2019) and the World Health Organization (WHO) Midwifery Core Educator Competencies (2013), no formal programme has yet been developed to assess and address the competencies of midwife educators in SA.

Against the backdrop of a disempowered midwifery profession, the lack of data on Midwife Educators Competence (MEC) in SA can contribute to not meeting the demand for human resources for health. Reaching the targets of universal health coverage and ending preventable maternal mortality will remain problematic.

Whilst an MEC gap analysis could inform the process of strengthening MEC and autonomy in SA, it is unlikely to bring about sustainable change. It was therefore deemed important to capitalise on the existing strengths to enhance positive potential.

[1] A framework capturing an action agenda to reform and address the needs of a group in need of change, who in this case will be midwife educators.

A strengths-based approach, in this case, appreciative inquiry (AI), was employed to explore the existing MEC, based on WHO Midwifery Core Educator Competencies (2013). In the spirit of appreciating the current MEC the intervention had a positive trajectory for transformation as the midwife educators contributed to the transformative framework. No emphasis was placed on problems or gaps, but rather on appreciating what works well. The data gathered were used to empower the MEC and could ultimately be used to transform midwifery education toward being more responsive to the needs of women and the healthcare system.

What did the different phases of the study involve?

Phase 1: Qualitative component (Concluded)

Appreciative Inquiry (AI) workshop for interested delegates at a national midwifery congress. The strengths of current midwifery educators' competencies were appreciated and elements needed to transform midwifery educators' competence was designed.

Phase 2: Quantitative component (Concluded)

Midwifery Educator Competencies Survey with South African midwife educators. The self-administered WHO Midwifery Educator Core Competency Gap Analysis Tool was employed. The questionnaire is based on the 19 WHO Midwifery Educator Core Competencies.

A brief summary of the current phase of the study is presented in the next table. This phase is applicable to your participation in this non-consensus Delphi round.

Phase 3 **Current phase**	
Mixed methods study element	Non-consensus Delphi for experts Members of specialist committees and positions (e.g. midwifery associations, ministerial committee, regulatory authority) and international contributors
Participants' contributions	Refinement of the transformative framework developed from Phases 1 and 2
Anticipated time expected from participants	± 30 minutes of personal time to provide feedback on an electronic version of the transformative framework, to return feedback by 17 December 2019.
Location of the participants	SA, SADC and WHO
Ethics approval identity	UFS-HSD2018/0147/2506 Health Sciences Research and Ethics Committee University of the Free State

Risks of being involved in this phase of the study were not identified.

Benefits of being in the study is that you are part of the strengthening of midwifery education through refinement of a transformative framework for MEC in SA.

Participation is voluntary, and an inability to participate will involve no penalty. You may discontinue participation at any time without penalty.

Confidentiality: Efforts will be made to keep personal information confidential. The electronic format is anonymous and will be accessed by the researcher and discussed with the research supervisor. Personal information may be disclosed if required by law.

Organisations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the Health Sciences Research Ethics Committee at the University of the Free State.

If results are published, this may lead to cohort identification.

Contact details of researcher:

E. Bekker bekkeree@ufs.ac.za/ 082 890 6824 – for further information/reporting of study-related questions.

Contact details of HSREC Secretariat:

Mrs Maré Marais (Head of Ethics Administration) T: +27 51 401 7795

Mrs Jemima du Plessis T: +27 51 401 7794

E: EthicsFHS@ufs.ac.za– for reporting of complaints/problems.

Please note: Return of the completed questionnaire implies consent.

Non-consensus Delphi

The research question was:

How could Midwifery Educators' Competence best be strengthened to transform midwifery education in SA?

The transformative framework presented in this section is a consolidation of the data, using the appreciated strengths and destiny and designs as suggested by participants and literature to strengthen MEC and transform midwifery education in SA.

Two data sets, one from the AI and one from the gap analysis of midwife educators' self-evaluations on the WHO Midwifery Educator Core Competencies were triangulated with literature. The transformative framework was developed from the interface of the data and literature.

The transformative framework is shown in the figure below. The framework is built by elements that will be explained shortly. The individual elements should evolve continuously, as none of the elements is stagnant. Continuous evolving will ensure transforming of the transformative framework to ensure that midwifery educators' competency will keep developing. This will strengthen midwifery and benefit childbearing families.

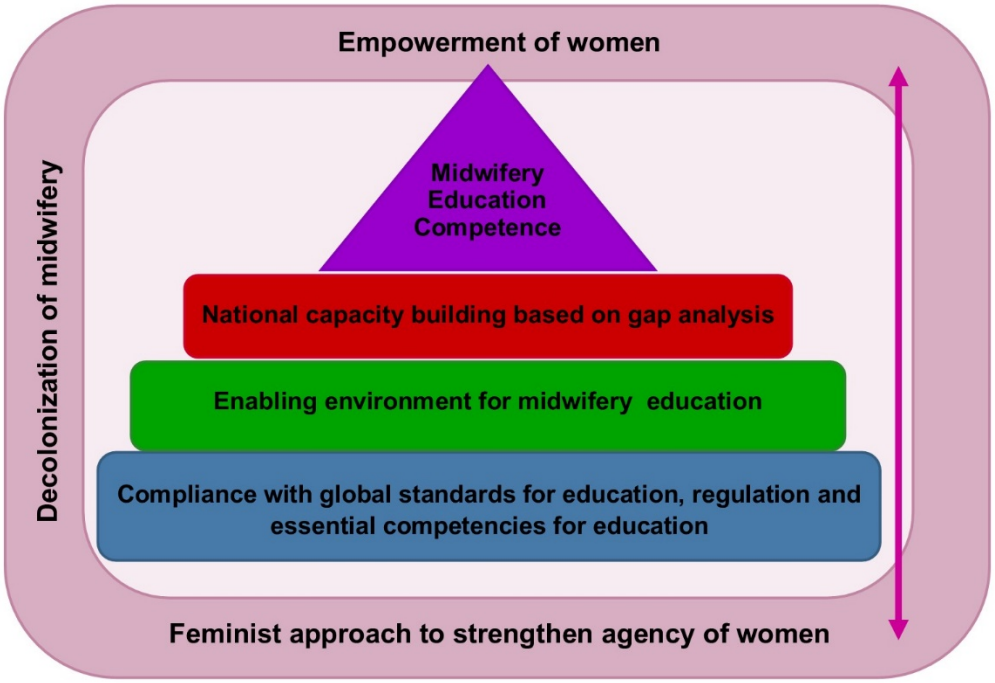
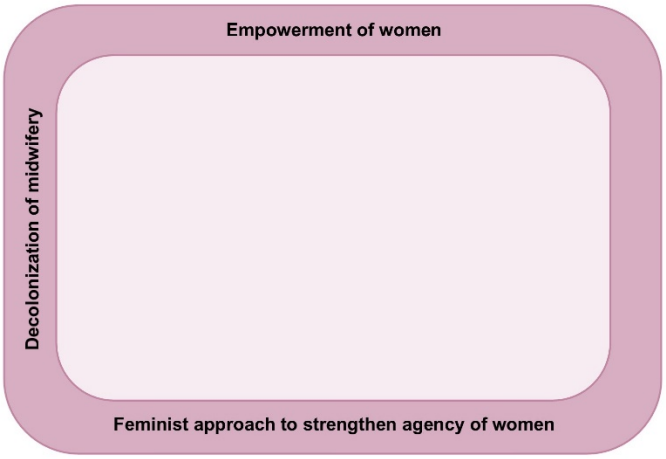


Figure 1 Transformative framework

Elements of the transformative framework

The elements that are part of the transformative framework are discussed individually, after which the flow and process of how individual components build on each other and contribute to strengthening MEC to transform midwifery education in SA are presented.

Frame



1 **Frame of profession encompassing midwifery educators, midwives, students and include recipients of care.**

The outer edge of the transformative framework is framing the entire midwifery profession including midwifery education, regulation, and practice. It includes the ME, students, practicing midwives and structures like the regulatory body and midwifery associations. The frame for the profession is found in a feminist approach that would provide women (as recipients of care and the educators and regulators that are part of the midwifery profession) with agency[2] to make decisions and influence their own agenda.

2 **Feminist approach seeks more agency (capacity, condition, or state of acting and exerting power) for women as care recipients or male or female midwifery practitioners.**

Agency for the midwife educators, midwifery profession and the women in need of midwifery care are all considered. There are many layers upon layers of disempowered individuals in midwifery, including men working as midwives. Although there is a feminist focus on the empowerment of women in midwifery. Male midwives

[2] The capacity, condition, or state of acting or of exerting power. Agency. In The Merriam-Webster.com Dictionary. Retrieved December 1, 2019, from https://www.merriam-webster.com/dictionary/agency

within this predominantly female environment are treated differently, whether positively or negatively, from others in the profession.

3. **Decolonization[3] of midwifery focused on normalizing pregnancy, labour and birth. Midwifery care to be restored from epistemicide (refers to the killing of knowledge systems. Knowledge democracy or decolonization acknowledges the importance of multiple knowledge systems).**

Flowing from the ability of women and midwives to own their agency is the decolonization of midwifery. The international concern and debate to normalize pregnancy, labour and birth is linked to the epistemicide[4] identified that regard midwifery care of pregnancy, labour and birth as abnormal, dangerous or primitive (Bennett, 2007:4). The care of women during pregnancy, labour and birth can be normalized, if provided by a competent midwife, who is educated by competent educators (International Confederation of Midwives (ICM), 2011d:1, 2014a:1). The concept of knowledge democracy acknowledges the importance of multiple knowledge systems (Hall & Rajesh, 2017:6) In this context physiological birth is threatened by an epistemicide that disregards physiological birth and the abilities of women (WHO, 2018:1). The use of the term decolonization in the transformative framework should not be regarded as de-professionalization of the profession, but restoring the value of physiological birth and midwives as primary caregivers for healthy pregnancy and birth(International Confederation of Midwives (ICM), 2008:1).

4. **The focus on agency and subsequent decolonization of midwifery will increase empowerment from within midwifery and midwifery education and within the transformation in society.**

The transformation should increase social justice for all the groups involved. Women and midwives should be able to claim joint rights as stated in the International Confederation of Midwives' (ICM) Bill of Rights. These include:

> "1. Midwives and women have the right to a system of regulation that will ensure a safe, competent and autonomous midwifery workforce for women and their babies.
>
> 2. Midwives and women have the right to national midwifery workforce planning to ensure sufficient midwives to meet the needs of women and babies

[3] To free from colonial status. Decolonize. In The Merriam-Webster.com Dictionary. Retrieved December 1, 2019, from https://www.merriam-webster.com/dictionary/decolonization

[4] Epistemicide refers to the killing of knowledge systems. (Hall & Rajesh, 2017)

3. Women and midwives have the right to be respected by governments and government institutions for health and education

4. The midwifery profession has the right to be recognised as a separate and distinct profession [International Confederation of Midwives (ICM), 2014:1].

Within the frame there are elements that follow as consecutive building blocks that are essential in the quest to strengthen midwifery educators' competency. The building blocks used in the transformative framework are introduced below.

Building blocks

Compliance with global standards for education, regulation and essential competencies for education

From literature and the data, the need to comply with the ICM global standards for education, and regulation of midwifery and the essential competencies for basic midwifery education is clearly indicated.

1. Compliance to ICM global standards for education and 2. Compliance to ICM global standards for regulation

In this regard the ICM global standards for education and regulations provide the norms to which our profession should comply if it is to remain relevant. The global standards ensure that SA midwifery education and regulations will address concerns highlighted by the participants to ensure autonomy in the both midwifery education and the profession at large. Compliance with global standards can open multiple education opportunities for midwifery. The time and workload of educators and choice on who should educate midwives are all stipulated in global standards.

3. Compliance in national curriculum to ICM Essential competencies of basic midwife

Elements like the ICM Essential competencies for basic midwifery education define the competence that every midwife should display before licensing to practice. Participants indicated that to have a standardized curriculum would strengthen education of midwives that can make a difference in safe motherhood and holistic care of childbearing families. This also aligns with the suggested action proposed in the WHO Framework to Strengthen Quality Midwifery Education (2019), where radical

thinking and innovation are considered to be ways of strengthening midwifery education. One avenue is that the way we are thinking about midwifery education should be reorganised to be based on what women need. The needs of childbearing women links to their agency and empowerment, as discussed in the frame. The importance of working in teams, including interprofessional teams should be implemented at a national level for optimal benefit (WHO, 2019:30).

The participants' views and the identified elements that should be captured in this transformative framework, in their opinion, echo a multitude of recent publications that confirm that a midwife educated to international standards is best positioned to impact positively on maternal health(Renfrew *et al.*, 2014:1129; WHO, 2019:vi).

Enabling environment for midwifery education

1. Review human resource needs for midwifery education

Apart from compliance to international standards, the literature and participants in this research agreed on the need for an enabling environment for midwifery education. Participants highlighted human resources and resources for teaching, simulation and clinical accompaniment in order to reach their envisioned destiny.

2. Review need for equipment like simulation equipment

The situation as described by participants in this research corresponds with a WHO survey of midwifery education in five WHO regions. This survey revealed that educators are less confident in clinical education but did not had access to clinical settings and simulation equipment. In addition, the WHO survey also showed a lack of basic facilities in water and sanitation in midwifery schools, which was not reported in this research (WHO, 2019:18, 19). There was however not any specific questions regarding the basic infrastructure of facilities.

3. Need for revival of clinical departments in hospitals and clinical areas (centre for clinical accompaniment with dedicated staff from education institution, remunerated by healthcare facility)

In order to address needs pertaining to an enabling environment for midwifery education, a survey of elements lacking in the enabling environment will ensure that needs as identified can be addressed. The value of a clinical department in facilities where students will be placed was emphasised by both groups of participants.

National capacity building based on gap analysis

1. Do gap analysis based on WHO Core Competencies for Midwifery educators

The findings of the study indicated that there is gaps in some of the WHO Core Competencies for midwife educators. This is confirmed as an element in the WHO Framework to Strengthen Quality Midwifery Education (2019) that is part of the radical thinking is to strengthen midwifery educators to international standards.

The steps proposed in the WHO Framework to Strengthen Quality Midwifery Education (2019) stipulate that the WHO Core Competencies for midwifery educators should be used to assess the competence of midwifery educators (WHO, 2019:40). In this research, a response rate of 31.1% and the multiple levels of permission as well as computer access might have affected negatively on the response rate of this research. The research barriers like obtaining multiple levels of permission even led to the exclusion of Kwazulu Natal from the public education institutions.

2. Develop National accelerated capacity development plan based on gap analysis

It is stated that due to a lack of investment in midwifery education, many educators struggle to maintain their own competence (WHO, 2019:32). Participants in both data sets voiced the concern about their access to continuing professional development.

3. Monitor Core competencies after development plan implementation

In order to comply with this crucial step in strengthening midwifery education, a national survey should be conducted. Based on the results the WHO Framework to Strengthen Quality Midwifery Education (2019) suggests an accelerated capacity building initiative that should be monitored at times (WHO, 2019:40). In our context, this should be driven by national structures like The Forum for University Deans in South Africa (FUNDISA) and the office of the Chief Nursing Officer. Professional associations like the Society of Midwives of South Africa (SOMSA) and the Nursing Education Association (NEA) are possible role-players in the education of educators. Unless a national strategy is developed, the lack of investment that led to the current situation may prevail. To keep this as part of monitoring implies that the transformation will be on going.

The last progressive link between the compliance to global standards, the enabling environment for midwifery education, the gap analysis and accelerated programmes is the collection of 19 competencies in the WHO Core competencies for midwifery educators.

1. Competencies should guide appointment, capacity building and deployment of midwifery educators.

The WHO Core competencies for midwifery educators covers 19 competencies in eight domains. The competence profile of a midwifery educator can guide appointment, capacity building and deployment of midwifery educators. The need to be clinically competent was mentioned by participants in both phases of the research.

2. Midwifery educators need to be clinically competent

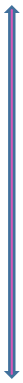
Educators should ensure that they penetrate clinical service. Midwife educators rendering midwifery care, will empower themselves with clinical competence. Mentoring and integration of theory and practice with more transfer of learning if educators are competent

Students will benefit with mentoring and integration of theory and practice leading to increased transfer of learning. Transfer of learning and student success was one of the most appreciated elements in the appreciative inquiry.

3. Women with midwifery care from midwife prepared to international standards will take agency for themselves and their families

Women as recipients of quality care may be empowered to take agency for themselves and their families.

Process



All the individual elements in the transformative framework are connected in a reciprocal process. It is believed that strengthening each element will positively influence the bigger frame of empowering women and normalising pregnancy labour and birth by decolonizing midwifery. Women, as recipients of care and midwives, both male and female with more agency can demand elements needed for the profession and themselves.

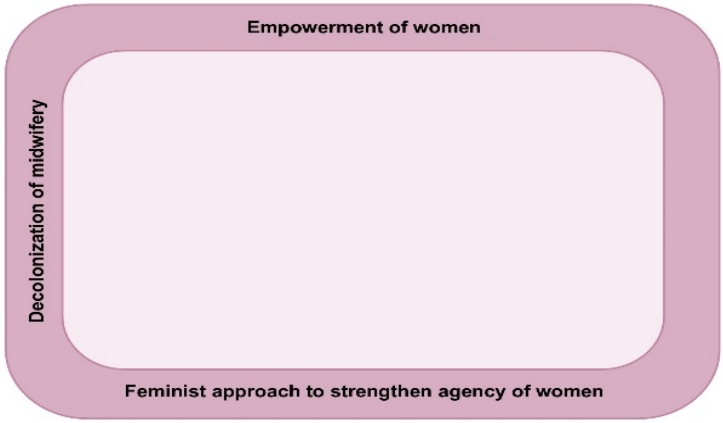
Reflecting on your own area of expertise, kindly review the elements and process as proposed in the transformative framework below.

Please look at each component and choose your response by indicating "x". Comments or suggested adaptations can be added.

Expert comments on framework

Please complete the demographic information

Demographic information (Please tick the applicable boxes)							
Gender	Male	Female	Other				
Professional group	Midwife	Medical Practitioner	Other				
Area of expertise (indicate all that apply)	Education	Regulation	Research	Association	Practice	Policy	Other
Please specify other							

Element 1: The Frame	Essential for transformation	Useful with adaptation	Can be omitted
			
1 **Framework of profession** encompassing midwifery educators, midwives, students and include recipients of care.			
2 **Feminist approach** seeks more **agency** (capacity, condition, or state of acting and exerting power) for women as care recipients or male or female midwifery practitioners.			
3 **Decolonization of midwifery** focused on normalizing pregnancy, labour and birth. Midwifery care to be restored from epistemicide (refers to the killing of knowledge systems. Knowledge democracy or decolonization acknowledges the importance of multiple knowledge systems).			
4 The focus on agency and subsequent decolonization of midwifery will increase empowerment from within midwifery and midwifery education and within the transformation in society.			
Suggested adaption			
Any other comments			

Element 2 (First building block- compliance with global standards)	Essential for transformation	Useful with adaptation	Can be omitted
Compliance to global standards for education, regulation and essential competencies for education			
1 Compliance to **ICM global standards for education**.			
2 Compliance to **ICM global standards for regulation**			
3 Compliance in **national curriculum** to **ICM Essential competencies of basic midwife.**			
Suggested adaption			
Any other comments			

Element 3 (Second building block - enabling environment)	Essential for transformation	Useful with adaptation	Can be omitted
Enabling environment for midwifery education			
1 Review **human resource** needs for midwifery education			
2 **Review** need for equipment like simulation equipment			
3 Need for **revival of clinical departments** in hospitals and clinical areas (centre for clinical accompaniment with dedicated staff from education institution, remunerated by healthcare facility).			
Suggested adaption			
Any other comments			

Element 4 (Third building block – capacity building based on gap analysis)	Essential for transformation	Useful with adaptation	Can be omitted
National capacity building based on gap analysis			
1 Do gap analysis based on WHO Core Competencies for Midwifery educators.			
2 **Develop National accelerated** capacity development plan based on gap analysis.			
3 Monitor Core competencies for midwifery educators after development plan implementation			
Suggested adaption			
Any other comments			

Element 5 (Fourth building block – midwifery education competence)	Essential for transformation	Useful with adaptation	Can be omitted
			
1. Midwife educators' competencies should guide appointment, capacity building and deployment of midwifery educators.			
2. Midwifery educators need to be clinically competent.			
3. Women with midwifery care from a midwife prepared to international standards will take agency for themselves and their families			
Suggested adaption			
Any other comments			

Element 6 (Process)	Essential for transformation	Useful with adaptation	Can be omitted
			
1. Reciprocal process evolve as more agency develop in women and midwives, they can advocate for building blocks to strengthen profession taught and lead by competent midwifery educators			

Is there any crucial element for transformation of midwifery educators' competence that is not reflected in the transformative framework?	

Thank you for your time. Please email back to bekkeree@ufs.ac.za

CONSENT TO PARTICIPATE IN RESEARCH

You have been asked to participate in a research study.

You have been informed about the study by the researcher.

You may contact Elgonda Bekker at 082 890 6824 or bekkeree@ufs.ac.za any time if you have questions about the research.

You may contact the Secretariat of the Health Sciences Research Ethics Committee, UFS at telephone number (051) 4017794/5 if you have questions about your rights as a research subject.

Your participation in this research is voluntary, and you will not be penalised or lose benefits if you refuse to participate or decide to terminate participation.

If you agree to participate, you will be given a signed copy of this document as well as the participant information sheet, which is a written summary of the research.

The research study, including the above information has been described to me in information leaflet. I understand what my involvement in the study means and I voluntarily agree to participate.

_____ _____

Signature of Participant Date

Programme workshop: Session 6.4: **Transforming midwife educators' competencies: An Appreciative Inquiry**

15TH Annual SOMSA Congress

29 August 2018@ 13h00-18h00

Elgonda Bekker and **Karen Venter** independent Appreciative Inquiry facilitator

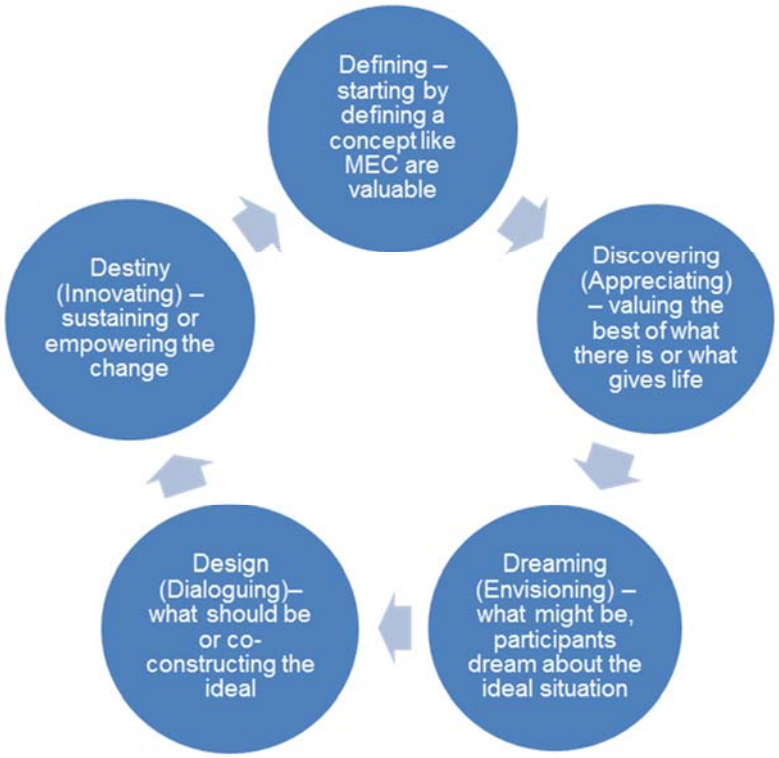
Session facilitators: SOMSA: Winnie Motlolometsi/ FS: Mpho Lekoatsa

Technical support Charne Human

13h00-13h30	Lunch and ice breaker	Share a character trait starting with the letter of your name
13h30- 13h45	Consent forms and demographic forms	Each participant
13h45-14h00	WHO Competencies of Midwife educators introduction	Elgonda Bekker
	AI Workshop	Karen Venter
14h00-14h30	Introduction to AI	
	Discover	
14h30-15h00	Conversation in pairs, 15 min each	At table, neighbors pair themselves
15h00-15h20	Discuss at table, Identify and formulate positive themes	Table discussion- scribe and table leader
15h20-15h40	Share between tables	Reporter from each table
15h40-16h00	Consensus from tables	Collective Nominal Group Teqnique
16h00-16h15	Tea break	Working tea- **Dream** exercise
16h15-16h45	**Design** Collage	All
16h45-17h00	Positive proposition	All
17h00-17h20	**Destiny**	Own actions and pairs discuss
17h20-17h30	Table discussion of actions	Table discussion- scribe and table leader
17h30-17h50	Feedback from tables	Reporter from each table
17h50-18h00	Consensus from tables	Collective Nominal Group Teqnique

Appreciative Inquiry

Appreciative inquiry is an approach or research technique that were developed by David Cooperrider. AI was developed in industrial psychology drawing on the work of positive psychologists like Martin Seligman. The process involves the four or five D process and include elements as depicted in the figure as adapted from Cooperrider & Whitney (2015:2).below:



Theoretical grounding of Appreciative Inquiry

Social constructionism is the theory that lies at the foundation of AI. Social constructionism postulates that a social system creates or determines its own reality (Cooperrider *et al.*, 2008:438). Social constructionism differs from social constructivism, where individuals develop subjective meanings of experiences in a quest to understand the world in which they live (Creswell, 2009:234).

In AI the central premise is that knowing is socially constructed. Interaction with the social system and human relatedness leads to knowing more. The social system (in this case, midwifery education stakeholders) can create their own reality (competent

educators for education of quality midwifery care) and this is the basis of social constructionism (Cooperrider *et al.*, 2008:14). This links very well with the notions from feminist research where the goal is to establish collaborative and non-exploitative relationships to transform current practice (Creswell, 2009:234).

Social constructionism principles flow from the idea that people control their destiny by envisioning what they want to occur and developing actions to move toward this end result (Cooperrider *et al.*, 2008:14). It also encourages multiple methods and values expanding forms of expression, using other forms of media to capture new knowledge (Gergen & Gergen, 2008:72,73). The theory supports the process of inquiry of AI that do not focus on what is considered to be factually correct, but rather on exploring the positive that can contribute to development, as it is also needed in this research (Reed, 2007:40).

There are five principles of AI that will be at the background of the process. These are summarised in Table 1.

Table 1: Principles of AI

Constructivist principle	Confirms the process of construction shape thoughts and actions (closely related to the social constructionist theory).
Simultaneity	Implies that inquiry and change are simultaneous.
Poetic principle or narrative principle	Peoples' ability to author their world continuously. Stories bridge the past with the future.
Anticipatory principle	Suggests that perceptions about the future will shape the future.
Positive principle	Suggests that a positive question will engage people deeper for a longer time.
Wholeness principle	Recognising the wholeness, co-creation and inter-connectedness of people reduces fragmentation and enhances cooperation.
Enactment principle	Embodying our future by practicing new behaviour.
Free choice principle	Power is liberated if we choose how and what we contribute and increased self-knowledge.
Awareness principle	The ability to keep reflecting on our actions, words, relationships reduces assumptions and increases common awareness.

Compiled from (Barrett, Frank & Fry, Ronald, 2008; Reed, 2007).

Benner's Stages of Clinical Competence

In the acquisition and development of a skill, a nurse passes through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert.

Stage 1: Novice

The Novice or beginner has no experience in the situations in which they are expected to perform. The Novice lacks confidence to demonstrate safe practice and requires continual verbal and physical cues. Practice is within a prolonged time period and he/she is unable to use discretionary judgement.

Stage 2: Advanced Beginner

Advanced Beginners demonstrate marginally acceptable performance because the nurse has had prior experience in actual situations. He/she is efficient and skilful in parts of the practice area, requiring occasional supportive cues. May/may not be within a delayed time period. Knowledge is developing.

Stage 3: Competent

Competence is demonstrated by the nurse who has been on the job in the same or similar situations for two or three years. The nurse is able to demonstrate efficiency, is coordinated and has confidence in his/her actions. For the Competent nurse, a plan establishes a perspective, and the plan is based on considerable conscious, abstract, analytic contemplation of the problem. The conscious, deliberate planning that is characteristic of this skill level helps achieve efficiency and organisation. Care is completed within a suitable time frame without supporting cues.

Stage 4: Proficient

The Proficient nurse perceives situations as wholes rather than in terms of chopped up parts or aspects. Proficient nurses understand a situation as a whole because they perceive its meaning in terms of long-term goals. The Proficient nurse learns from experience what typical events to expect in a given situation and how plans need to be modified in response to these events. The Proficient nurse can now recognise when the expected normal picture does not materialise. This holistic understanding improves the Proficient nurse's decision making; it becomes less laboured because the nurse now has a perspective on which of the many existing attributes and aspects in the present situation are the important ones.

Stage 5: The Expert

The Expert nurse has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions. The Expert operates from a deep understanding of the total situation. His/her performance becomes fluid and flexible and highly proficient. Highly skilled analytic ability is necessary for those situations with which the nurse has had no previous experience.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park: Addison-Wesley, pp. 13-34.

Theoretical perspectives: Feminism, Social constructionism, ICM Philosophy and Model of Care and Benner

Grand theory, Feminism.

A transformative paradigm is often used in research where various levels of social change, including issues of race, gender inequality, disability, sexual orientation and oppression, influence the lens by which the research problem will be investigated (Mertens, 2015:21). In this research the focus is midwifery educator's competence as a component of the midwifery profession.

Creswell identifies three variants in the transformative design based on the lens used. These are a feminist lens, disability lens or socioeconomic lens. The specific cause for power imbalances need to be identified (Creswell & Plano Clark, 2011:99,100). As midwifery educators have similar a social standing and their racial distribution is similar to the population, the only explanation for the transformation need is gender inequality. Disability can occur but due to the practical nature of the discipline is not a frequent trait amongst midwife educators. Gender inequality can best be addressed by using the grand theory of Feminism.

Midwifery per se is described in feminine terms. The ICM defines the concept as "an approach to care, of women and their newborn infants whereby midwives:

- optimise the normal biological, psychological, social and cultural processes of childbirth and early life of the newborn;
- work in partnership with women, respecting the individual circumstances and views of each woman;
- promote women's personal capabilities to care for themselves and their families;

- collaborate with midwives and other health professionals as necessary to provide holistic care that meets each woman's individual needs.

Midwifery care is provided by an autonomous midwife" (International Confederation of Midwives (ICM), 2017:1).

If these elements are considered against the backdrop of the reality in SA the question does arise whether the lack of autonomy that midwives face can be contributed to gender inequality. The majority of midwives are female and care for women at a vulnerable time of childbearing.

The development and status of the profession of midwifery, as well as the education of midwives are influenced by the gender specific nature of midwifery. Universal health coverage and reproductive health issues are embedded within a human rights perspective that in practice is underpinned by elements, such as gender. Even in a country with a constitution that supports equality, gender is still an organising principle that shapes the conditions for the lives of women and midwives. Effective measures to change systemic barriers, amongst others the low status of women and midwives is crucial to scale up midwifery care (Ten Hoope-Bender *et al.*, 2014:2).

The centrality of gender in shaping the consciousness that is the basic departure of feminist research, as well as the focus that this lens brings, questions a number of issues in midwifery and also midwifery education, including the competencies of the midwife educators:

- Does the unequal social position of women create an invisibility and distortion of issues affecting women? In this research the clear unmet need for maternal and reproductive health and the lack of autonomy of the profession can directly influence midwifery education and the competencies of educators.

- How can collaborative and non-exploitative relationships be created to transform, in this case, midwifery education and educators competencies?

- How can the transformative agenda still protect indigenous knowledge and intersectionality? With inequalities in SA dispensation this should be considered in midwife educators competencies.

- How does social devaluation and powerlessness of women as care giver and as care recipient influence the agency and autonomy of midwife educators?
- How does gender as a social construct determine the power relationships affecting social position, also for midwifery educators? (Creswell, 2013:25–27)

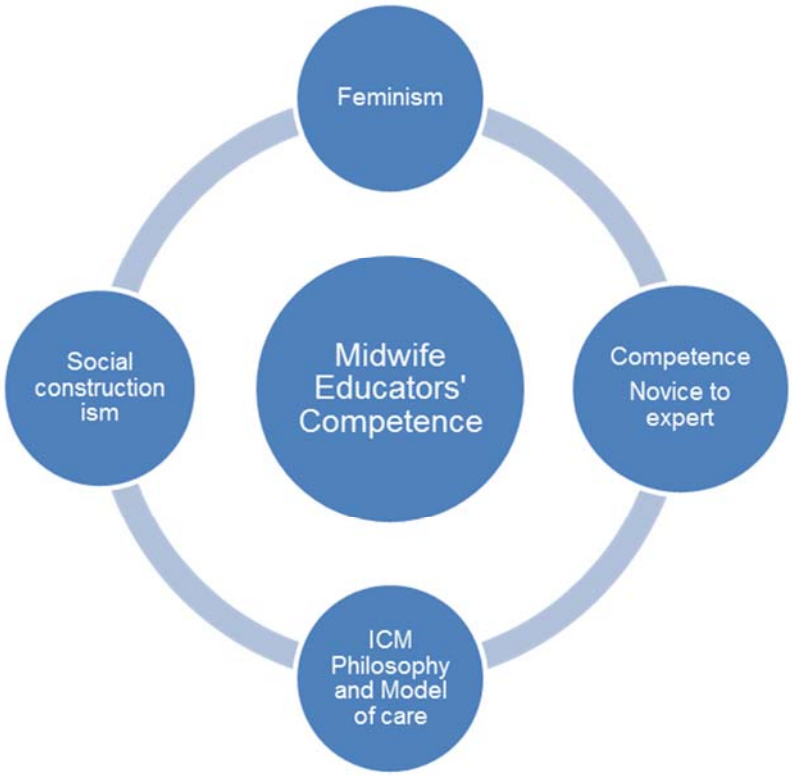
The gender inequality lens of feminist research focuses the issue of midwifery educator's competencies as a key element negatively influenced by the social constructs of gender and autonomy and subsequently MEC. To reach the targets of the SDG's and to aim at ending preventable maternal mortality, the needs of childbearing women, the human rights and reproductive rights should be respected. The quality of maternal health care for all women will ensure equity and dignity within a transformed healthcare dispensation for all childbearing families and improve maternal health (Kinney *et al.*, 2016:2067).

Safe, effective, and respectful quality of care is only possible if transformation to broaden the meaning of health to ensure social, economic, and political determinants of healthcare is addressed. One determinant in midwifery is the role of women, both as receiver and giver of care (Ceschia & Horton, 2016:2065).

Theoretical perspectives related to competence:

Patricia Benner's theory: From Novice to Expert: Excellence and Power in clinical nursing practice, will add value to the development of competence. This theory argues that caring practices have knowledge and skills about everyday human needs that will be attuned to the specific persons' needs and the situation (Tomey & Alligood 2006:156).

The ICM Philosophy and Model of care will be at the background as a guide to contextualize caring from a general nursing perspective to the specific care in midwifery practice. Therefore the feminist research approach is used, whilst content is shaped by the ICM Philosophy and model of care. Data are gathered and analysed at the backdrop of all these theoretical perspectives. See Figure 3 for the visual representation of how the different theories are thought to support the MEC.



The characteristics of AI, based on social constructionism can be matched to elements in the grand theory of Feminism and the ICM Philosophy and model of care. The journey from novice to expert, as described by Benner in 1984, implies that there is an increase in competence that can quantify competence (Alligood, 2014:123)(Cooperrider *et al.*, 2008)(Reed, 2007).

- Strengths based: In Feminism, the constructs of powerlessness based on gender is addressed by recognising that all human systems, including midwife educators, already have strengths (Barrett, Frank & Fry, Ronald, 2008)Creswell, 2013). One of the central themes in the ICM Philosophy and Model of care is empowerment, which relies on respect for women and their capabilities, linking it to Feminism as well (International Confederation of Midwives, 2014:2).

- An artful search: The art of appreciation, which seeks to identify and value that which gives life in a given context, starts with discovery and then proceeds to imagining the possibilities of the element being appreciated (MEC) (Barrett, Frank & Fry, Ronald, 2008:26). In the ICM Philosophy and Model of care the creation of a new generation of competent midwives is placed in the hands of midwives (International Confederation of Midwives, 2014:4).

- Collaborative: The focus on current successes and past strengths, lead to a collective discovery of a new destiny (in this research a transformative framework to enhance MEC) (Barrett, Frank & Fry, Ronald, 2008:26). The collaborative nature of midwifery care is voiced by emphasising the partnership relationship with women, childbearing families, communities and other healthcare providers (International Confederation of Midwives, 2014:2,3,4). This is based on respect and preserving human rights, which lies at the core of Feminism.

- Inclusive: Inclusivity creates the opportunity for hearing everyone's voice to co-discover, co-imagine and co-create their own reality to improve (Barrett, Frank & Fry, Ronald, 2008:26). The partnership elements and respect for women implied in the ICM document and Feminism also alludes to inclusivity.

- Generative: The co-creative element puts the solutions to improving current context (MEC) in the hands of midwife educators themselves (Barrett, Frank & Fry, Ronald, 2008:26).

References

Barrett, Frank, J. & Fry, Ronald, E. 2008. Appreciative Inquiry. A positive Approach to Building Cooperative Capacity. 1 st ed. Taos Institute Publications: Ohio.

Ceschia, A. & Horton, R. 2016. Maternal health: time for a radical reappraisal. *Lancet*. 388(10056):2064–2066.

Cooperrider, D.L., Whitney, D., & Stavros, J.M. 2008. Appreciative Inquiry Handbook. 2nd Ed. ed. Berrett-Koehler Publishers, Inc.: San Francisco.

Creswell, J.W. 2013. Qualitative Inquiry & Research Design. 3rd Ed. ed. SAGE: London.

Creswell, J.W. & Plano Clark, V.L. 2011. Designing and Conducting Mixed Methods Research. 2nd Ed. ed. SAGE: London.

International Confederation of Midwives. 2014. Philosophy and Model of Midwifery Care. *Strength. Midwifery Golbally*. :1–4.

International Confederation of Midwives (ICM). 2017. Definition of midwifery.

Kinney, M. V., Boldosser-Boesch, A., & McCallon, B. 2016. Quality, equity, and dignity for women and babies. *Lancet*. *Elsevier Ltd*. 388(10056):2066–2068.

Mertens, D.M. 2015. Research and Evaluation in Education and Psycology. SAGE.

Reed, J. 2007. Apprecative Inquiry, Research for Change. SAGE: London.

Ten Hoope-Bender, P., De Bernis, L., Campbell, J., Downe, S., Fauveau, V., Fogstad, H., Homer, C.S.E., Kennedy, H.P., Matthews, Z., McFadden, A., Renfrew, M.J., & Van Lerberghe, W. 2014. Improvement of maternal and newborn health through midwifery. *Lancet*. *Elsevier Ltd*. 384(9949):1226–1235.

MIDWIFERY EDUCATOR CORE COMPETENCIES

World Health Organization

MIDWIFERY EDUCATOR CORE COMPETENCIES

World Health Organization

WHO Library Cataloguing-in-Publication Data

Midwifery Educator Core Competencies.

I.World Health Organization.

ISBN 978 92 4 150645 8

Subject headings are available from WHO institutional repository

Design & layout by L'IV Com Sàrl, Villars-sous-Yens, Switzerland.
Printed by the WHO Document Production Services, Geneva, Switzerland.

CONTENTS

ACKNOWLEDGEMENTS

The publication of this document is a result of a collaborative effort between key stakeholders including, the United Nations Population Fund (UNFPA), the International Confederation of Midwives (ICM), the International Council for Nurses (ICN), the World Health Organization Collaborating Centres for Nursing and Midwifery Development and Jhpeigo.

WHO acknowledges the many participants who participated in the initial global consultation, 4–6 December 2012, and in particular the Technical Review Group who moved the agenda forward: Fadwa Affara, Consultant, International Council of Nurses, Geneva, Switzerland; Apirach Indarangkura Ayutthaya, Assistant Professor WHO Collaborating Centre for Nursing and Midwifery Development, Faculty of Nursing, Chiang Mai University, Thailand; Mary Barger, Education Standing Committee, International Confederation of Midwives; Jean Barry, Consultant, Nursing and Health Policy, International Council of Nurses, Switzerland; Martha Bokosi, Project Coordinator, International Confederation of Midwives; Peggy Chibuye, Independent Consultant, Lusaka, Zambia; Frances Day-Stirk, President, International Confederation of Midwives; Valerie Flemming, Education Standing Committee, International Confederation of Midwives; Joy Fraser, Professor, Athabasca University, Canada; Atf Gherissi, Education Standing Committee, International Confederation of Midwives; Peter Johnson, Jhpiego Director, Global Learning, Washington, D.C., USA; Patricia Jones, Associate Director, GC Health Ministries, Nursing, Loma Linda University, School of Nursing, California, USA; Geeta Lal, Midwifery Programme Coordinator, SRHB, Technical Division, UNFPA, USA; Dorothy Lazaro, Midwifery Specialist, United Nations Population Fund, Addis Ababa, Ethiopia; Anne Lekeux, Professor, European Nursing Education and International Coordinator, Nursing Department, Belgium; Rachael Lockey, Technical Midwife Adviser, International Confederation of Midwives; Ans Luyben, Education Standing Committee, International Confederation of Midwives; Address Malata, Director, WHO Collaborating Centre, Kamuzu College of Nursing, University of Malawi, Malawi; Frances McConville, Technical Officer, Department of Maternal, Newborn, Child and Adolescent Health, World Health Organization, Geneva, Switzerland; Florence Mirembe, Makerere University, Kampala, Uganda; Alison Moores, Clinical Midwifery Educator, University of Technology, Faculty of Nursing, Midwifery and Health, City Campus, Australia; Arwa Oweis, Dean of Nursing, Director of WHO Collaborating Centre, Associate Professor, Maternal and Child Health Department, Faculty of Nursing, Irbid, Jordan University of Science and Technology; Mayumi Ohnishi, Professor, Faculty of Nursing, Nagasaki University, Japan; Gloria Seguranyes Guillot, Education Standing Committee, International Confederation of Midwives; Andrea Stiefel, Education Standing Committee, International Confederation of Midwives; Joyce Thompson, International Consultant in Midwifery Education, Michigan, USA; Nadia Yusufu, Head, Nurse Midwifery Programme, WHO Collaborating Centre for Nursing Development, College of Health Sciences, Ministry of Health, Manama, Bahrain.

Participation of the World Health Regional Advisers for Nursing and Midwifery is greatly appreciated in particular, Fariba Al-Darazi, Margaret Phiri, Kathlyn Fritsch and Prakin Suchaxaya.

The validation process was completed by Nadia Yusuf Abdulhadi, Head Midwifery Programme, College of Health Sciences, University of Bahrain, Kingdom of Bahrain and Désiré Gapira Kamanzi, Community Health Specialist, Independent Public Health Consultant, Kigali, Rwanda. All participants in the survey are acknowledged for their in-depth contribution to the contents of the educator competencies. The World Health Organization Country Office in Rwanda and the World Health Organization Collaborating Centre for Nursing, College of Health Sciences, the Kingdom of Bahrain are acknowledged for their technical and administrative support in the validation of the draft competencies.

The competencies were drafted by: Mayumi Ohnishi, Professor, Faculty of Nursing, Nagasaki University, Graduate School of Biomedical Sciences, Japan and Joan Skinner, Senior Lecturer, Graduate School of Nursing, Midwifery and Health, Victoria University of Wellington, New Zealand.

The project coordination and finalization of the competencies was conducted by: Annette Mwansa Nkowane, Technical Officer, Health Systems Policies and Workforce, World Health Organization, Geneva, Switzerland. The project was a collaboration between the Department of Health Policies and Workforce and the Department of Maternal, Newborn, Child and Adolescent Health under the leadership of Drs Elizabeth Mason, Wim Van Lerberghe and Ties Boerma with support from Drs Matthews Mathai and Bernadette Daelmans.

Editing: Vivien Stone, Crowborough, East Sussex, UK.

Layout and design: L'IV Com Sàrl, Villars-sous-Yens, Switzerland

FOREWORD

As the year 2015 comes nearer it is already obvious that in many countries the target for maternal mortality reduction – Millennium Development Goals (MDG) – will not be met. It is also clear that in spite of the major progress in MDG 4 on child mortality, newborn mortality is not declining at the same rate as child mortality after the first month of life. Both maternal and neonatal mortality need more attention: quality services for all women and babies during pregnancy, delivery and the postnatal period.

The demand for quality services continues unabated. The fertility decline is modest in most low- and lower middle-income countries and numbers of deliveries continue to grow. Many women still deliver at home with limited skilled attendance, because services are not accessible or are perceived to be of poor quality. New approaches such as incentives for women to deliver in health facilities and pay-for-performance of health workers are intended to increase coverage of deliveries by health institutions and increase the quality of services provided.

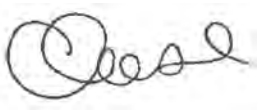
The foundation for quality services lies in having an adequate competent midwifery workforce. In many countries there are still critical shortages of midwives. Moreover, the training programmes are suboptimal. This is not only because of a dearth of training resources, but particularly because competent educators are lacking.

The key to a competent workforce is education. Strong education institutions are needed to secure the numbers and quality of health workers as the performance of health care systems depends on the knowledge, skills and motivation of the people responsible for delivering services.

This publication focuses on midwifery educator competencies, which is a critical but neglected component of education. One survey suggested that only 6.6% of the present teaching staff in developing countries have formal preparation in education. The quality of educators is an important factor affecting the quality of graduates from midwifery programmes. Well-prepared midwifery educators can provide quality education within an enabling environment including adequate resources, policy and governance.

Adopting these core competencies can provide a strong basis for a significant improvement in the quality of care for pregnant women, mothers and newborns. The core competencies can be used to develop innovative curriculum contents and teaching approaches, with strong effective links between theory and midwifery practice.

Ties Boerma
Director, Health Statistics and Information Systems
Director, a. i., Health Systems Policies and Workforce
World Health Organization
Geneva, Switzerland



Elizabeth Mason
Director, Maternal, Newborn, Child and Adolescent Health (MCA)
World Health Organization
Geneva, Switzerland

INTRODUCTION

The World Health Report of 2006 suggested that "in preparing the workforce, the curriculum is expected to meet standards that are often defined as core competencies".[1] Such curricula should be responsive to the changing state and knowledge in health and needs to meet the clients' expectations. In addition, several World Health Assembly resolutions have been passed.[2] The State of World's Midwifery 2011 report estimated that over 100 000 more midwives are needed to achieve 95% coverage.[3] In order to produce the required numbers of midwives, there needs to be concerted efforts to ensure teachers who are adequately prepared. Both the quantity and the quality of midwifery educators need improving, along with necessary improvements in the resources and capacity of the educational institutions in which they work. Resources such as good teaching infrastructure, laboratories for skills acquisition and technology must be ensured for quality education. The faculty to student ratio in most developing countries is reported to be as high as 1:45 in the classroom (compared with 1:12 ratio in developed countries) and only 6.6% of the present teaching staff in some developing countries have formal preparation in education and the qualifications needed to enter, or progress as teachers in higher educational institutions. There is also concern about the quality and quantity of the clinical experience provided to midwifery students. Well prepared teachers/educators need to have an understanding of how to teach and how to effectively facilitate competency among learners by using a variety of teaching methods for both theory and clinical practice.

A well-educated midwifery workforce is critical to the provision of quality health services. Existing evidence clearly shows that the majority of programmes, especially in developing countries are not preparing midwifery educators to respond to the main professional and health needs of their countries. It is therefore imperative that guidance is made available to educational institutions for developing competence-based curricula for the education programmes.

In recognition of the need to strengthen midwifery education, the World Health Organization and its partners have compiled a list of competencies for midwifery educators in support of Member States' efforts to improve midwifery education and ultimately the quality of midwifery services. This work is a result of a concerted effort among key partners in response to the World Health Assembly resolutions, in particular the most recent ones: WHA59.23 Rapid scaling up of health workforce production (2006); WHA59.27 Strengthening nursing and midwifery (2006); WHA64.6 Health workforce strengthening (2011); and WHA64.7 Strengthening nursing and midwifery (2011) and other global mandates such as the Millennium Developments Goals.

This document outlines competencies for midwifery educators. The development of these competencies evolved through an elaborate consultative process which addressed issues of comprehensiveness, relevancy, adaptability and accessibility. Subsequently, if the competencies are appropriately adopted/adapted, educational institutions will be equipped to prepare educators to provide quality midwifery education which meets the needs of the country in terms of quantity, quality and relevance of the midwives they educate.

There are many challenges envisaged in the adaptation and/or adoption of these competencies, such as, diversity among the regional categories of midwifery educational programmes and the need for resources to implement the programmes. This document offers a starting point for defining attributes of midwifery teacher competency as a basis for developing a competency-based curriculum for midwifery educators, encompassing knowledge, skills and attitudes. The process of developing the competencies, the list of competencies and various annexes are presented in the follow-up pages.

1 WHO, 2006. *Working together for health: The World Health Report 2006.* Geneva, World Health Organization.

2 World Health Assembly resolutions WHA59.23 Rapid scaling up of health workforce production (2006); WHA59.27 Strengthening nursing and midwifery (2006); WHA62.12 Primary health care, including health system strengthening (2009); WHA64.6 Health workforce strengthening (2011); and WHA64.7 Strengthening nursing and midwifery (2011).

3 UNFPA, 2011. *The State of the World's Midwifery 2011: Developing Health, Saving Lives. New York, United Nations Population Fund.*

HOW THE DOCUMENT WAS DEVELOPED

The process for the development of these competencies entailed extensive consultations. The various steps are outlined below.

Literature review

The initial process involved a literature review beginning with the examination of global policy documents and went on to examine guidance from professional health councils and associations. Following this, a review was undertaken of research articles which examined the competence and preparation of the health practitioner faculty, competence of teachers of midwifery, nursing, medicine and physical therapy. This review culminated in a background paper summarizing the evidence (Annex 1), and a first draft of what could be considered the essential elements of midwifery teacher competencies.

Global expert consultative meeting

The review was followed by a global consultation involving 70 experts in Geneva on 4–6 December 2012. Participants were provided with both the background paper and the draft competencies. Considerable time was spent by the participants discussing and providing a critique of the competencies. This involved first, examining the domains of competence and then the knowledge, skills and attitudes that would reflect competent educator practice. There was considerable agreement about the competencies in the first draft. However, there were several changes indicated for the domains, the competencies themselves and a variety of additional comments regarding the knowledge, skills and behaviour sections. There was widespread consensus for many of the changes identified. It was decided that a Technical Working Group would be selected to develop the competencies to completion. A second draft of the competencies was prepared in light of the changes recommended during the global consultation. This revised version was circulated among WHO focal points for review and was sent to the 16 members of the Technical Working Group.

This group was asked to provide further detailed feedback. At this stage of the process there were no radical changes recommended but there were very useful suggestions provided in relation to positioning and wording which added considerably to both the clarity and utility of the document.

Global Delphi survey

After the revisions were made to the competencies document an online survey instrument was developed and distributed internationally. Distribution included, firstly, the Technical Working Group which then disseminated it to:

- American College of Nurse Midwives (ACNM);
- Canadian Association of Midwives (CAM);
- Global Alliance for Nursing and Midwifery (GANM) web-based discussion group;
- Health Information for All by 2015 (HIFA 2015) web-based discussion group;
- International Confederation of Midwives (ICM);
- International Council of Nurses (ICM);
- Midwifery and reproductive health research web-based discussion group;
- Midwifery, reproductive and women's health education web-based discussion group; and
- United Nations Population Fund (UNFPA).

All recipients were encouraged to distribute the survey widely among interested individuals and groups. Among the 287 responses there was, in general, very strong support for the competencies. No extra or different domains or competencies were suggested. In consultation with selected members of the Technical Working Group who had access to the survey results, some minor wording changes were made to improve clarity and relevance. This version of the draft was re-distributed to the Technical Working Group and to WHO focal points.

Validation of the midwifery educator competencies

This last stage in the preparation of these competencies involved two countries: The Kingdom of Bahrain (WHO Regional Office for East Mediterranean) and Rwanda (WHO Africa Region). The validation process was based on a simple tool which was prepared by WHO and is presented in Annex 2 together with the list of participants (annexes 3a and 3b). This tool added a dimension of measurability of the competencies. The two countries that participated in the validation process brought together practising midwifery educators. Their reports confirm that the outlined competencies are key to the training of midwifery educators.

Figure 1. The process for the development of midwifery educator competencies

HOW THE COMPETENCIES ARE ORGANIZED

Competency domains

The competencies are organized under eight domains or areas of teaching practice.

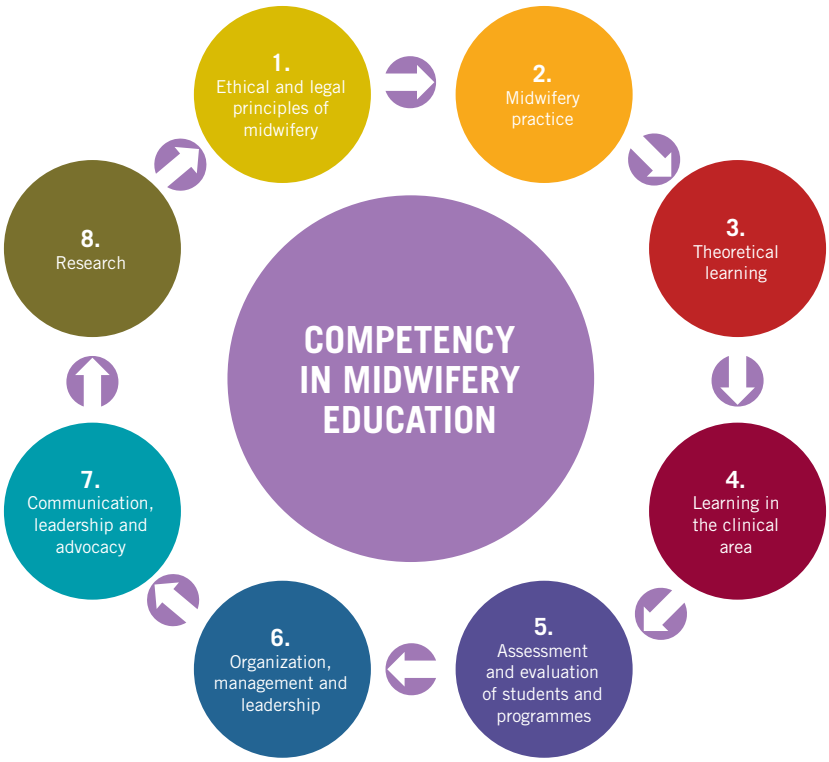
Table 1. Competency domains

DOMAIN	COMPETENCY
1. Ethical and legal principles of midwifery	Midwifery educators incorporate and promote ethical and legal aspects of midwifery care in teaching/learning activities and by consistent role modelling. *Competency 1: Behave in ways that reflect the ethical standards of the teaching and midwifery professions.* *Competency 2: Demonstrate an understanding of the legal and regulatory statutes relevant to midwifery teaching and practice.*
2. Midwifery practice	Midwifery educators maintain current knowledge and skills in midwifery theory and practice based on the best evidence available. *Competency 3: Maintain competence in midwifery practice.* *Competency 4: Practise midwifery in ways that reflect evidence-based and up-to-date knowledge.*
3. Theoretical learning	Midwifery educators create an environment that facilitates learning. *Competency 5: Incorporate educational strategies to promote active learning.* *Competency 6: Select and use effective teaching and learning materials/ resources.* *Competency 7: Recognize and support different learning styles and the unique learning needs of students.*
4. Learning in the clinical area	Midwifery educators create an environment for effective clinical teaching of midwifery care. *Competency 8: Facilitate a safe and effective learning environment in the clinical setting.* *Competency 9: Foster individualized experiential learning.*
5. Assessment and evaluation of students and programmes	Midwifery educators are responsible for conducting regular monitoring, evaluation and assessment of programmes and students. *Competency 10: Continuously monitor, assess and evaluate the effectiveness of the educational programme.* *Competency 11: Assess student competence.*
6. Organization, management and leadership	Midwifery educators participate in formulating the policy and programme outcomes and in designing and implementing curricula. *Competency 12: Actively participate in organizing and implementing a midwifery curriculum.* *Competency 13: Implement and revise midwifery educational courses/ programmes.*

DOMAIN	COMPETENCY
7. Communication, leadership and advocacy	Midwifery educators are effective communicators and function as advocates, change agents and leaders. *Competency 14: Communicate effectively using a variety of methods in diverse settings.* *Competency 15: Demonstrate cultural competence in course design and development, teaching and midwifery practice.* *Competency 16: Function as change agents and leaders in order to improve both midwifery practice and midwifery education.* *Competency 17: Use a variety of advocacy strategies to promote midwifery education and practice including professional, community, human rights and structural advocacy.*
8. Research	Midwifery educators promote the use of research and use it to inform midwifery education and practice. *Competency 18: Use research to inform teaching and practice.* *Competency 19: Cultivate a culture supporting critical inquiry and evidence-based practice.*

Maintaining competency is not achieved through one-off training; it should be continuous and cyclical and can also be the basis for continuous professional development.

Figure 2. Educator competencies



KEY REFERENCE DOCUMENTS

It is important that implementers of these competencies have access to up-to-date information. Selected key documents are provided below for further reading. In applying these competencies reference should be made to key resources that are currently being used in relation to midwifery education which can be found at the web sites provided below. The resources include:

- WHO global standards for initial education of professional nurses and midwives (WHO, 2009): http://www.who.int/hrh/resources/standards/en/
- International classification of health workers (ISCO, 2008): http://www.who.int/hrh/statistics/Health_workers_classification.pdf
- The international definition of the midwife (ICM, 2011).
- *The essential competencies for basic midwifery practice* (ICM, 2010): http://www.internationalmidwives.org/assets/uploads/documents/Global%20Standards%20Comptencies%20Tools/English/MIDWIFERY%20EDUCATION%20PREFACE%20&%20STANDARDS%20ENG.pdf
- *The global standards for midwifery education* (ICM, 2010): http://www.internationalmidwives.org/assets/uploads/documents/CoreDocuments/GlobalStandardsforMidwiferyEducation_CompanionGuidelines-Eng.pdf
- Model curriculum outlines for professional midwifery education (ICM, 2012): http://www.internationalmidwives.org/what-we-do/education-coredocuments/model-curriculum-outlines-for-professional-midwifery-education.html
- Midwifery training modules (WHO, 2008): http://www.who.int/maternal_child_adolescent/documents/1_9241546662/en/index.html and (WHO, 2004): http://www.who.int/maternal_child_adolescent/documents/9241591692/en/

Other reference materials can be obtained through the WHO regional offices. In this document the terms educator and teacher are used interchangeably.

MIDWIFERY EDUCATOR COMPETENCIES AND RELATED KNOWLEDGE, SKILLS AND BEHAVIOURS

An educator who has achieved competency should be able to perform both theoretical and clinical teaching including participating and or conducting research depending on the academic level of the programme. A well qualified educator should have the necessary qualifications indicated in Table 2.

Requirements to become a midwifery educator

Table 2. Requirements for becoming a Midwifery educator

Midwifery education	Completed a recognized midwifery education programme in both theory and practice.
Midwifery qualification	Holds a current licence/registration or other form of legal recognition to practise midwifery.
Clinical midwifery experiences	Completed a minimum of two years' full-time clinical experience across the scope of practice within the last five years.
Educational training	Formal teaching preparation either before or soon after employment.

The requirements for becoming a midwifery educator can be achieved through the core competencies outlined in Table 3 which encompass knowledge, skills and behaviours.

Core competencies

Table 3. Core competencies

Domain 1: Ethical and legal principles of midwifery

Midwifery educators incorporate and promote ethical and legal aspects of midwifery care in teaching/learning activities and by consistent role modelling.

COMPETENCY	KNOWLEDGE
Competency 1: Behave in ways that reflect the ethical standards of the teaching and midwifery professions.	**Knowledge of:** The international and local ethical responsibilities and obligations related to teaching and practice. **Skills (ability to):** Use knowledge of ethical issues as a basis for influencing, designing, implementing and evaluating policies and procedures related to students, faculty and the educational and clinical environment. **Behaviour:** Display ethical intent incorporating fundamental ethical principles of respect and responsibility. Protect the rights of the client when teaching or delivering midwifery care. Recognise potential ethical issues and dilemmas in the workplace and discuss with students and other appropriate persons.
Competency 2: Demonstrate an understanding of the legal and regulatory statutes relevant to midwifery teaching and practice.	**Knowledge of:** The law and regulation relating to teaching and midwifery. **Skills (ability to):** Incorporate legal and regulatory requirements into midwifery education including the implementation and assessment of teaching and learning. **Behaviour:** Act at all times in compliance with legal and regulatory statutes. Ensure students comply with legal and regulatory statutes.

Domain 2: Midwifery practice

Midwifery educators maintain current knowledge and skills in midwifery theory and practice based on the best evidence available.

COMPETENCY	KNOWLEDGE
Competency 3: Maintain competence in midwifery practice.	**Knowledge of:** All areas of the theoretical component of the midwifery curriculum. All areas of best practice in the clinical practise of midwifery. Evidence-based and up-to-date midwifery content and related subjects. **Skills (ability to):** Provide safe, competent and effective midwifery care to women and their newborns. Apply research findings in practice. Fulfil the requirements of the midwifery regulating/registration body. **Behaviour:** Participate in professional development activities to increase effectiveness. Practice in accord with a code of ethics. Provides high quality care. Demonstrate and value lifelong learning.
Competency 4: Practise midwifery in ways that reflect evidence-based and up-to-date knowledge.	**Knowledge of:** Research processes. Locally relevant epidemiology, community health issues, health policies and provision of health services. **Skills (ability to):** Access, interpret and implement research into practice. Review literature for evidence related to effective practice. **Behaviour:** Willingness to adjust practice in light of evidence.

Domain 3: Theoretical learning

Midwifery educators create an environment that facilitates learning.

COMPETENCY	KNOWLEDGE
Competency 5: Incorporate educational strategies to promote active learning.	Knowledge of: Theories of learning that result in development of clinical competency. Competency-based education. **Skills (ability to):** Acknowledge students as adult learners. Ground teaching strategies in educational theory and evidence-based teaching practices. Use educational approaches reflecting contemporary educational theory and practice in midwifery including: • Problem-based learning; • Case study or narrative based learning; • Discussion and group work; • Seminar presentations; • Experiential learning (e.g. role-play, simulation, simulated patient/client); • Workshops; • Projects; • Active/participatory lectures; • Effective use of audio-visual materials; and • E-learning. Create opportunities for learners to develop their critical thinking, critical reasoning skills and innovative thinking. **Behaviour:** Model critical and reflective thinking. Show enthusiasm for teaching, learning and midwifery that inspires and motivates students. Foster a relationship of mutual trust and respect.
Competency 6: Select and use effective teaching and learning materials/ resources.	**Knowledge of:** Educational and learning resources and materials based on best available evidence. **Skills (ability to):** Evaluate and choose appropriate teaching and learning materials and resources. Develop appropriate educational materials that are matched to the learning domain. Use information technologies skilfully to support the teaching-learning process. Ensure safe and appropriate physical learning environments including classroom conditions such as light, temperature, desk arrangement, and classroom size and number of students and advocate for change when these are not provided.

COMPETENCY	KNOWLEDGE
Competency 7: Recognize and support different learning styles and the unique learning needs of students.	**Knowledge of:** Theory and methodology of educational needs assessment. Social and human relationships and the conditions for learning. Interaction between educator and learner. Principles of counselling. **Skills (ability to):** Provide resources to diverse learners that help meet their individual learning needs. Engage in effective advice and counselling strategies that help learners meet their learning goals. Create learning environments that are focused on socialization of the role of the midwife and facilitate learners' self-reflection and personal goal setting. Recognize the influence of teaching styles and interpersonal interactions on learner outcomes. Foster the cognitive, psychomotor and affective development of learners. Assist learners to develop the ability to engage in thoughtful and constructive self- and peer evaluation. **Behaviour:** Demonstrate interest in and respect for learners. Support learner's continuous lifelong learning as a professional midwife. Use personal attributes (e.g., caring, confidence, patience, integrity and flexibility) that facilitate learning.

Domain 4: Learning in the clinical area

Midwifery educators create an environment for effective clinical teaching of midwifery care.

COMPETENCY	KNOWLEDGE
Competency 8: Facilitate a safe and effective learning environment in the clinical setting	**Knowledge of:** The clinical environment and governing structures. Competency-based clinical learning. How students integrate into a new practice setting. Evidence informed practice. Ethical expectations of midwifery practice including supporting informed choice. **Skills (ability to):** Facilitate effective learning and the development of competence within an area of practice by correctly teaching students the process of assessment, planning, implementation, evaluation and documentation of midwifery care. Create an environment in which practice development is fostered, evaluated and disseminated. Demonstrate effective midwifery relationships with patients/clients. Obtain free and informed consent for student involvement in care. Protect the woman and her baby from harm. Enable students to relate theory to practice encouraging reflective thinking. Build and maintain collegial relationships with staff in the clinical environment. Demonstrate to students principles of effective delegation and supervision. **Behaviour:** Demonstrate effective interpersonal skills. Seek clarification or assistance from staff as needed. Set effective professional boundaries whilst creating a dynamic, constructive teacher-student professional relationship. Foster professional growth and personal development by use of effective communication. Facilitate and develop the ethos of interprofessional learning and working. Identify teaching opportunities in the clinical setting. Set boundaries of safe practice.

COMPETENCY	KNOWLEDGE
Competency 9: Foster individualized experiential learning	**Knowledge of:** Experiential learning. Diversity of learning processes. **Skills (ability to):** Design, deliver and assess programmes of learning in practice settings supporting a range of students in their area of practice. Assist, create and develop opportunities for students to identify and undertake experiences to meet their learning needs. Provide positive feedback and constructive criticism to students. Provide advice and support to identify changes required. **Behaviour:** Assess students' ability to integrate their professional role, their capacity to undertake that role and the knowledge-base with which that professional identity and performance are intermeshed. Act with respect and interest in the students. Demonstrate patience.

Domain 5: Assessment and evaluation of students and programmes

Midwifery educators are responsible for conducting regular monitoring, evaluation and assessment of students and programmes.

COMPETENCY	KNOWLEDGE
Competency 10: Continuously monitor, assess and evaluate the effectiveness of the educational programme.	**Knowledge of:** Theory and methodology of learning outcomes assessment and evaluation including: • Examination; • Essay; • Seminar presentation; • Midwifery case study; • Project; and • Objective Structured Clinical Examination (OSCE). **Skills (ability to):** Use methods of assessment and evaluation of learning that are linked to learning goals. Use a variety of strategies and tools to assess and evaluate learning in the cognitive, psychomotor and affective domains, for formative and summative evaluation. Participate in the selection and/or construction of the key elements of assessment tools (e.g. examination blueprinting, examination item writing, validity, reliability). Construct tests and appropriate evaluation tools. Participate in setting pass or fail standards and assessment criteria. Provide timely, constructive and thoughtful feedback to learners. Use assessment and evaluation data to enhance the teaching-learning process. Maintain accurate records of student progress and achievement. Participate in programme evaluation. **Behaviour:** Display ethical intent and objectivity in all evaluation processes.
Competency 11: Assess student competence.	**Knowledge of:** Assessment procedures. **Skills (ability to):** Adapt, design and use of tools for assessing and documenting clinical practice. In partnership with other members of the teaching team, use knowledge and experience to design and implement assessment frameworks. Assess progress in order to plan for the students' increasing level of skill acquisition. Make accurate judgments about the competence/proficiency of students including cultural and respectful care competency. Provide constructive feedback to students and assist in identifying future learning needs and actions. Manage unsuccessful students so that they may either enhance their performance and capabilities for safe and effective practice, or are able to understand their failure and the implications of this for their future. Be accountable for confirming that students have met, or have not met agreed standards of competency and are capable of safe and effective practice. **Behaviour:** Act as a role model. Display ethical intent and objectivity in all competence assessments.

Domain 6: Organization, management and leadership

Midwifery educators participate in formulating the policy and programme outcomes and in designing and implementing curricula.

COMPETENCY	KNOWLEDGE
Competency 12: Actively participate in organizing and implementing a midwifery curriculum.	**Knowledge of:** Educational management theories. Teaching and learning methodologies. National health priorities. Curriculum design and development. Timetabling and scheduling. **Skills (ability to):** Participate in developing midwifery curriculum including identifying programmatic and student outcomes, developing competency statements, writing learning objectives, and selecting appropriate learning activities and evaluation strategies. Participate in the design of midwifery curriculum based on educational decisions, principles, theory and research. Participate in the development of syllabi, and class/course outlines including learning objectives, target audience, contents of subject, teaching materials and evaluation methods. Ensure the curriculum reflects the institutional philosophy and mission, current midwifery and health care trends, and community and societal needs so as to prepare graduates for practice in a complex, dynamic, multicultural health care environment. Incorporate strategies for efficient management of time and resources. Work in multidisciplinary, interdisciplinary team. **Behaviour:** Make inclusive and collaborative decisions. Participate as an effective team member.

COMPETENCY	KNOWLEDGE
Competency 13: Implement and revise midwifery educational courses/ programmes.	**Knowledge of:** Curriculum monitoring and evaluation. Curriculum revision. Organizational management including organizational monitoring and evaluation. Quality assurance of organizational performance. **Skills (ability to):** Revise the curriculum based on systematic monitoring and evaluation of programme outcomes, learner needs, midwifery and health care trends and evolving community and societal needs. Implement curriculum revisions using appropriate change theories and strategies. Collaborate with external constituencies throughout the process of curriculum design, implementation and revision. Design and implement programme assessment models that promote continuous quality improvement of all aspects of the programme including: • Student performance; • Student evaluations; • Peer observations; • Graduation rates; and • Qualification or registration success. Monitor and review midwifery programmes to ensure congruence with international and regional goals and national standards. Contribute to the quality assurance processes of the organization. Participate in the evaluation of organizational effectiveness in midwifery education. **Behaviour:** Keep thorough and accurate records. Display integrity in undertaking monitoring processes.

Domain 7: Communication, leadership and advocacy

Midwifery educators are effective communicators and function as advocates, change agents and leaders.

COMPETENCY	KNOWLEDGE
Competency 14: Communicates effectively using a variety of methods in diverse settings.	**Knowledge of:** Communication techniques. Presentation methodologies. Report writing. **Skills (ability to):** Communicate effectively using oral, written and electronic communication in order to achieve learner outcomes. Write clearly, produce concise reports and present effectively. Demonstrate effective communication skills in working with clients, learners and other members of the health care team in clinical teaching. Teach students how to engage in education of the childbearing women and her family. Document effective feedback. Maintain accurate records. Engage in conflict resolution as necessary. Demonstrate public speaking and active listening skills. Demonstrate excellent interpersonal and communication skills. **Behaviour:** Demonstrate an awareness of self and others.
Competency 15: Demonstrate cultural competence in course design and development, teaching and midwifery practice.	**Knowledge of:** Cultural diversity and identity. Human rights. Impact of power relations, racism and sexism. **Skills (ability to):** Recognize and describe multicultural, gender and experiential influences on teaching and learning. Facilitate the provision of culturally appropriate care. Encourage the expression and exchange of multicultural views. Respect and protect human rights and to foster in students the ability to act and speak up when there are violations of human rights. **Behaviour:** Demonstrate cultural sensitivity. Model cultural sensitivity when advocating for change. Be accountable for own actions and inactions in safeguarding human rights.

COMPETENCY	KNOWLEDGE
Competency 16: Function as change agents and leaders in order to improve both midwifery practice and midwifery education.	**Knowledge of:** Change management. Leadership theory. Interdisciplinary collaboration. **Skills (ability to):** Act as a guardian of safe, competent respectful midwifery care. Create and maintain community and clinical partnerships that support educational goals. Integrate a long-term, innovative and creative perspective into the midwifery educator role. Participate in interdisciplinary efforts to address health care and educational needs. Implement strategies for organizational change. Provide organizational leadership in different disciplines as well as in the midwifery programme to enhance the visibility of midwifery identity and its contributions to the academic community. Assume a leadership role in various levels of institutional governance as appropriate. Use feedback gained from self, peer, student and administrative evaluation to improve role effectiveness. Mentor and support colleagues. **Behaviour:** Integrate interpersonal values of respect, collegiality, professionalism, and caring to build an organizational climate that fosters the development of students and educators. Demonstrate integrity, courage, perseverance, vitality and creativity. Develop collegial working relationships with students, faculty colleagues and clinical agency personnel to promote positive learning environments. Engage in self-reflection and continued learning to improve teaching practices that facilitate learning.
Competency 17: Use a variety of advocacy strategies to promote midwifery education and practice including professional, community, human rights and structural advocacy.* *Structural advocacy could address issues such as respectful maternity care, bad attitudes of health workers, beliefs and misconceptions etc.	**Knowledge of:** Advocacy strategies. Organizational functioning. **Skills (ability to):** Demonstrate a leadership role outside of the institutions e.g. with government and professional associations. **Behaviour:** Display confidence in presentation and argument. Communicate effectively and professionally.

Domain 8: Research

Midwifery educators promote the use of research and use it to inform midwifery education and practice.

COMPETENCY	KNOWLEDGE
Competency 18: Use research to inform teaching and practice.	**Knowledge of:** Evidence-based practice and levels of evidence. Available research resources. Qualitative and quantitative approaches. **Skills (ability to):** Use online resources to locate research and clinical guidelines relevant to an issue. Interpret the quality and applicability of research papers and reports. Use research in teaching and in practice. **Behaviour:** Demonstrate and encourage inquiry.
Competency 19: Cultivate a culture supporting critical inquiry and evidence-based practice.	**Knowledge of:** Evidence-based practice and levels of evidence. Critical enquiry. **Skills (ability to):** Create a climate where inquiring minds can be actively involved in incorporating research into practice. Provide positive feedback for research endeavours. **Behaviour:** Role model critical thinking in all areas of teaching. Prioritize questioning and reflection.

Implementation

The core competencies presented in this document are applicable to diploma and degree level educators. However, any adaptation would have to take into account the depth of the desired programme. The competencies also form the basis for the development of curricula content including learning and methods of teaching, assessment and evaluation. Resources should be made available to implement these competencies.

MONITORING AND EVALUATION

Monitoring and evaluation can provide information concerning the process of implementation of midwifery programmes and programme outcomes, including personal, behavioural and professional practices of teachers, students and graduates. This can help to ascertain the relevancy of the educational programme/curriculum and the different roles and responsibilities of a midwifery educator including legal principles and practices of midwifery, the theoretical and clinical teaching, leadership and research. The consistent use of measurement of core competencies in midwifery education would not only enhance confidence in midwifery national and international standards, but it can also facilitate the ability to compare educator competencies and the performance of students. Any institution implementing the competencies would wish to know the extent to which these competencies have contributed to the improvement of midwifery education and how educators who have been trained based on these competencies have made a difference in their educational approaches. Lessons learnt from this process offer the opportunity for a critical reflection not only on the programme content but on appropriate teaching and learning approaches, as well as career development. Institutions are encouraged to develop a competency-testing tool designed to monitor and evaluate aspects of the eight domains and the 19 related core competencies. The checklist can be developed and applied every year or semester or quarterly, depending on the existing national education system. It is important to include the qualitative dimension in order to have in-depth information on the usefulness of the midwifery educator core competencies, limitations and areas of improvement. Midwifery educator core competencies could be assessed at three levels:

1. Educator self-evaluation: to assess own performance in teaching and professional growth.

2. Training institution: to address education capacity needs of its faculty or for research purposes.

3. National evaluation in midwifery education: to ensure educational quality assessment and performance of educators in meeting the required standards and inform planning for appropriate interventions. Quality reviews can be coordinated, for example by the Ministry of Health and/or Nursing and Midwifery Council and Ministry of Education.

ANNEX 1: BACKGROUND PAPER: MIDWIFERY FACULTY COMPETENCIES

Prepared by Professor Mayumi Ohnishi, Faculty of Nursing, Nagasaki University Graduate School of Biomedical Sciences, Japan.

Introduction

Despite global improvement in the rate of maternal deaths, there still remains considerable focused work to be done to reach the MDG5 target of a 75% reduction in maternal mortality by 2015 (WHO, 2012). Progress is also inconsistent, with some countries making much slower progress than others. Improving maternal mortality requires a complex and multifaceted approach. One of the key interventions in any improvement has been identified as access to skilled health care, in particular, to care from a competent and well-supported midwife.

There has been considerable scaling up of global activity in relation to this, with most countries attempting to increase the numbers of midwives in their workforce. However there remains a significant shortage both in numbers and quality of midwives. *The State of the World's Midwifery 2011* report estimates that over 100 000 more midwives are needed to achieve 95% coverage (UNFPA, 2011). The report goes on to state that although there are increasing numbers of midwives being trained there is a significant gap in the number and competence of midwifery teachers. It is clear that there is an urgent need to address what has the potential for being a considerable bottleneck in the effort to rapidly increase the midwifery workforce. Both the quantity and the quality of midwifery educators need improving, along with necessary improvements in the resources and capacity of the educational institutions in which they work. The faculty to student ratio in developing countries is reported to be as high as 1:45 in the classroom (compared with 1:12 ratio in developed countries). In addition, only 6.6% of the present teaching staff in developing countries have formal preparation in education and the qualifications needed to enter or progress as teachers in higher educational institutions. There is also concern about the quality and quantity of the clinical experience midwifery students are exposed to.

There are many challenges in the process. These include an increasing diversity in the regional categories of midwives, types of programmes and practice areas. Therefore, defining attributes of core competency of midwives will help to provide international guidance. It also supports the development of a relevant and effective curriculum in terms of the knowledge, skills and attitudes of the new practitioner. It is critical that teachers understand how to teach using these curricula and also learn how to effectively achieve competency among learners by using a variety of teaching methods in both theory and practice. This is crucial if the midwives they educate are to be able to contribute to better health outcomes for mothers and babies. It is timely then to look the competency of the teachers.

Current policy guidance

Current policy supports this approach. The World Health Organization in its 2006 report highlighted the need for an accelerated expansion of the health workforce and that the preparation of this workforce should be relevant and competency-based (World Health Organization, 2006a). The report highlights that curricula should be responsive to the changing state and knowledge in health and that it needs to meet the clients' expectations. Furthermore, several WHA resolutions have been passed which emphasize the importance of providing quality education so that the health workforce can better contribute services of good quality. For

example, WHA59.23: Rapid scaling-up of health workforce production; WHA62.12: Primary health care, including health system strengthening; and WHA64.6: Strengthening the health workforce; all point to the need for skilled teachers. There have also been numerous WHA resolutions calling for the "strengthening of nursing and midwifery" (WHA42.27, WHA45.5, WHA47.9, WHA48.8, WHA49.1, WHA54.12, WHA59.27 and WHA64.7). Global strategic alliances such as the H4+ Alliance, the Global Health Workforce Alliance and the Partnership for Maternal, Newborn and Child Health have all contributed to policy advice supporting the need for an increase in competent and skilled midwives (H4+ Alliance, 2012; Global Health Workforce Alliance, 2011; Partnership for Maternal, Newborn and Child Health, 2010). In addition, supporting documents have also been produced such as *The State of the World's Midwifery 2011* report (UNFPA, 2011) and the Report on the WHO/PEPFAR Scaling up nursing and medical education (WHO, 2009). There is also on-going work in the WHO regions on standards and curricula for the midwifery workforce. This activity and these background documents all provide a firm foundation for rolling out the work on faculty development.

Faculty development

In order for teachers to be competent they require a faculty that is functioning well. So in a sense, competent faculty need a competent faculty. Educational institutions need to function in a policy and regulatory environment that provides clear guidance about what needs to be taught, how it is taught and to whom (WHO, 2009). Health workforce planning is imperative so that the right practitioners are educated in the right place and have work to go to. Schools need curricula that are relevant to the health needs of the population. They need to be well resourced. Teachers need to be given the opportunity to maintain clinical skills. They need to be paid well and have sustainable working conditions. Schools need to invest and support innovative educational strategies and technologies, have sound quality assurance and performance mechanisms in order to deploy good quality, well supported and motivated teaching staff (WHO, 2006).

An effective pre-service education programme needs to have strong governance and administrative processes; educational and communication technologies and learning materials; and processes to encourage and support faculty excellence. The teachers need to be trained, sustained and retained (Jhpiego, 2011). The scaling up of midwifery education has implications across many areas, from national policy to institutional planning. The competence of the teaching faculty is not an insignificant part of this complex puzzle.

Faculty competence: skills, knowledge and experience

Faculty members are the ultimate resource of all educational institutions. They are the teachers, stewards, agents of knowledge transmission, and, most importantly, they are the role models for students (Frenk et al., 2010). It is crucial that they are competent to undertake this complex and demanding role. The literature provides some guidance about what needs to be included in the skill mix of the teachers of health practitioners. This guidance varies to some extent but there are commonalities. In general they include knowledge of teaching theory, which is, in turn, reflected in the classroom/skills laboratory and skill in teaching in the clinical environment. Role modelling and taking a values-based approach are also seen as important. It should be noted here that faculty competence for pre-service education of health practitioners can be seen as generic. Apart from the profession specific knowledge, the knowledge related to teaching approaches and

methodologies are shared across health disciplines. The teaching skills of midwifery teachers are the same as those required for teachers of nurses, doctors, physical therapists or dentists, to name but a few. Most commonly, in developed countries, teachers are prepared across disciplines, often within their teaching institution. This model of teacher preparation has some distinct advantages as shared, collaborate preparation of teachers has the potential both to be more cost effective and to build collaboration and linkages across disciplines.

The literature summarized below looks at competencies required for midwifery faculty and for health faculty more generally. It firstly presents global policy documents and then guidance from professional health councils and associations. Research articles which examined the competence and preparation of health practitioner faculty were identified. There were relevant papers looking at the competence of teachers of midwifery, nursing, medicine and physical therapy. A summarized list of competencies reported in the literature is provided in Table A2.

The two key global policy documents specifically related to the competence of midwifery educators are from the WHO and from ICM. The WHO guidance was contained in the *Strengthening Midwifery Toolkit, Module 6* (WHO, 2011). This tool provides guidance on developing effective programmes for preparing midwifery teachers and describes eight domains of competence. ICM has also described competency of midwifery teachers in a document adopted at their 2008 council meeting. Eleven competencies were identified. These competences are detailed and compared in Table A1.

Table A1. A comparison of basic conditions of midwifery faculty by WHO and ICM

	STRENGTHENING MIDWIFERY TOOLKIT, MODULE 6: DEVELOPING EFFECTIVE PROGRAMS FOR PREPARING MIDWIFE TEACHERS (WHO, 2011)	QUALIFICATION AND COMPETENCIES OF MIDWIFERY TEACHERS (ICM, ADOPTED AT THE GLASGOW COUNCIL MEETING, 2008)
Midwifery qualification	Completed a basic midwifery education programme with good academic achievement in both theory and practice.	Holding a current licence/registration or other form of legal recognition to practise midwifery.
Clinical (practice) experience	A minimum two years' full-time recent clinical experiences.	Two years' of previous full-time work in a variety of areas (antepartum, intrapartum, postpartum, newborn, family planning).
Training programme for midwifery teachers	Two years' full-time education.	Formal preparation for teaching or undertakes such preparation as a condition for continuing to hold the position.

	STRENGTHENING MIDWIFERY TOOLKIT, MODULE 6: DEVELOPING EFFECTIVE PROGRAMS FOR PREPARING MIDWIFE TEACHERS (WHO, 2011)	QUALIFICATION AND COMPETENCIES OF MIDWIFERY TEACHERS (ICM, ADOPTED AT THE GLASGOW COUNCIL MEETING, 2008)
Competencies of midwifery teachers	Practise all clinical midwifery skills to mastery level. Conduct simple research using qualitative and quantitative methodologies. Teach students effectively. Assess students fairly. Clear accurate, concise report and record keeping. Management. Good communicator. Intercultural competence.	Knowledge of theories of adult learning. The ability to use a variety of competency-based teaching methods to facilitate learning, given the range of behaviour among students. A solid foundation in organizing, implementing and evaluating the effectiveness. Maintain an up-to-date knowledge base in midwifery theory and practice, and promote evidence-based practice at all times. Understand their own values and biases related to teaching and learning and provide an environment for values clarification among learners related to working with a variety of clients. Provide an environment for values clarification among learners related to working a variety of clients (provision of culturally relevant care). Promote the professional/ethical aspects of midwifery care in keeping with the ICM International Code of Ethics for Midwives. Create a learning environment based on mutual respect and trust. Be guardians of safe, competent, respectful midwifery care. Collaborate with other professionals as members of the health care team. Maintain current clinical practice.

The World Health Organization has also produced a document called *Effective teaching: A guide for educating healthcare providers* (WHO, 2005). This document identifies five modules for the preparation of teachers. These include: the foundations of educating health care providers, developing learning objectives, planning teaching, preparing the teaching environment, using visual aids, facilitating group learning, facilitating the development of healthcare delivery skills, managing clinical practice, preparing and using knowledge assessments, and finally, monitoring and revising learning. The joint WHO/ICM midwifery education modules, in their section on guidance for teachers, stress the importance of maximizing student involvement based on the principles of adult learning and the application of theory to practice. The modules work on the basis of the development of critical thinking skills and the importance of adequate time, both in the clinical areas and in the community (WHO, 2006b). In addition, ICM has developed a comprehensive set of standards for midwifery education which includes the requirements of the midwifery faculty. The standards that the midwifery teacher must meet include the need for formal preparation for teaching and the maintenance of competence in both midwifery practice and education. Midwifery teachers should provide education, support and supervision of individuals who teach students in practical learning sites (ICM, 2011).

The report of the Global Independent Commission on the Education of Health Practitioners stated that "All health professionals in all countries should be educated to mobilize knowledge and to engage in critical reasoning and ethical conduct so that they are competent to participated in patient and population-centred health systems as members of locally responsive and globally connected teams" (Frenk *et al.*, 2010, p.1924). One of their recommendations stated the need for increased investments in the education of educators, with the provision of satisfying career paths, and constructive performance assessments. They particularly mentioned "the power of the IT revolution" which they say has the potential to be the most important driver in transforming learning.

Some countries also have guidance for what teachers of health professionals should the term be competent to undertake. For example, the Australian Nurse Teacher's Society (ANTS) (1996) has developed ten competency standards for teachers with sub-elements and associated performance criteria. These cover aspects such as integrating knowledge, implementing curricula, effective communication, managing resources and fostering critical enquiry. Experiences in Australia demonstrated a strong agreement that most of the competencies in the ANTS document were reflective of the respondents' roles as nurse teachers. However, this document does state that it is difficult to have a generic set of competencies for teachers that fit every role exactly. Guy, Taylor, Roden, Blundell and Tolhurst (2011) state that these competencies could be modified to better reflect their real role such as changing trends in health care; including cultural issues and technological changes; preparation for teaching; understanding of the language of the competencies; contextual issues of the nurse teacher role, such as workload; the use of the competencies; nurse teachers as change agents; and resource management.

The National League for Nursing in the United States of America also provides guidance. It identified six fields of teacher competence: facilitating learning; facilitating learner development and socialization; using assessment and evaluation strategies; participating in curriculum design and evaluation of programme outcomes; and functioning as a change agent and leader (National League for Nursing, 2005). In the United Kingdom the Nursing and Midwifery Council has also developed standards for the preparation of teachers of nursing and midwifery. These standards cover communication, facilitation of learning, assessment and evaluation, creating a learning environment, role modelling and leadership (Nursing and Midwifery Council, 2002).

The research investigating the impact of competencies for teachers of health practitioners is not extensive. Kohtz *et al.* (2008) described the skills domains included in an examination for certified nurse educators. These were: facilitating learning, facilitating learner development, assessment and evaluation strategies, curriculum design, continuous quality improvement and engagement in scholarship. Rogan *et al.* (2008) undertook another descriptive study. They described nursing education standards as including a leadership role, a clinical development role and a professional development role. Five domains of teacher competence emerged from a survey conducted in Norway which aimed to determine the most important domains of teaching competence. These were: nursing competence, teaching skills, evaluation skills, personality factors and relationship with students (Johnsen, Aasgaard, Wahl and Salminen, 2002). Similar categories of clinical nursing faculty competence were described in the study by Hou *et al.*(2010) of 237 nursing faculty members in China. The five categories were: leadership ability, problem solving, educational intelligence, general teaching ability and clinical nursing skills.

Steinert *et al.* (2006) in their systematic review of faculty development initiatives identified the key features of faculty development as being experiential learning, feedback on learning, effective peer relationships, well designed teaching and learning interventions and a diversity of educational methods. It would seem that much of what builds student competence also builds teacher competence. Steinert (2009) went on to propose that the development of a framework for describing the competency of teachers would help to define standards of teaching, enable assessment and accountability of teaching and promote its professionalization.

Two articles describing specific frameworks for the development of faculty competence were identified. The first, by Srinivasan *et al.* (2011), proposed a framework which was grounded in four key values: learner engagement, learner-centredness, adaptability and self-reflection. The six core competencies in the framework were medical (or content) knowledge, learner-centredness, interpersonal and communication skills, professionalism and role modelling, practice-based reflection and systems-based practice. They included four extra competencies for educators with programme roles. These were: programme design/implementation, evaluation/scholarship, leadership and mentorship. Molenaar *et al.* (2009) developed a more complex three-dimensional framework for teaching competencies. They described the three dimensions of teaching. The first dimension outlined six domains of teaching: (development, organization, execution, coaching, assessment and evaluation). The second dimension described the levels at which the teacher functioned (micro, meso and macro). The third dimension described the competencies in detail and related these specifically to the different levels at which teachers function. This framework captured the complex and multilevel work of the teacher, not all of which happens in the classroom or the clinical area.

Studies related specifically to clinical teaching and the role of the preceptor highlighted the importance of the relationships of students with teachers. Carlisle, Calman and Ibbotson (2009) examined the role of the preceptor and found that the aspects that the preceptors thought were most important in their role were "making students feel welcome in the practice setting", "supervising students" and "planning a programme of learning for the students". Kaviani and Stillwell's (2000) evaluative study aimed to identify the skills that preceptors needed. These included, identifying learner needs, teaching, prioritizing and time management. One study by Little and Milliken (2007) highlighted the issue of teachers (in this case nurses) needing to have dual competencies; that of both clinical practice and teaching practice. They proposed that there were challenges of sustainability and feasibility in this expectation.

One study examined models of preceptoring and the differences in outcomes between one-to-one preceptorship and group preceptoring. It concluded that one-to-one preceptoring improved the students understanding of the role and improved performance but there was no evidence of improved critical thinking, clinical competence or examine pass rates (Udlis, 2008). None of the research reviewed investigated the importance of the clinical preceptor's role in protecting health consumers, students and staff in the clinical environment, nor of providing support for clinical staff who were working with students.

Thompson (2002) in her commentary of the competencies needed for midwifery faculty firstly identified the personal qualities required. She stated that midwifery faculty need to act as role models, modelling professional ethical behaviour. They should exhibit critical thinking and commitment to lifelong learning. They should be confident practitioners with formal preparation in adult teaching theory and should know what to teach (curriculum design) and how to teach (teaching methods) both in the classroom and in the clinical area.

Table A2. Summary of competencies for teachers of health professionals located in the literature

KNOWLEDGE	SKILLS	ATTITUDES
• Adult learning • Student centred • Critical thinking • Problem solving • Experiential learning • Integrating knowledge • Facilitating learning • Identify learner needs • Engaged in scholarly practice • Research methods • Evidence-based practice • Application of theory to practice	• Variety of teaching methods • Group learning • Curriculum design • Curriculum implementation • Planning • Learning objectives • Preparing the teaching environment • Using visual aids • Facilitating the development of health care delivery skills assessment • IT • Research skills • Evaluation • Organization • Prioritizing • Managing resources • Managing time and workload • Preparation for teaching • Communication • Socialization to role • Mentorship	• Role modelling • Values based • Good communicator • Cultural competence • Ethical and professional • Respect and trust • Change agent • Leadership • Adaptable • Self reflective • Professional development • Quality improvement • Commitment to lifelong learning • Collaboration • Peer relationships
Clinical practice Current in clinical practice Mastery of midwifery Competent, confident midwife		

Further considerations

A faculty or school with responsibility for preparing health practitioners needs to have teaching staff who possess the capacity and appropriate combination of skills to prepare competent practitioners. There needs to be the potential for teachers to develop particular expertise in their areas of interest. Not all teachers will have identical skills. For example, a school may want to employ staff with considerable clinical skill and experience who can offer highly skilled support in clinical practice. These clinicians may be from local health institutions so be able to build collaborative links with those institutions. They may not have formal teacher preparation but will need support and development of teaching skills particularly related to clinical teaching. The school may want a staff member who can bring more in-depth research experience to build the capacity of the staff, but who may have less clinical experience. It is the skill mix of the faculty and the learning experience of the students that is crucial. However, a tool providing details about what one might consider the core competencies of individual faculty members is useful to ensure the overall quality of the students' learning experiences.

Summary

There is an urgent need for more skilled midwives and thus an equally urgent need to educate them. The need to provide midwifery schools and clinical environments that can enable educators to provide competent teaching is imperative. Thus, interventions in midwifery education need to be carefully assessed and strategically planned and coordinated. Competent teachers need resources and a working environment that both supports and values them. The qualities of competence in the teachers of health practitioners revealed in both policy guidance and in the research included a number of common themes. These themes reflected firstly a need for clinical competence; sound teaching and assessment skills which were reflective of an adult and learner focused approach; and organizational and communication skills. Personal qualities of the teacher were mentioned, such as having a leadership role in the profession and acting as a change agent and a role model for the student. Socialization of students into clinical practice was valued. Continuous improvement and ongoing professional development were expected. Values and ethics and the personality of the educator were also mentioned. It would also appear that teachers function at different levels within a school. Therefore, it would seem that the development of basic or core competencies, common to all teachers of health practitioners would be worthwhile. This document provides the background to support the development of a set of competencies for teachers of health practitioners, in this case, midwives. Such competencies can provide guidance for the preparation and ongoing support for midwifery faculty.

Bibiliography

Australian Nurse Teachers Society, 2010. Australian nurse teacher competencies, (http://www.ants.org.au/ants/mod/url/view.php?id=233, accessed 16 September 2013).

Carlisle C, Calman L and Ibbotson T, 2009. Practice-based learning: The role of practice education facilitators in supporting mentors. *Nurse Education Today*, 29(7): 715–721.

Frenk J, Chen L, Bhutta Z, Cohen J, Crisp N, Evans T, et al., 2010. Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. *The Lancet,* 376(9756): 1923–1958.

Global Health Workforce Alliance, 2011. Annual report. *Enabling Solutions ensuring healthcare*, (http://www.who.int/workforcealliance/knowledge/resources/annualreport2011/en/, accessed 16 September 2013).

Guy J, Taylor C, Roden J, Blundell J and Tolhurst G, 2011. Reframing the Australian nurse teacher competencies: Do they reflect the "REAL" world of nurse teacher practice? *Nurse Education Today,* 31(3): 231–237.

H4+, 2012. Joint statement. Accelerating efforts to improve the health of women and children, (http://www.everywomaneverychild.org/images/H4_Joint_Statement_2012_for_Web_posting_2.pdf, accessed 16 September 2013).

Hou X, Zhu D and Zheng M, 2011. Clinical nursing faculty competence inventory – Development and psychometric testing. *Journal of Advanced Nursing*, 67(5): 1109–1117.

International Confederation of Midwives, 2011. Global standards for midwifery education, (http://www.internationalmidwives.org/assets/uploads/documents/Global%20Standards%20Comptencies%20Tools/English/MIDWIFERY%20EDUCATION%20GLOSSARY%20ENG%20FINAL12.5.pdf, accessed 16 September 2013).

International Confederation of Midwives, 2008. ICM Council Meeting. Agenda Item 10.1.q Proposed Amendment to Position Statement: Qualifications and Competencies of Midwifery Teachers. Glasgow, 28–31 May 2008.

Jhpiego, 2011. *Program roadmap. Pre-service education,* (http://www.k4health.org/sites/default/files/MCHIP%20Preservice%20Roadmap%20Aug%2011%202011%20v1.2.pdf, accessed 16 September 2013).

Johnsen K, Aasgaard H, Wahl A and Salminen L, 2002. Nurse educator competence: A study of Norwegian nurse educators' opinions of the importance and application of different nurse educator competency domains. *Journal of Nursing Education*, 41(7): 295–301.

Kaviani N and Stillwell Y, 2000. An evaluative study of clinical preceptorship. Nurse Education Today, 20(3): 218–226.

Kohtz C, Ferguson P, Sisk R, Gowda C, Smith J and Fortson A, 2008. The certified nurse educator exam: a plan for success. *Nursing Education Perspectives,* 29(1): 8–9.

Little M and Milliken P, 2007. Practicing what we preach: balancing teaching and clinical practice competencies. *International Journal of Nursing Education Scholarship*, 4(1), Article 6.

Molenaar W, Zanting A, van Beukelen P, de Grave W, Baane J, Bustraan J et al., 2009. A framework of teaching competencies across the medical education continuum. *Medical Teacher,* (31)5: 360–396.

National League for Nursing, 2005. *Core Competencies of Nursing Educators with Task Statements*, New York, (http://www.nln.org/profdev/corecompetencies.pdf, accessed 16 September 2013).

Nursing Council of New Zealand, 2008. *Standards for competence assessment programmes.* Nursing Council of New Zealand, (http://nursingcouncil.org.nz/Education/Competence-assessment-programmes, accessed 16 September 2013).

Nursing and Midwifery Council, 2002. *Standards for the preparation of teachers of nursing and midwifery.* London: Nursing and Midwifery Council.

Partnership for Maternal, Newborn and Child Health, 2010. *Global Strategy for Women's and Children's Health,* (http://www.who.int/pmnch/topics/maternal/201009_globalstrategy_wch/en/index.html, accessed 16 September 2013).

Rogan M, Crooks D and Durrant M, 2008. Innovations in nursing education: standard development for nurse educator practice. *Journal for Nurses in Staff Development*, 24(3): 119–123.

Srinivasan M, Meyers F, Pratt D, Collins J, Braddock C, Skeff K et al., 2011. Teaching as a competency: Competencies for medical educators. *Academic Medicine: Journal of the Association of American Medical Colleges*, 86(10): 1211–1220.

Steinert Y, 2009. Mapping the teacher's role: the value of defining core competencies for teaching. *Medical Teacher*, (31)5: 371–372.

Steinert Y, Mann K, Centeno A, Dolmans D, Spencer J, Gelula M and Prideaux D, 2006. A systematic review of faculty development initiatives designed to improve teaching effectiveness in medical education: BEME Guide No. 8. *Medical Teacher* 28(6): 497–526.

Thompson J, 2002. Competencies for midwifery teachers. *Midwifery,* 18(4): 256–259.

Thompson J, 2002. Competencies for midwifery teachers. Plenary paper presented at ICM Triennial Congress, May 2002. *Midwifery,* 18(4): 256–259.

Udlis KA, 2008. Preceptorship in undergraduate nursing education: *An integrative review. Journal of Nursing Education,* 47(1): 20–29.

UNFPA, 2011. *The State of the World's Midwifery 2011: Developing Health, Saving Lives.* New York, United Nations Population Fund, (http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/en_SOWMR_Full.pdf, accessed 16 September 2013).

WHO, 2012. *Trends in Maternal Mortality: 1990 to 2010, WHO, UNICEF, UNFPA and The World Bank estimates,* (http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf, accessed 16 September 2013).

WHO, 2011. *Strengthening Midwifery Toolkit, Module 6: Developing effective programs for preparing midwife teachers,* (http://whqlibdoc.who.int/publications/2011/9789241501965_module6_eng.pdf, accessed 16 September 2013).

WHO, 2009. *Scaling up nursing and medical education.* Report on the WHO/PEPFAR planning meeting on scaling up nursing and medical education, Geneva, 13–14 October 2009, (http://www.who.int/hrh/resources/scaling-up/en/index.html, accessed 16 September 2013).

WHO, 2006a. *The World Health Report 2006 – Working together for health.* Geneva, World Health Organization.

WHO, 2006b. Midwifery education modules – education material for teachers of midwifery, (http://www.who.int/maternal_child_adolescent/documents/9241546662/en/index.html, accessed 16 September 2013).

WHO, 2005. *Effective teaching: A guide for educating healthcare providers.* USAID, WHO, Jhpiego, (http://www.jhpiego.org/files/EffTeach_facgd.pdf, accessed 16 September 2013).

ANNEX 2: MIDWIFERY EDUCATOR COMPETENCIES VALIDATION TOOL

COMPETENCE DOMAIN	VALIDATION MEASURE	YES	NO	COMMENTS/ SUGGESTION/ ADDITIONS
1	Relevance			
	States what is important in understanding the content area			
	Addresses conceptual content			
2	Concepts			
	Includes skills that are transferable across areas with real life			
	Concepts can be supported by topics and facts			
	Promotes understanding of relationships between theories, principles and concepts			
3	Depth of knowledge			
	Requires deep understanding of content and application of knowledge			
	Helps learner to create conceptual connections and exhibit a level of understanding that goes beyond the stated facts or literal interpretations			
	Promotes deep knowledge using reasoning, planning, interpreting, hypothesizing, investigating or explaining			

COMPETENCE DOMAIN	VALIDATION MEASURE	YES	NO	COMMENTS/ SUGGESTION/ ADDITIONS
4	Assessment			
	Defines what is to be measured			
	Promotes multiple/varied opportunities to demonstrate evidence of learning			
5	Comprehensiveness			
	Includes all essential elements and is technically sound			
6	Clarity			
	Level of language acceptable			
	Terminology used accessible			
7	Adaptability			
	Can easily be adapted to various contexts			

Source: Adapted from: 9.15.10 NHDOE for New Hampshire State Board of Education FINAL: Course level competency validation rubric.

ANNEX 3A: PARTICIPANTS AT THE WORKSHOP ON VALIDATION OF MIDWIFERY EDUCATOR CORE COMPETENCIES IN RWANDA

NAMES	INSTITUTION	E-MAIL
Nsaba Uwera Yvone Delphine	Kabgayi School of Nursing and Midwifery	yvodely@yahoo.fr
Nyirandegeya Jacqueline	Kabgayi School of Nursing and Midwifery	Nijacky85@yahoo.com
Mtangampundu Kiberinka Adeline	Byumba School of Nursing and Midwifery	Mukadek200@yahoo.fr
Uwimana Beatrice	Byumba School of Nursing and Midwifery	uwibetri@yahoo.fr
Musengimana Denyse	Byumba School of Nursing and Midwifery	denismusenga@yahoo.com
Nwankwo Helen Chinwe	Nyagatare School of Nursing and Midwifery	helennwankwo@yahoo.com
Mparirka Kabeza Teddy	Nyagatare School of Nursing and Midwifery	kabezateddy@yahoo.com
Uwimana Marie Chantal	Kigali Health Institute	uwimac@yahoo.fr
Musabirema Priscille	Kigali Health Institute	Priscillemusa10@yahoo.fr
Ayinkamiye Christine	Centre Hospitalier Universitaire de Butare (CHUB)	chrayin@yahoo.fr
Uwababyeyi Mediatrice	Centre Hospitalier Universitaire de Butare (CHUB)	mediatriceuwababyeyi@ymail.com
Murekezi Josephine	King Faisal Hospital (KFH)	Jrekezi74@yahoo.com
Maribori Consolee	King Faisal Hospital, R (KFH, R)	Maribori.conso@libero.it
Mukankusi Juliet	Council of Nurses and Midwives	Julimuka2001@yahoo.com
Musabyimana Catherine	Rwamagana School of Nursing and Midwifery	musabyimanacatherine@yahoo.fr
Mukarewgo Beata	Kibungo School of Nursing and Midwifery	mukarwego@hotmail.com
Muhawenimana B. Immaculee	Centre Hospitalier Universitaire de Kigali (CHUK)	barindima@yahoo.fr
Natuza Eugenie	Centre Hospitalier Universitaire de Kigali (CHUK)	tuzae@yahoo.fr

ANNEX 3B: PARTICIPANTS AT THE WORKSHOP ON VALIDATION OF MIDWIFERY EDUCATOR CORE COMPETENCIES IN THE KINGDOM OF BAHRAIN

NAMES	INSTITUTION	E-MAIL
Nadia Abdulhadi	College of Health Sciences	nabdulhadi@uob.edu.bh
Mariam Saleh	College of Health Sciences	mabdulrahim@lives.com
Leena Abbas	College of Health Sciences	malakalrahma@hotmail.com
Zainab Jaffer	College of Health Sciences	zainabjaffer@hotmail.com
Aysha Yahya	Bahrain Defence Force Hospital	ayshayahya@gmail.com
Mariam Shareeda	Bahrain Defence Force Hospital	mariamsh@yahoo.com
Hameeda Abdulwahab	Salmaniya Medical Complex	HWahab2@health.gov.bh
Zuhoor Khamis	Hamad Kanoo Health Centre	zkhamis@health.gov.bh
Felcy Disooza	Salmaniya Medical Complex	fdisooza@health.gov.bh
Zainab Khamis	Salmaniya Medical Complex	zainabkhamis@hotmail.com
Fatima Abdulla	Salmaniya Medical Complex	fabdulla@health.gov.bh
Francena Alfanso	Salmaniya Medical Complex	falfanso@health.gov.bh
Joice Mathew	Salmaniya Medical Complex	joicemathew@hotmail.com
Mariama Koshy	Salmaniya Medical Complex	mkoshy@health.gov.bh
Sherly Frances	Salmaniya Medical Complex	sherly88@gmail.com
Sarama Mathew	Salmaniya Medical Complex	saramamathew@hotmail.com
Beena Shaji	Salmaniya Medical Complex	bshaji@gmail.com
Sara Sathi	Salmaniya Medical Complex	sarasathi@hotmail.com

ANNEX 4: MEMBERS OF THE TECHNICAL WORKING GROUP

1. Peggy Chibuye, Education Consultant, Lusaka, Zambia
2. Joy Fraser, Athabasca University, Canada
3. Peter Johnson, Jhpeigo Director, Global Learning, Washington, D.C., USA
4. Anne Lekeux, Professor, European Nursing Education and International Coordinator, Nursing Department, Belgium
5. Mayumi Ohnishi, Professor, Faculty of Nursing, Nagasaki University, Japan
6. Joyce Thompson, International Consultant in Midwifery Education, Michigan, USA
7. Fadwa Affara, Consultant, International Council of Nurses, Geneva, Switzerland
8. Frances Day-Stirk, President, International Confederation of Midwives, The Netherlands
9. Geeta Lal, Midwifery Programme Coordinator, SRHB, Technical Division, United Nations Population Fund, USA
10. Dorothy Lazaro, Midwifery Specialist, United Nations Population Fund, Addis Ababa, Ethiopia
11. Address Malata, Director, WHO Collaborating Centre, Kamuzu College of Nursing University of Malawi
12. Nadia Yusuf, Head, Nurse Midwifery Programme, WHO Collaborating Centre for Nursing Development, College of Health Sciences Ministry of Health, Manama, Bahrain
13. Arwa Oweis, Dean of Nursing, Director of WHO Collaborating Centre, Associate Professor, Maternal and Child Health Department, Faculty of Nursing, Irbid Jordan University of Science and Technology
14. Apirach Indarangkura Na Ayutthaya, Assistant Professor WHO Collaborating Centre for Nursing and Midwifery Development, Faculty of Nursing, Chiang Mai University, Thailand
15. Florence Mirembe, Makerere University, Kampala, Uganda
16. Alice Sony, Professor in Obstetrics and Gynaecology, College of Nursing Christian Medical College, Vellore, India

Notes

Notes

Notes

World Health Organization
Department for Health Systems Policies
and Workforce
20 Avenue Appia
CH–1211 Geneva 27
Switzerland
www.who.int/hrh/nursing_midwifery/en/

ISBN 978 92 4 150645 8

TRANSFORMING MIDWIFE EDUCATORS' COMPETENCIES: AN APPRECIATIVE INQUIRY

Elgonda Bekker and
Karen Venter
University of the Free State

August 28, 2020

T: 051 401 9111 info@ufs.ac.za **www.ufs.ac.za**

UNIVERSITY OF THE
FREE STATE
UNIVERSITEIT VAN DIE
VRYSTAAT
YUNIVESITHI YA
FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

DR. RENETTE MYBURGH 1953-2013. RIP.

WHAT IS APPRECIATIVE INQUIRY?

- **Appreciate**:- Valuing, the art of recognizing the best in people, affirming past strengths, successes, what gives life
- **Inquiry**:- The act of exploration and discovery. To ask questions, to be open to seeing new potentials and possibilities
- Answer from positive psychology to problem-based management
- Developed by Dr David Cooperrider, Case Western University, USA –industrial psychology

(Cooperrider & Whitney, 2005)

APPRECIATIVE INQUIRY (AI) IS:

- Cooperative co evolutionary search for the best in people, organizations and world around them
- Systematic discovery of what gives life
- Asking unconditionally positive questions
- Uses positive to find solutions to perform better

POSITIVE CORE

- Human systems grow in the direction what they persistently ask questions about (Cooperrider & Whitney, 2005)

- <u>Includes:</u>
- Achievements, product strengths
- Core competencies
- Social capital
- Collective spirit
- Lived values

FROM PROBLEM-SOLVING TO APPRECIATIVE INQUIRY

Problem solving

- Felt need
- Identification of problem
- Analysis of causes
- Analysis and possible solutions
- Action planning (treatment)

- *Basic assumption: an organization is a problem to be solved*

Appreciative Inquiry

- Appreciating and valuing the best of what is
- Envisioning what might be
- Dialoguing what should be

- *Basic assumption: an organization is a mystery to be embraced.*

USES

- Organizational development
- Philosophy
- Research
- Intervention
- Action research

World Health Organization
Midwife Educators Competencies

CONTACT FOR INFORMATION: ELGONDA BEKKER

bekkeree@ufs.ac.za

Thank You
Dankie

T: 051 401 9111 info@ufs.ac.za **www.ufs.ac.za**

UNIVERSITY OF THE
FREE STATE
UNIVERSITEIT VAN DIE
VRYSTAAT
YUNIVESITHI YA
FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

Data summary: Discovery Phase

Participant ID	1) Tell me about a peak experience, or high point, in your current practice as educator or witnessed in education – a time that you felt alive, most engaged, or really proud of what you did or experienced.	2) What was it about you, the situation, and/or the midwifery educator's competence that created the space for that peak experience to emerge?	3) What do you value most about yourself as a midwife educator or stakeholder in education regarding midwifery educator's competence?	4) What is the one thing that gives life to your practice without which it just would not be the same?	5) Tell me about the best example of midwifery education competence that you experienced in midwifery education. What was it about that incident that made it so memorable?	6) Tell me what you do when you feel highly relaxed, most secure, or most cherished as midwife educator – when it is simply great to be a midwife educator?	7) What do you regard to be the best aspect of the midwifery educators' competence to igniting change in an environment of gender inequality?	8) Imagine that you have a magic wand, and you would have any three wishes granted in order to create ideal midwifery education. What would those wishes be? (Please – THINK BIG)
1	Innovation in education- new programme and clinical accreditations	Change training of staff outside province (C 6)	Focused Diligence in duties	Passion	Students' competence	*T/P integration of students*	Change agent	• Capacity development • Resources • Infrastructure
2	Advocacy in practice	Confidence in midwife (C3 +C 17)	Competence Autonomy Advocacy	Team work	Students' competence	*Competence and confidence*	Love and caring attitude Good communication	• Midwifery regulatory body • Career pathways • Stop political interference
3	+ student/midwife relationships	Suitable environment for learning	Passion Optimizing teachable	Passion	+ management of students' attitudes	*See change in students' behavior,*	Communication Caring attitude	• More competent ME

		Climate ToL	moments "**Walk the talk"**		(C7)	*character and performance*		• Resources • Ratio ME:ST
4	Clinical competence-personal goals	CPD (C3)	EBP	Passion	Innovative teaching-increased pass rate (C13+10)	*Student readiness*	Advocacy Human rights based approach	• Direct entry • Selection of midwifery students • Resources
5	Student engagement ME Competence	ToL, Theory and practice integration (C4 +C8)	Advocacy **" I value to promote and instill ethical and legal aspects of midwifery care by considering patients' rights, confidentiality and privacy."**	Passion	Innovative teaching (C6)	*Students passed*	Allocation, inclusion	• Direct entry • Ratio • Clinical department
6	Clinical competence Midwife and woman relationship	Theory/practice integration (C9) Compassion and caring	CPD "**Adherence to the hallmarks of midwifery practice. Maintaining and upgrading standards of midwifery practice."**	Passion	Innovation in education (C5+6)	Self-satisfaction	Leadership-agents for change	• Passionate educators • GBV focus • SA Midwifery Council
7	Innovation in education	(C2+C3) Knowledge of SANC	Positive and supportive attitude to	Competence	Clinical skill-obstetric emergencies	Self-worth "**Great to be a midwife**	Inclusion	• Midwifery educators' directorate

		regulations "**Expert knowledge in theory and practice of midwifery"**	students "**Practice what you teach"**		(C3)	**educator"** EBP (C19)		• EBP • No political interverence
8	**Former student as community service competence in managing shoulder dystocia** **"** ***A comm serve sister (former undergraduate student) came excited and bright eyed told the story that she was left alone with a woman in labour, while adv midwives and others went for tea. The woman gave birth and shoulder dystocia occurred, now all the techniques came back as were taught in***	Lecturer competence in Theory/practice integration	Engaged learning (C7)	Observing student development	Innovation in education – simulation Maintain clinical competence (C3)	*Student reflection on experience*	*Confidence and competence*	• Direct entry midwifery • Student placement facilities • Resources

	class, she applied them and the baby was born and got praises from the seniors when they got back"							
9	Gender sensitivity towards male students	C7- male students C9 Experiential learning	Nurturing students to achieve competencies	Empowerment of students	*Midwifery practice Learning in clinical area research- no examples*	*Change in attitude of students*	Mix gender in student allocation Inclusion	• Managerial support for ME • CPD and capacity building • Resources
10	Community based midwifery education "*First experience with students during postnatal home visits and engaged with mothers and their families 7 days post birth"*	EBP (C4) Environment for learning (C5 + C8)	Facilitating deep learning	Reciprocity in learning	Curriculum development C12+13	*Students competence in Primary healthcare engineering*	Inclusion	• Passion • Resources HR • Student centered communication
11	Educator competence in practice T/P Integration	EBP (C4)	Ethical approach	Clinical engagement **" One thing that gives life to my practice is real practice at the hospital or home visits with my**	T/P Integration (C17)	*Positive feedback from HoD, dean, students*	Inclusion	• Time for MEs • Ratio of students • Political support for midwifery **"Governments say that midwifery is very important for humanity"**

				students- it have to be"				
12	Education: Innovation Policy informed	Assessment in T+P improved (C10)	Passion Contextual knowledge- advocate for students Communication flexibility "**I make it my priority to know the exact situation in clinical areas, I use my communication skills to accommodate these situations to the benefit of the students"**	Student development- Self-satisfaction	EBP (C4) Student competence	Inspired "**When I get appreciation and positive feedback I feel I want to do more"**	Inclusion Advocate for name change- accouchers	• Assessment part of T/L • MW –PT Ratios • Contextual appropriate textbooks
13	Enhanced student attitude, confidence and passion " *When I see positive change in student regarding midwifery learning where they correlate theory and*	ToL T/P Integration (C9)	Passion	Passion Student competence "**When students develops passion and succeed in mastering midwifery as evidenced**	RMC(C17) EBP(C4)	*Student mastery and confidence*	Inclusion	• ME- Student centered • Attitude of ME approachable • Resources- sim

	practice- they developed confidence and passion in the subject"			**during assessment"**				
14	Education: Innovation T/L strategy T/P Integration	ToL (C6)	Passion Inquisitive- CPD EBP	Student development- self-satisfaction	Clinical competence of students (C3+6)	*Positive feedback from clinical midwives on students*	Inclusion	• Strengthening of postnatal care • Passionate ME • Resources- simulation
15	Education , student competence	ToL (C7) **"Was in the right position to make a difference to the different students"**	Experience CSL	Passion	Appreciate + performance by a peer +Attitude Team approach	*In-service training- squatting during birth*	Advocacy **"Is gender equality for midwifery educators of whom? Empowering women on SRH trough advocacy".**	• Scope of MW to be "big" • Autonomy of MW
16	Education, student competence Differentiation between education of different midwifery courses(adv. and basic)	(C 12+13) Partnerships "**Midwifery was sold to the Nursing Dept. programs established and partnerships established with DoH"**	Advocacy- for ME through research Teaching students to be assertive	Passion	Student competence and + attitude **" Student sending a message at night reporting on a gained skill due to ME"**	*Graduating students- confidence in their competence*	Empowerment of women	• DE **"Faculty of Midwifery"** • Independent practices- midwives not in hospitals • Regulations midwifery based- autonomy
17	Education and moderation Contextualizing	Educator growth in competence T/P Integration	Policy development "***Ability to***	Self-directedness Application of	Incorporate education strategies(C5)	*See policies implemented that you*	Equality	• Accountability of midwives • Standardization of

	education- safe motherhood Education innovation **"*Looking in the content of what is happening in the country especially the burden of disease in the country. Whether strategies are applied to reduce maternal and child mortality and morbidity*"**	(C 12+13)	***participate in policy formulation which will affect the training and education of students".*** Knowledge sharing "**Ability to share experiences with other lecturers and students"**	knowledge by students in practice	Team work Curriculum development(C 12+13)	*developed*		education • Safe motherhood reached • Autonomy (**" Advocate for midwifery raining")**
18	Education contextualizing safe motherhood T/P Integration	CPD (C 3+4)	Knowledge on Theory and practice of midwifery	Reflexivity "**Assessment of students assists me to know whether the education and training I provide them is effective thus being able to introspect and sharpen my skills"**	Student competence in theory and practice	*Student success*	*They are all students despite gender*	• Passionate students • Direct entry
19	Education	Challenged to	Module	Passion for	Education to	Self-	Advocacy	• Policy

	innovation	develop module	development Research skills Technical skills Team work CSL (C 12+13)	midwifery "**the internal drive to develop a model that will produce the product you are expecting"**	practice (C 5+6)	satisfaction "**I feel good from inside-feel fulfillment"**		• Adequate infrastructure and resources • Innovative ME- E-learning
20	Advocacy for protection of mother-baby dyad	*Integration of maternal and neonatal care principles*	Protection of mother-baby dyad	Safe motherhood	Self-directness	*Students grasps content*	Equality	• Midwives do own research • Clinical department • Expansion of scope of practice of adv mw, consultant role
21	Student competence, +feedback from practice	Student mentoring (C9)	Facilitating engaged learning Student clinical competence and confidence	Educational process	Research into practice (C18) Culture of EBP(C19)	*Positive student feedback*	Inclusion and equality	• Student success • Change agent • *Personal goals like representing in DoH panel and leadership roles*
22	CPD, Student competence, academic development	ToL (C5)	Facilitating engaged learning Student competence and confidence	EBP	Tenacity to continue with class	*Result driven and spiritual awareness*	Inclusion Respect HR "**To be accommodative of your students regardless of their gender and sexual orientation. Respect of human rights**	• Be a change agent • Student success in practice • Collegiality with students, clinical staff and faculty for + learning environment

							and encourage the expression of and discussion of multicultural views"	
23	Student competence "**Transfer of knowledge and ability to build the character of midwives"**	Transfer of learning Theory and practice integration (C5,7,9)	Facilitation of engaged learning, Student competence	EBP	Student competence	Engage with EBP material	Inclusion	• Passion" **All midwifery students to be enthusiastic about midwifery"** • Student success • Information sharing amongst ME
24	Student success	Educator commitment(C7) "**Commitment and ability to run extra mile for the students"**	Competence	Education process	Tenacity to continue with class "**…I reach class and putting my USB it was empty. I managed to deliver the lesson with my preparation work"**	*Read, Google watch movies*	Inclusion and equality	• Clinical preceptors • Safe motherhood goals • Respectful care of midwives "**Caring attitude of all midwives irrespective of shortage of staff"**
25	Education innovation	Educator competence	CPD EBP	Self-satisfaction as student develop	Advocacy(C17)	*Spiritual awareness*	Inclusion	• Standardization • Resources, also simulation • Competent preceptors
26	Education innovation "**Encourage**	T+L Conducive learning (C5+6)	CPD	+Feedback of student development	Student competence in obstetric	*Spiritual awareness*	Inclusion Equality	• Resources including simulation • Competent

	students to use gadgets as part of their learning and obtain information from reliable sources moving away from being dependent on prescribed books"				emergencies "**…students that delivered breech successfully when the intern could not"**			preceptors
27	Student competence	*PMTCT training by external staff*	Student academic guidance and support	CPD	Clinical competence(C3)	Student success	Advocacy for equality	• New curriculum in place • Scope of practice suitable –adv mw • Recourses • Clinical Dept.
28	Passion Student engagement "***Passionate about midwifery so much that when or through her teaching was able to transfer the passion to students who also became passionate. They are now midwives because she has***	Engage with students(C7) CPD (C3)	Clinical competence Mentor Consultant	Conveying clinical competence	Innovative education strategies(C5)* **"I love it when students starts getting excited and an active debate is started in the classroom. Students come forward with really great problem-solving skills in a way that I**	Deep engagement reciprocity	Equality	• Innovative ME • International collaboration • CPD

	a trust relationship with them"				**learn something new"**			
29	Competency development of students, Conducive learning environment	EBP Safe learning environment (C8+9)	Facilitating engaged learning Clinical competence (C3)	Teamwork	Selection of effective T+L Material (C6+13) Teamwork	*Sleeping peaceful*	Distancing "***I feel that someone who cannot experience pregnancy, birth and baby cannot be able to have empathy with a mother in such situation"***	• Transfer of learning-role models • HR • DE
30	Student success	Implementation of EBP(C4)	Continuous professional development (CPD)	Clinical engagement, real person	Clinical competence(C3) Example insertion of IUCD	Student success	Advocacy for students	• Competent educators for new curriculum • DE • Clinical department • ME EBP • Scope of practice
31	Witness and enabled Family Centered Care(FCC) "***During clinical accompaniment educator demonstrated how to involve the father as a birth companion.***	Clinical Competence (C3) Able to use Evidence Based Practice(C4) Able to do clinical facilitation(C5) Select teachable moments (C6)	Facilitate engaged learning Equity in learning styles of students	Reflexivity	Curriculum development(C 12+13)	*Pat self on the back*	Distancing "Males do not fit"	• Resources, HR • Simulation resources • Educators EBP

	During birth the father collapsed to the anguish of the students. Learning: Father said family planning will be encouraged by him in future"	Created a safe learning environment (C8)						
32	Student success, educator engagement with student	Education competence (C7)	Creation of conducive learning environment	Community appreciation of competence of students, safe motherhood	T+L strategies to promote active learning (C7) Implement and revise programme (C13)	Deep engagement with students (C5)	Advocacy for human rights, professional, community and education	• Direct entry (DE) programme in midwifery/Autonomy • Passion • Human Resources(HR) plan including clinical midwifery department(CD)

Dream, Design Destiny

Participant ID	Dream: Four years from now: What is the most extraordinary thing that you personally liked to accomplish as a member of a team in four years	Design: Provocative proposition Single line statement/ possibility statement	Resources/frameworks needed for meeting the opportunities identified?	Destiny: Framework elements crucial to strengthen MEC. Novice to expert Complying to ICM philosophy and model of care within an environment of gender equality
1	Not completed			
2	Retention of ME Career pathways for growth and opportunities	Not completed	Scale up lecturers- CPD Revive clinical department Scale up clinical mw	Not completed
3	Not completed			
4	Not completed			
5	EBP "**Produce competent, competitive cadres that are marketable in the world. With a research culture and primary health orientated."**	Not completed		
6	ME as role model and advocates for respectful care and GBV prevention	Not completed		
7	Standardization and competency driven education	Not completed		
8	Autonomy Competence and Passion	Not completed		

	“**Competent, passionate midwives working in a team in a midwifery school”**			
9	Resources Clinical departments Direct entry	Not completed		
10	Direct entry Clinical departments	Not completed		
11	Student success EBP Collaboration and well-being- global “**Happy midwives, happy women and children”**			
12	Not completed			
13	Midwives part of the primary health engineering programme	Not completed		
14	Colleges to be higher education institutions Safe motherhood	Not completed		
15	Comprehensive integration of ICM Competencies in all programmes	**“ Competent educators- competent midwives- confident practitioners”**	Not completed	
16	Competent graduates Passionate educators Safe motherhood	“**SA Midwives of the future: strong and competent”**	Not completed	Opportunities Competence Assertive
17	Not completed			
18	Not completed			
19	Restoring image of profession	Not completed		Education by compassionate and competent lecturers

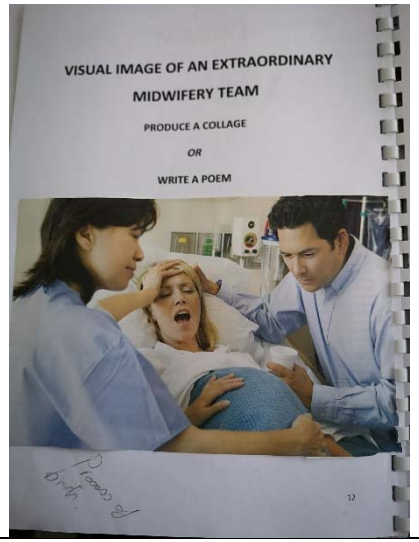
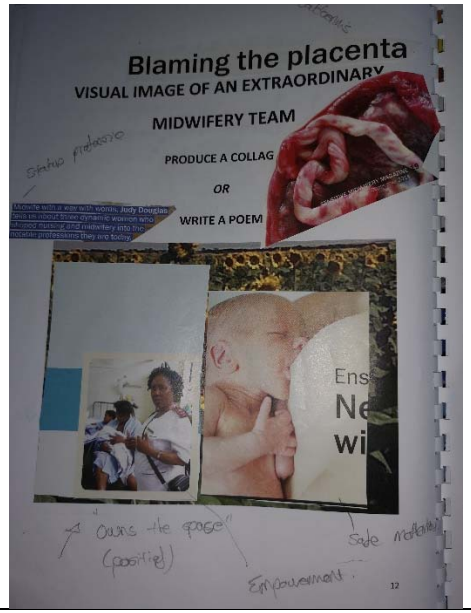
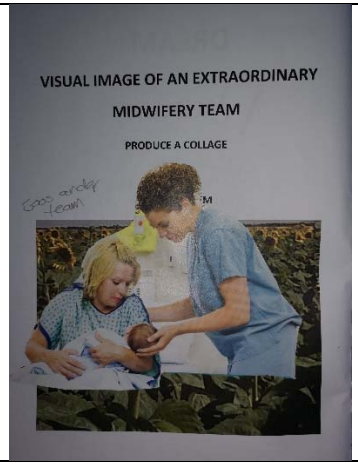
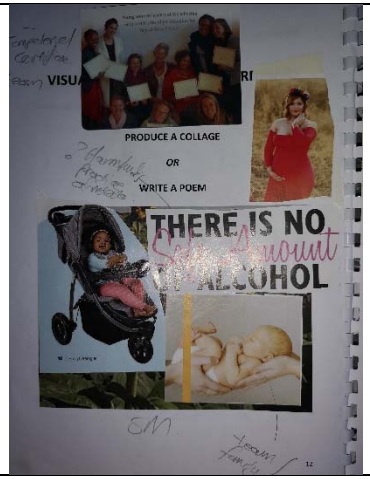
	“ Midwives to attach value to their profession so we can regain the good image we used to have.”		SA Midwifery Council, not appointed by political person
20	To be an independent practitioner	Not completed	
21	Standardized curriculum to sustain SDGs	**<u>Visual image:</u>** *Birth parents and care giver-* Process of birth  	Not completed
22	Standardized curriculum	**<u>Visual image:</u>** *“Blaming the placenta” (**image of placenta included in collage**)*? Reference to content of subject? *“Midwife with a way with words, **Judy Douglas,** tells us about three dynamic women who shaped nursing and midwifery into the notable professions they are today”*	Not completed

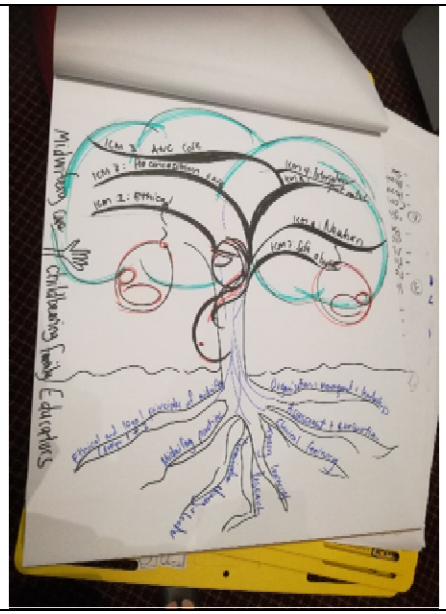
		Image of midwife and mother feeding infant in background- "Owns the space+ empowerment ***Image of infant latched to breast-*** Safe motherhood 	
23	Standardized curriculum to reach SDGs	**Visual image**: *Birth parents and care giver-* Process of birth	Not completed

			
24	Standardized curriculum to reach SDGs	**Visual image:** One caption from magazine": *There is no safe amount of alcoho*l"- related to elimination of harmful practice Four images from magazines: One of student leaders with certificates-? **competence** Second one of pregnant woman Third of two parents holding infant Fourth of happy baby in stroller **All of these themed as safe motherhood and partnership with families**	Not completed

				
25	Standardized curriculum to reach SDGs	**Visual image:** One caption from magazine": *There is no safe amount of alcoho*l"- related to elimination of harmful practice <u>Four images from magazines:</u> One of two graduates, one of a pregnant mother and two of parents with babies. **All of these themed as safe motherhood and partnership with families** **The word TEAM was constructed from individually cut letters.**		

				
26	Standardized curriculum to reach SDGs	**Visual image:** **Own words and pictures and text from magazines** One photo of mother with baby in KMC and a baby below that, her own words with arrow indicating these: *'Good cause final outcome"* *Other pictures and captions "Small legs and great heights…and it all was for a good cause" with pictures of a team during a climb.* This was categorized as victory over a difficult task – safe motherhood linked.		

				
27	Technology, Wi-Fi internet Well-resourced clinical laboratories	Not completed		
28	Accompany for home birth-normalization of midwifery	Not completed		
29	Finish masters	Not completed		
30	Technology, Wi-Fi internet Well-resourced clinical laboratories	Not completed		
31	Colleges to be higher education institutions	Not completed		
32	Direct entry	Capacity building, infrastructure and resources "**SA midwives must be a midwife"** ***Question asked by me(in capacity as president of the association during welcoming address the previous day: Is a midwife A MIDWIFE in SA?"**	Not completed	

Known midwife was a participant but cannot link to her completed book drafted a large picture on a flip chart and also asked to share her thoughts as captured in a video.				

1.1 ***Transcribing of video clip of participant***

The picture starts with the educator's competencies wat die wortels is. En uit hulle uit gee dit die lewe aan die boom en die boom is die vroedvroue of midwifery care en die sterk stam is die ICM se basic midwifery competencies and the fruit it bears is die gesonde stam en die gesonde boom en gesonde ma en the fruit is the newborn baby. Die boom en stam kan nie gebeur sonder die partnership between mother and child, ag midwifery and the childbearing family so dit gaan oor die hande vat tussen die twee.

Hmmm!!

Elgonda se gedagtes as sy dit sien, ek sal haar gesig afneem as sy dit sien…

ANNEXURE J: GAP ANLYSIS PERMISSIONS

Permission were obtained from the following gatekeepers before contacting the midwifery educators for their individual informed consent procedure.

1 Eastern Cape Department of Health- Zonwabele Merile- 03 May 2018
   1.1 Lilitha College of Nursing (Eastern Cape Department of Health) Dr JE Bereda-Thakhathi: Acting College Principal 27 May 2019
   1.2 Lilitha College Of Nursing- Campus permissions
      1.2.1 East London Campus- Mrs N.B. Mhlahlo 18 June 2019
      1.2.2 Port Elizabeth Campus – L.H. Zonke 12 June 2019
2 Mpumalanga College of Nursing- Dr J. Maunye- 20 June 2018
3 Free State Department of Health- Dr David Motau HOD- 27 June 2018
4 Northern Cape Department of Health- Dr E. Worku- 27 June 2018
5 Fundisa, by Dr K.E. Mokoka dated 26 July 2018
6 Western Cape Department of Health- Dr Thendani Mabuda Director of Nursing Services- signed 28 July 2018, only approved by Dr M. Moodley Health Impact Assessment 28/01/2019
7 Limpopo Department of Health Dated 06 August 2018- enquiries to S.S. Stander
8 North West Department of Health- Ms M. Mangonyane- 28 March 2019
9 Gauteng Department of Health- Acting Chief Nursing Officer (P.Ntamane) granted permission for Chris Hani Baragwaneth College, Ann Latskey College, Garankua College and S. G. Louwrens College- 20 May 2019

Permission refused

Email from S. Maharaj (Vice Principal KZN College of Nursing) dated 9 July 2018 Stating:

> “Dear Ms Bekker
>
> Your email request to conduct research at the KwaZulu-Natal College of Nursing and our discussion refers:

Please note that there are currently two research studies of a similar nature taking place at the KwaZulu-Natal College of Nursing currently.

Data Collection is currently underway for both these studies.

It is for this reason that we recommended that the KwaZulu-Natal College of Nursing be excluded from your study.

We nevertheless wish you well with the rest of your study.”

International Confederation of Midwives

Strengthening Midwifery Globally

25 June 2018, The Hague

Dear Elgonda:

On behalf of The International Confederation of Midwives it gives me a great pleasure to inform you that you are one of the WINNERS of the ICM Research Award 2018 funded by Johnson & Johnson. We received many high-quality applications, and were impressed with your proposal and its possible contribution towards improving maternal and newborn health.

The award includes:

- USD 7000,00 contribution towards completion of your research project
- Full sponsorhip (travel including cost for Visa application, hotel accommodation, congress/conference registration and USD 75/day for your meals and other incidental costs) for the upcoming Regional ICM Conference in DUBAI, being held between 6-8 September 2018.

  At this conference you will have the opportunity to present your work via a poster presentation. We are still planning the conference programme but expect that we will have a session where all award winners present their posters. More details will follow.

To proceed with the process, please email the following to: admin@internationalmidwives.org by 3 July 2018.

- A filled-in copy of the attached form for transfer of the awarded money
- A filled-in copy of the Declaration of commitment to follow-up, reporting
- A filled-in copy of the Declaration of availability for the ICM conference in Dubai, 6-8 Sep 2018
- A filled-in copy of the Passenger Profile for travel to Dubai
- For the announcement of the winners on our website: a high-resolution photo of you (preferably while at work/in action) and a short description of your research project and its importance for midwifery, maternal or newborn health

Congratulations on your excellent achievement and contribution to maternal and newborn health.

We look forward to your presentation and final report.

Yours sincerely,

Sally Pairman
Chief Executive
ICM

International Confederation of Midwives
La Confédération Internationale des sages-femmes
Confederación Internacional de Matronas

Koninginnegracht 60
2514AE, The Hague
The Netherlands

Telephone +31 (0) 70 30 60 520
Email: info@internationalmidwives.org
www.internationalmidwives.org

Research Proposal: Competencies of South African midwifery educators: A transformative framework

International Confederation of Midwives (ICM) Research award 2018

Elgonda Bekker, Dr. Deirdre van Jaarsveldt

School of Nursing, Faculty of Health Sciences, University of the Free State, Bloemfontein, South Africa

Midwifery Education in South Africa

- Midwifery in South Africa is disempowered by a system of a combined nursing-midwifery education
- International guiding documents such as the World Health Organization Midwife Educators' Competencies (MEC) (World Health Organisation, 2013) are not yet utilized in SA midwifery education
- A self-evaluation of a gap analysis of MEC can describe the current situation to ultimately address the human resources for health needs in midwifery
- Focussing on deficits rarely brings about change. Using strengths-based approach (Appreciative Inquiry) to co-create a transformative framework based on what works well in MEC Mertens, 2007; Cooperrider et al., 2008

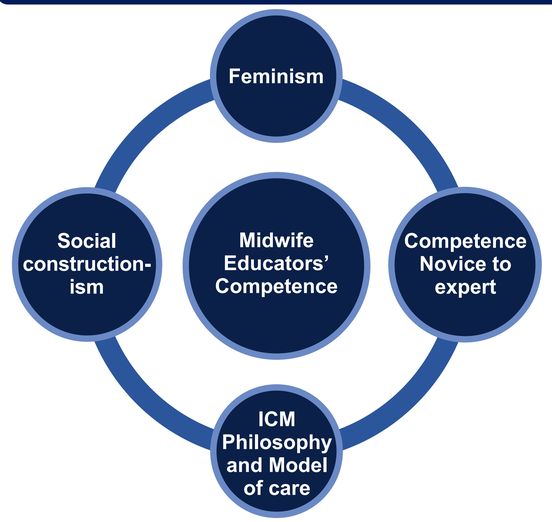
Aim of research

To develop a transformative framework to strengthen MEC in SA midwifery education

Objectives

- Evaluate SA midwife educators' competencies using a self-rated MEC gap analysis
- Appreciate the MEC strengths of SA midwife educators
- Use the MEC strengths to inform the development and subsequent validation of a transformative framework addressing the MEC gaps in SA midwifery education

Guiding Theories



- Transformative research using the lens of Feminist Theory (Creswell, 2014)
- At the background the ICM Philosophy and Model of Care is guiding midwifery competence. The theory of Patricia Benner: From Novice to Expert is guiding competence
- Social constructionism as a social system creates or determines its own reality, in this case it co-creates the transformative framework

Methods

Research sub questions, population, methods, analysis and end products

Sub questions	What are the current gaps of SA midwife educators? (Quantitative strand)	What are the appreciated MEC strengths of SA midwife educators? (Qualitative strand)	What MEC strengths should be included in a transformative framework to address the MEC gaps in SA midwifery education?
Target population/ unit of analysis	Midwifery lecturers at higher education institutions (HEI) and nursing education institutions (NEI) in SA.	Midwife educators at congress workshop during 15th Annual Congress of the National Midwives Association. Unit of analysis – co-constructed data.	Professional association Society of Midwives of South Africa (SOMSA) executive members, members of SANC education committee, NCCEMD members.
Methods	Use gap analysis questionnaire.	Appreciative Inquiry (AI) workshop, Following 4D process.	Delphi to experts indicated above.
Analysis	Gap analysis - quantitative using descriptive statistics.	Nominal Group Technique (NGT) used in AI.	Support of 80% of elements.
End product	Competency deficit profile.	Actions needed to transform MEC as basic elements of transformative framework.	Transformative framework.

References:

Cooperrider, D.L., Whitney, D. & Stavros, J.M. 2008. Appreciative Inquiry Handbook. 2nd Ed. Berrett-Koehler Publishers, Inc.: San Francisco.
Creswell, J.W. 2014. Educational Research: Planning, Conducting and Evaluating Quantitative and Qualitative Research. 4rth Ed. Pearson: Essex.
Mertens, D. 2007. Transformative Paradigm. J. Mix. Methods Res. 1(3).
World Health Organisation. 2013. Midwifery educator core competencies. :1–48.

T. :+ 27 51 4012527 | BekkerEE@ufs.ac.za | www.ufs.ac.za

Declaration

2 September 2020

PO Box 4
Otjiwarongo
Namibia

Student: E.E. Bekker

Thesis: Competencies of South African midwifery educators: A transformative framework

I edited this thesis and recommended changes to the text, though I could not follow up on changes the student made after my involvement.

Other service providers were responsible for technical editing and checking the references.

MA Language Practice.

Hettie Human
WRITER | EDITOR | TRANSLATOR | INTERPRETER

+264 813 359 120 | hettie.human@gmail.com