

Thesis

COMPETENCIES OF SOUTH AFRICAN MIDWIFERY EDUCATORS: A TRANSFORMATIVE FRAMEWORK

Submitted by

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School of Nursing

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DECLARATION

"I, **Elgonda Eritzema Bekker** declare that the thesis (or interrelated, publishable manuscripts/published articles or mini-thesis) that I herewith submit for the Doctoral Degree **PhD** at the University of the Free State, is my independent work, and that I have not previously submitted for a qualification at another institution of higher education."



17 November 2020

Signature

Date

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CONCEPT CLARIFICATION

Concepts that appear in the title and those closely related to the study are explained. As some concepts in healthcare education are used interchangeably, these key terms and their application in this thesis are clarified.

Appreciative inquiry

Appreciative Inquiry (AI) is a research method that is based on appreciating the values and beliefs of what works, in an inquiry that can engage and inspire change. It provides a non-threatening way of finding solutions and is widely implemented as a change management solution (Cooperrider & Whitney, 2005:vii; Cousin, 2009:167; Reed, 2007:2). In this research, AI was employed to gather data while embracing the work and voice of midwifery educators.

Competence

Competence is regarded as a combination of knowledge and psychomotor, communication and decision-making skills that enables an individual to perform a specific task to a defined level of proficiency (International Confederation of Midwives, 2010:1). Competence involves a combination of components and leads to professionally meaningful actions or know-acting; alternatively, ability based on the utilisation of an integrated and interchangeable set of internal and external resources. Competence that is acquired through experience and learning depends on potential abilities under certain circumstances (external resources), as well as the motivation to utilise those abilities (internal resources) (Fernandez *et al.*, 2012:363; Fukada, 2018:1; Fullerton, Ghérissi, *et al.*, 2011:6).

Competence is measured through a process of structured assessment, using objective standards of professional practice (knowledge, skills and abilities or attitudes) as the criteria of quality, in order to document an acceptable level of performance (Fullerton, Ghérissi, *et al.*, 2011:6). The authors continue that competence is not static, but develops over the professional lifetime of individuals as they move from being

beginners to expert practitioners, and as they respond to technological changes and progress in the research and science that underpin their work – whether in practice or education (Fullerton, Ghérissi, *et al.*, 2011:6). The midwife needs to continuously acquire new information and new skills to continue providing safe, high-quality midwifery care (WHO, 2011:5). In this research competence as comprehensive construct in midwifery education and practice are considered.

Competency

Competency represents the broad set or combination of complementary knowledge, skills and abilities/behaviours that are required (or enable a person) to perform a function with proficiency. Competency refers to behavioural characteristics that are shaped by interests and experiences and influenced by attitude and motivation (Fullerton *et al.*, 2013:1130). A set of optimal behavioural traits relies on competence (ability) likely to developing competency (behavioural characteristics) (Fukada, 2018:1). Competencies serve as a standard or benchmark to measure an educator's competence (WHO, 2014:8). In this research, the focus is on eight domains and 19 midwifery educator competencies, as described by the World Health Organization (WHO). The domains cover areas such as teaching and learning, research, leadership and midwifery practice (WHO, 2013:13,14).

Midwife

In South Africa, the Nursing Act 33 of 2005 states: "a midwife is a person who is qualified and competent to independently practice midwifery in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice". Men registered with the South African Nursing Council for midwifery are referred to as accoucheurs, however, in this research, midwife applies to both men and women who practice midwifery (including maternal and neonatal care).

Midwifery educators

Midwifery educators are qualified midwives who have successfully completed a programme of study and who have demonstrated competency in teaching, including the art and science of curriculum development, methods of theoretical and practical teaching of adult learners, and methods of measurement and evaluation of student learning (International Confederation of Midwives, 2010:3). A midwifery educator is a specialist in the theory and practice of midwifery education and in this research educating student midwives at basic or specialist level.

Transformative framework

A transformative framework is a framework that captures an action agenda to reform and address the needs of a group in need of change (Creswell, 2013:25), who, in this case, is South African midwifery educators. The focus was on empowering midwifery educators to co-create action that could bring about positive change in competencies and practice. Constraints that limit midwifery educators' competencies (MECs), as well as strengths, were identified. Through active participation in the inquiry, a specific plan to address the emerging issues was incorporated in the transformative framework.

LIST OF ABBREVIATIONS AND ACRONYMS

AAAQ - Availability, accessibility, acceptability and quality (of care)

AI - Appreciative Inquiry

CFR - Case fatality rate

CPD – Continuing Professional Development

EPMM - Ending Preventable Maternal Mortality

ESMOE - Essential Steps in Managing Obstetric Emergencies

EBP - Evidence-based practice

HSREC - Health Sciences Research Ethics Committee

ICM - International Confederation of Midwives

ICN - International Council of Nurses

iMMR - Institutional maternal mortality ratio

MEC - Midwifery educators' competencies

MMR - Maternal mortality ratio

NCCEMD - National Committee on Confidential Enquiry into Maternal Deaths

NEI - Nursing education institutions

QMNC - Quality Maternal and Newborn Care

SANC - South African Nursing Council

SBA - Skilled birth attendant

SDG - Sustainable Development Goals

SOMSA - Society of Midwives of South Africa

SoWMy - State of the World Midwifery Report

SRMNH - Sexual, reproductive, maternal and neonatal health

UFS - University of the Free State

UHC - Universal health coverage

UNFPA - United Nations Population Fund

UNICEF - United Nations Children's Fund

WHO - World Health Organization

ABSTRACT

Midwifery educators' competencies are a crucial component in strengthening midwifery education and maternal healthcare. Moreover, quality midwifery education is fundamental in reaching universal health coverage by 2030. In this research, a transformative paradigm with the focus on gender inequality as the social justice element, enhanced by theoretical perspectives from feminism and social constructionism, was followed. A concurrent mixed-method design was deemed most appropriate to answer the research question: "How can midwifery educators' competencies best be strengthened to transform midwifery education in South Africa?"

Competence strengths were defined and discovered, dreams were expressed, and the designed destiny framed during an Appreciate Inquiry session. The strengths-based approach was integrated with a realistic view of South African midwifery educators' competencies gained by the self-administered WHO Midwifery Educator Core Competency Gap Analysis Tool. After analysis of the separate data sets, inference of the findings in triangulation with literature culminated in a transformative framework, which was refined by experts in maternal healthcare and midwifery education through a non-consensus Delphi. The meaning of all the contributions from the different perspectives of the interprofessional stakeholders were incorporated to strengthen the framework, thus taking a dialectic stance.

The transformative framework consists of consecutive building blocks. Compliance with global standards for midwifery education, regulation and essential competencies forms the foundation. An enabling environment is the next element that facilitates national capacity building to address gaps in midwifery educators' competence. Supported by the building blocks, midwifery education competence could ultimately improve the quality of midwifery care. The context of midwifery, including education, is framed by four elements emanating from a feminist approach, resulting in agency for midwives and women. This agency contributes to empowerment of women and decolonisation of midwifery, aimed at knowledge democracy. The transformative framework is presented to strengthen midwifery educators' competencies and transform midwifery education in South Africa.

Chapter 1

Overview of the research



CHAPTER 1 OVERVIEW OF THE RESEARCH

1.1 INTRODUCTION

"South Africa cares: No woman should die while giving life" (South Africa. National Department of Health, 2012:1).

This profound statement by the Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA) (2012) initiative draws urgent attention to the tragedy of maternal (and child) death. The call to promote safe motherhood serves as a compass for maternal and child health practitioners, including midwives and midwifery educators.

In the quest to answer the call to improve maternal health and confirm that, in South Africa, no woman should die in the process or because of pregnancy and birth, the importance of midwifery education is central. This sentiment was reiterated by the World Health Organization (WHO), which declared that, "[q]uality midwifery education is urgently needed to improve quality of care, end preventable maternal and newborn mortality and stillbirths and deliver the agenda of universal health coverage (UHC)" (WHO, 2019:1). Midwifery educators are responsible for "birthing" the new generation of midwives, thus, playing an integral part in answering the call to promote safe motherhood.

Midwifery care and education have experienced the development of several strategies to achieve safe motherhood goals. In this regard, strategies to improve maternal care focus mainly on healthcare service elements. One such international strategy is the Ending Preventable Maternal Mortality (EPMM) programme. EPMM resonates with the target of the Sustainable Development Goals (SDG), and confirmation of this WHO strategy, can be reached in our lifetime (WHO, 2015a:9).

The following three strategic objectives were set for EPMM. Firstly, inequities in access to and quality of sexual, reproductive, maternal and neonatal healthcare must be corrected. Secondly, UHC for comprehensive sexual, reproductive, maternal and

newborn healthcare should be ensured. Causes of maternal mortality, reproductive and maternal morbidities, and related disabilities should be addressed by a health system that is responsive to the health needs of women and girls. Lastly, if accountability regarding improvement of quality of care and equity could be achieved, the target of eliminating all preventable maternal deaths by 2030 is within our reach (WHO, 2015a:9).

The link between midwifery education and reaching the strategic objectives of the EPMM has been receiving attention, and during the 2019 World Health Assembly, the WHO framework for action, Strengthening Quality Midwifery Education for UHC 2030, was launched (WHO, 2019). This document is a confirmation of the importance of quality midwifery education, and the goal of reaching UHC by 2030. If the UHC goals are to be met by 2030, the strategic objectives of EPMM should be included in quality midwifery education.

Midwifery and midwifery education link several strategies for providing quality maternal health and UHC. The significance of midwifery education as a contributor to quality midwifery care and the strengthening of women's rights and human rights is captured in these mentioned WHO strategies and are discussed in more detail in Section 1.1.1-1.1.3.

1.1.1 Midwifery as a key to quality maternal health

The importance of midwifery as an essential component of solving the problem of poor maternal and newborn health has been delineated by researchers and policy-makers (Bharj, Luyben, Avery, Johnson, O'Connell, *et al.*, 2016:3; Renfrew, Homer, *et al.*, 2014:2). A systematic review of 461 publications confirmed that 56 maternal and child health outcomes could be improved by practices in the midwifery scope of practice (Gavine *et al.*, 2019:106). In addition to improving outcomes, midwives, if educated and regulated to international standards, are associated with more efficient use of resources. Midwives are most effective when the healthcare system is well resourced, and interprofessional teams and referral systems are in place (Renfrew *et al.*, 2019:396; Renfrew *et al.*, 2014:13; WHO, 2019:1).

An exposition of the South African statistics that measure maternal healthcare is discussed in Section 2.3.

The focus on midwifery competence (which includes skills) is also evident in a review of midwifery services in 58 countries (including South Africa), which is captured in the first State of the World Midwifery (SoWMy) Report (2011). The evidence gathered for the report reveals key issues regarding the status of the profession, and identifies challenges and barriers that affect midwives. A triple gap concerning competencies, coverage and access exists: There are not sufficient numbers of competent midwives who can cover maternal health services with appropriate services that address the needs of women.

Furthermore, the SoWMy Report found that there is insufficient focus on the triad of education, regulation and professional association in providing quality midwifery care. Educating sufficient numbers of midwives according to international standards and competencies, and ensuring they are regulated and supported by professional associations, will strengthen the profession. In addition the report stated that national policies do not focus on the need to improve the quality of care with respect to patients' rights and the central role of midwives in the workforce (UNFPA, 2011:iv, v).

The second SoWMy Report, launched in 2014, included 73 countries and elaborated on the first report's findings. Four domains to ensure that every woman and every child benefit from sexual, reproductive, maternal and neonatal health (SRMNH) were identified:

- a) The *availability* of essential SRMNH, which could be directly converted into the need for skilled midwives;
- b) Services must be *accessible*, which implies that sufficient numbers of competent midwives, working within a functional healthcare system, should be available close to the women in need of SRMNH care;
- c) Care should be *acceptable*, which implies that it should be sensitive to social and cultural needs. Furthermore, care should not be negatively influenced by discrimination and the status of women, as both healthcare providers and consumers of SRMNH care; and

- d) The quality of midwifery education, regulation and the role of professional associations must be improved to ensure *quality* SRMNH service (UNFPA, 2014:8).

Described domains of availability, accessibility, acceptability and quality of care (AAAQ) imply that, to achieve UHC and EPMM, more midwives who are competent are needed. Therefore, gaps identified by the SoWMy Report should be covered. The midwifery workforce should be available and accessible, and should provide quality and acceptable care. These midwives will be the product of a midwifery education programme based on a sound philosophy. Midwifery education should comply with global standards and be delivered by competent educators.

1.1.2 Significance of midwifery education

The link between improving maternal health and education of midwives was identified as early as 2002, when Joyce Thompson, international midwifery education consultant and leader, said:

"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).

It is crucial for the country and profession to focus on midwifery education. The need for adequately prepared midwifery 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 essential for quality midwifery education. There are, however, many barriers to quality midwifery education, including professional barriers, economic and employment-related problems and sociocultural issues, of which gender inequality is the most important (Renfrew *et al.*, 2019:367; WHO, 2019:20).

There is a very high midwifery educator-to-student ratio (1:45) in developing countries such as South Africa, and the situation is compounded by the level of educator preparedness. In some areas of Africa, only 6.6% of midwifery educators have qualifications or preparation as educators. There is a need to capacitate midwifery

educators, especially in developing countries (WHO, 2013:9). It is acknowledged that globally, midwifery education is facing challenges that may vary between countries, due to the context of healthcare in any given country. Therefore, the need to optimise midwifery education is not only applicable to developing countries.

The International Confederation of Midwives (ICM), which has a global representation of more than 100 midwifery associations, also recognises the importance of competent midwifery educators. As a global advisory body for the development and strengthening of midwifery, the ICM developed several core documents for the education, regulation and associations of midwifery. Midwifery education is one of the three pillars identified by ICM that could strengthen midwifery. The other two pillars are strong midwifery association and regulation of the profession. The ICM core documents include *Essential Competencies for Basic Midwifery Practice* (International Confederation of Midwives, 2019) and *Global Standards for Midwifery Education* (ICM, 2013a), which serve as benchmarks for midwifery education and practice globally (Bharj, Luyben, Avery, Johnson, O'Connell, *et al.*, 2016:3). Additionally, a position statement on the required qualifications and competencies of midwifery educators emphasises the importance of competencies over different domains, including education and clinical fields (International Confederation of Midwives, 2014a:1). If midwifery educators are responsive to the needs of women, and also competent, they could shape new midwives, to achieve the demand for competent midwives, end preventable maternal mortality and render quality midwifery care.

1.1.3 Impact of women's rights and human rights in midwifery and midwifery education

The focus on meeting the needs of women has been becoming more important in shaping midwifery education and practice. Two of the guiding principles of EPMM refer to human rights and empowerment of women and girls (WHO, 2015a:9). **Empowering women in healthcare** is a well-known principle. In addition, the SoWMy reports explain that, in reproductive healthcare, providers must ensure services that will meet the needs of women and provide AAAQ care. Refer to Section 1.1.1 for clarification. Another crucial element of empowering women, is that women should have the power to make decisions that benefit them (UNFPA, 2017:iii; WHO, 2015a:10).

Furthermore, another principle of EPMM, which requires that reproductive healthcare should be based on a framework of **human rights**, is to ensure availability, accessibility and acceptability of care. Human rights and women's rights can be measured by the maternal health statistics of a country. The United Nations Human Rights Council regards maternal morbidity and mortality as human rights violations (WHO, 2015a:12). The dire need for midwives, as providers of quality care, who will ensure that every childbearing family has access to what their human rights dictate, relies on midwifery education to produce midwives who are responsive to the needs of childbearing families (Luyben *et al.*, 2017:185).

From research and evaluation it is clear that **inequality based on gender** is embedded in major institutions and societal norms, including education, the media, religion and government. Donna Mertens (2015:22, 23), a scholar working within transformative education research, explains the critical contribution that the feminist perspective brought to research and evaluation. There are elements in her work that resonate with the midwifery profession and the cadre that should prepare the next generation of midwives, to ensure UHC for childbearing families, and midwives able to provide AAAQ care.

Donna Mertens (2015:22, 23), confirms that gender inequality affects who has power, and agency. The lack of agency and power negatively impacts the attainment of human rights, and disempowers childbearing families (Renfrew *et al.*, 2019:396; WHO, 2015a:12). A gap identified in meeting the essential needs of childbearing women, their babies and families are not met, although these needs were identified decades ago.

1.2 BACKGROUND

Bringing this closer to home, it is evident that, despite concerted efforts, South Africa is not meeting the global targets for maternal health, because 3 814 mothers died in the past triennium (2014-2016), compared to 4 452 in the previous triennium from 2011-2013 (Pattinson & Moodley, 2014:105, 2018:v). The full picture of maternal health in South Africa is discussed in Section 2.3. In preparing human resources for health (especially midwives, if maternal health is to be considered), multiple needs

and competing priorities must be considered. To meet the population's needs, the WHO recommends using informed decision-making to ensure that, despite challenges, there are competent educators to prepare fully qualified and competent midwives (WHO, 2015b:13).

One such challenge that applies to the South African context is that midwifery is not viewed as a separate profession from nursing. The majority of documents and statements of the South African Nursing Council (SANC), the regulatory body of the profession, does not clarify the two professions as separate. This disempowered state becomes clear when maternal health issues are investigated. The majority of nurses have a professional registration as a midwife, but not the expected competencies (Schoon & Motlolometsi, 2012:784).

An international position paper states that

"Professional autonomy, therefore, implies that midwives determine and control the standards for midwifery education, midwifery regulation and midwifery practice" (ICM, 2011a:1).

In South Africa, the profession of midwifery is captured within the Nursing Act 33 of 2005. However, the recognition of midwifery as an independent profession is not adequate. The accurate number of competent midwives who will meet the ICM definition of the midwife (where the competencies are essential in defining the midwife) is not captured. The latest (2017) SoWMy report focusses on the eastern and southern African region. In its analysis of the sexual, reproductive, maternal, newborn and adolescent health workforce, the country analysis for South Africa states that there are only 1 284 midwives listed in the South African country report.. This number reflected in the report is not accurate as the number of registrations as a midwife for 2016 was 94 687 female and 8 878 males with a total of 103 565 according to the SANC. The inability to quantify the number of midwives accurately confirms the disempowerment and inequity of the midwifery profession, as the country has, according to the SoWMy report, 124 045 nurses, while the SANC listed 46 513 females and 7 386 males with a total of 53 899 (SANC, 2016:2,3; UNFPA, 2017:68). The category of nurse-midwife was not recorded in the SoWMy report of 2017. The actual number of competent

midwives who comply with the ICM definition of the midwife is consequently not known in South Africa.

In addition to the inability to identify the midwives in South Africa who comply with the ICM definition (discussed in Section 2.3.1), most nurses and midwives in South Africa are female. In 2018, the SANC registered a total of 286 116 people on the register for nursing and midwifery, of whom only 28 217 were male (South African Nursing Council, 2018:1). In a predominantly woman-led profession, and existing primarily to deal with female reproductive health, the priorities of this group (midwives) are not addressed. Hence not recognising midwifery as an independent profession is regarded as inequality. An article published in 2019 states that the intersectionality of gender and social, professional, and economic disempowerment are systemic barriers to midwifery (Renfrew *et al.*, 2019:3). The struggles of even well-resourced countries are presented in a recent publication of research conducted throughout Europe. This research indicates that organising midwifery with other professions creates a situation that makes it difficult to maintain a professional identity (Vermeulen *et al.*, 2019:1).

Problems specific to low and middle-income countries, such as South Africa, include system and equipment inadequacies, as well as challenges facing educators (Fullerton *et al.*, 2016:37). In addition to inadequate resources in low and middle-income countries, there is a need to strengthen midwifery (Ten Hoope-Bender *et al.*, 2014:1).

Strengthening midwifery includes building the workforce, which, in my opinion, should be achieved by acknowledging the inequities in the midwifery profession. Reducing autonomy of the midwifery profession disempowers midwives. The necessary transformation will ensure that midwifery educators are competent to produce a new generation of midwives, which is needed to end preventable maternal mortality.

The WHO and its partners, including the ICM, recognised the need to strengthen midwifery education, and followed a consultative process to compile a list of competencies for midwifery educators. These competencies could assist to prepare educators to ensure that midwives are educated to render quality midwifery care that responds to the needs of the women, newborns, families and countries (WHO, 2013:5). In 2019, the WHO published a framework for action to

strengthen quality midwifery education for UHC. Although this framework was published after the proposal for thesis research had been approved, it confirms the importance of midwifery education. The need to strengthen midwifery educators to international standards is one of the solutions offered for transforming midwifery education (WHO, 2019:32). However, the South African midwifery education focus is not clarified in relation to the global developments as stated.

1.3 RESEARCH STATEMENT

The need to emancipate midwife educators in a current, non-autonomous profession, with the aim of transforming midwifery education is not debatable. Although there have been several critical guiding developments in midwifery education, such as the Global Standards on Midwifery Education, developed by ICM (2011 and revised 2013), the Essential Competencies for Basic Midwifery Education (revised 2011 and 2019), and the WHO Midwifery Educators' Competencies (MEC) (2013), no action has yet been taken to assess and strengthen the competencies of midwifery educators in South Africa.

Against the backdrop of a disempowered midwifery profession, a lack of data and action on MEC in South Africa can contribute to a failure to meet the demand for human resources for health. Reaching the targets of UHC and EPMM depend on having enough midwives who have been educated to international standards. South African midwifery educators also need to have the competencies required to produce the midwives who are needed by childbearing families and the health system. As confirmed by the WHO framework (2019), assessing the current competence levels of midwifery educators is a crucial first step.

In South Africa, midwifery is regulated with nursing, and this lack of autonomy negatively influences identifying, assessing and strengthening ME, as proposed by the WHO framework. The WHO framework for action and strengthening quality midwifery education for UHC by 2030, confirms the need for a MEC gap analysis, which could inform the process of strengthening MECs and autonomy in South Africa. The gap analysis is, however, unlikely to bring about sustainable change. To capitalise on existing strengths to enhance positive potential by using a strengths-based approach,

in this case, Appreciative Inquiry (AI), could explore the MECs that exist. In the spirit of appreciating current MECs, the intervention could create a positive trajectory for transformation, as the educators could contribute to the transformative framework.

The data gathered on current competencies and appreciated strengths were included in the transformative framework. The transformative framework could guide both preparatory and developmental learning programmes for midwife educators. It should cover all the elements needed to transform midwifery education, to be more responsive to the needs of women and the healthcare system.

1.4 RESEARCH QUESTION

The following research question was asked in response to the stated problem:

How can midwifery educators' competencies best be strengthened to transform midwifery education in South Africa?

1.4.1 Sub-questions

To answer the research question, the following sub-questions evolved.

- i. What are the appreciated strengths of MEC of South African midwifery educators?
- ii. What are the current self-rated midwifery educators' competency gaps of South African midwifery educators?
- iii. What MEC strengths should inform a refined transformative framework that addresses the MEC gaps in South African midwifery education?

1.5 AIM AND OBJECTIVES

1.5.1 Aim

The study aimed to develop a transformative framework to strengthen midwifery educators' competencies in South African midwifery education.

1.5.2 Objectives

The objectives set for this study were to

- i. Appreciate the midwifery educators' competency strengths of South African midwifery educators;
- ii. Determine South African midwifery educators' competencies gaps through a self-rated midwifery educators' competency gap analysis; and
- iii. Use the midwifery educators' competency strengths to inform the development and subsequent refining of a transformative framework to address the midwifery educators' competency gaps in South African midwifery education.

1.6 PARADIGMATIC PERSPECTIVE

A transformative paradigm guided the research. Denzin and Lincoln (2018:45) refer to the researcher as a bricoleur who often "works between and within competing and overlapping perspectives". In the case of this research, the bricolage (a unique creation using diverse items) was influenced by my own worldview. My experience as a midwife and midwifery educator also added to the bricolage. Being a white woman (a minority group in the country) belonging to the same social class and profession as the majority of the participants influenced how the research unfolded. My worldview was also shaped by my involvement (despite being part of a racial minority), on local, national and international levels, in a professional association for midwives. The transformative paradigm consequently best framed the this context and research (Denzin & Lincoln, 2018:46).

The transformative paradigm, as other paradigms, guides action in research, and covers ethics, epistemology, ontology, and methodology. Details of the philosophical assumptions that informed the choices and applications of the made in this research are presented in Table 1.1 (Brink *et al.*, 2018:19; Denzin & Lincoln, 2018:62; Polit & Beck, 2017:7; Teddlie & Tashakkori, 2009:22).

The research question introduced sub-questions that needed answers, which are arrived at through both deductive and inductive reasoning (quantitative and qualitative approaches) and, therefore, mixed-method research was the most appropriate approach. Pragmatism, as single worldview, often guides mixed-method research. In response to the so-called paradigm war that followed the introduction of mixed-method research, other paradigms, such as positivism for quantitative components and or constructivism for qualitative components are also chosen by some researchers (Denzin & Lincoln, 2018:35; Grove & Gray, 2019:529). With mixed-method research, the discussion of how the quantitative and qualitative components link and how the components are influenced by the chosen paradigm, led to different reactions in the world of mixed-method research, and to new paradigms in mixed-method research. One argument in the discussion on paradigms for mixed-method research put forward is an a-paradigmatic approach that makes no philosophical assumptions. A contrary argument is made for using multiple paradigms. A positivist paradigm is usually chosen for its quantitative component, and constructivism is chosen in a qualitative component. Yet another option is dialectical pragmatism, where the research question dictates the paradigm (Brink *et al.*, 2018:19; Grove & Gray, 2019:529).

Despite various motivations for choosing from the different paradigms, the best fit for this research, flowing from my worldview, was the transformative paradigm. This paradigm allowed me to capture the complex issues related to human rights and social transformation (Mertens, 2015:11,21,306; 2016:256; Shannon-Baker, 2015:323). The paradigm influences the approach to research on many levels. The findings of the study were shaped within the frame of restoring and respecting rights. If another paradigm had been selected, the guidance of the methodology and interpretation of findings might be different (Brink *et al.*, 2018:20; Denzin & Lincoln, 2018:45).

The fundamental beliefs of the transformative paradigm that guided this research are presented in Table 1.1.

Table 1.1 Basic beliefs of the transformative paradigm

Basic belief	Transformative paradigm	Application in this research
Axiology (nature of ethical behaviour – philosophical branch dealing with ethics, aesthetics, and religion)	Respect for cultural norms, the benefit of research is defined as addressing human rights and increased reciprocity and social justice.	Give agency to midwife educators by appreciating their strengths in MEC to transform MEC. The decision-making and conduct of the insider-researcher were guided by ethics and values.
Ontology (nature of reality – traditional choices between realism and idealism)	Reality is multifaceted and is based on social positioning and consequences of privileging versions of reality.	Consider the reality of midwifery educators could be influenced by a women-centred profession and by claiming their agency.
Epistemology (nature of knowledge and the relationship between the knower and would be known)	The relationship between the researcher and participants, as power and trust, should be given to participants.	Acknowledge that as a midwife educator, the researcher is an insider. Co-construction of knowledge through AI and a Delphi process.
Methodology (approach to inquiry)	Mixed-method, using qualitative and quantitative methodologies.	Select a mixed-method, which included a strengths-based and transformative qualitative component.

Adapted from (Denzin & Lincoln, 2018:229; Mertens, 2015:11; 2016:256; Savin-Baden & Howell Major, 2013:58).

In Table 1.1 the set of fundamental beliefs, the way they match the transformative paradigm, and how, in this research, the beliefs shaped elements of the research, are presented.

The basic beliefs, as depicted in Table 1.1, are often associated with the transformative paradigm. It is, however, important that the researchers in any research declare their personal stance and reflexivity. These positions will influence elements of the research, in the same way as the paradigm shapes planning and findings of the research. A more in-depth discussion of the application of the paradigm follows in Section 4.2.

1.7 THEORETICAL PERSPECTIVES

Two theoretical foundations, of which a detailed discussion can be found in Sections 3.2 and 3.3, guided the research. Firstly, the grand theory of feminism, as primary transformative drive, and secondly, social constructionism, through the application of AI, shaped the research. A grand theory explains major categories. Middle-range theories such as social constructionism describe more specific elements as in this case, AI (Savin-Baden & Howell Major, 2013:132). The selection of the transformative paradigm pre-empted the need to address issues of social justice or human rights. As discussed in Section 1.1.3, the human rights issue of maternal health is well described in scholarly and advocacy work. As the study focus was on midwifery education, the only denominator of the classic transformative agenda being either socio-economic status, race, or gender in this case was gender.

In feminist research, the belief is that gender affects three areas: understanding of the topic area, selection of approaches to the topic researched, and how gender influences social and political roles of the group involved in the study (Yuill, 2012:39). Being a midwife educator, the researcher held a deep understanding of the research area. The approaches that were chosen were congruent with the topic and the levels of power within the female dominated and female focussed profession. Recent reports and evidence link the lack of progress in maternal health to the need for quality midwifery education, which is, hampered by systemic barriers. These barriers stem from patriarchal systems and structures that reduce the agency of midwife educators (Renfrew *et al.*, 2019:396; WHO, 2019:20).

Building on the foundation of feminism as a grand theory, the selection of approaches for the study, such as AI, was influenced by the grand theory. In feminist research, the inclusion of other theoretical orientations enriches the research (Denzin & Lincoln, 2018:264). In this research the addition of social constructionism as theory related to AI, complimented feminism.

AI was chosen to give a voice to midwife educators who are not able to exert their agency. The theory that lies at the foundation of AI is social constructionism. The principles of social constructionism are a further extension of how the theory enabled a positive influence on midwife educators. Social constructionism postulates that a

social system creates or determines its own reality (Cooperrider *et al.*, 2008:438; Denzin & Lincoln, 2018:264; Yuill, 2012:39). The determination of an own reality relates well with notions from feminist research, where the goal is to establish collaborative and non-exploitative relationships and to transform current practice (Creswell, 2009:234).

The gender inequality lens of feminist research focuses on the issue of MECs, as a critical element that is negatively influenced by the social constructs of gender and autonomy, and subsequently, MEC. Feminist research aims to think differently about a given problem (Denzin & Lincoln, 2018:271), in this case, with the goal of strengthening midwifery education. A strengthened midwifery education system can, ultimately, ensure the quality of maternal healthcare for all women and equity and dignity within a transformed healthcare dispensation for all childbearing families, and improve maternal health (Kinney *et al.*, 2016:2067).

1.8 DEMARCATION OF RESEARCH

The field of the research was midwifery, with a specific focus on midwifery education in South Africa as sub-field. Although there are many interrelated fields in midwifery, South African midwifery educators have not been part of any inquiry or intervention, despite the publication of the WHO Competencies for Midwifery Educators (2013). The gap analysis included educators at higher education and nursing institutions who were involved in midwifery programmes. In South Africa, midwifery education is currently provided by public nursing colleges and universities. The colleges form part of the Department of Health, and universities operate under the auspices of the Council on Higher Education.

Midwifery education as sub-field encompass a multitude of strategies and research concerns. This research was focussed on the core competencies of midwife educators, as the link between competent midwife educators and the ability to produce competent midwives is well described (Bharj, Luyben, Avery, Johnson, O'Connell, *et al.*, 2016:4; Thompson, 2002:257; UNFPA, 2014:v; WHO, 2013:5).

1.9 RESEARCH DESIGN AND METHODS

The transformative paradigm, feminism as grand theory, research question, aim and objectives indicated that a mixed-method approach would be suitable for this research. A transformative concurrent mixed-method design was chosen, through which qualitative and quantitative data were collected and analysed separately, and then integrated (Fetters *et al.*, 2013:2137). The findings were triangulated with literature to develop a transformative framework, after which the multiple experts' perspectives on the framework were integrated, thus, incorporating a dialectic approach (Mertens 2010:19; Zuber-Skerritt *et al.* 2015:6).

The transformative paradigm, with the focus of restoring social justice for the research group (midwifery educators and stakeholders in this research), and the grand theory of feminism informed and shaped the research. In feminist research, involvement through time leads to embracing multiple applications of designs and methods (Denzin & Lincoln, 2018:264). The research question that emanated, asked:

How can midwifery educators' competencies best be strengthened to transform midwifery education in South Africa?

The best way to answer the transformative question was by a mixed methods design. The benefit of employing both quantitative and qualitative methods increased the quality of the findings (Grove & Gray, 2019:529; McKim, 2015:203; Teddlie & Tashakkori, 2009:7). The procedures for design, data collection, analysis and reporting, and the final step, compiling the framework to strengthen MEC, were guided by the research problem, question, aim, and objectives of the research. Research techniques will be explained in Section 1.10.

To achieve the first research objective (to appreciate the midwifery educators' competency strengths of South African midwifery educators), AI was chosen as one of the qualitative methods. AI is a radical approach to understanding the social world and is based on positive core values, recognition, valuing and gratitude. The best in people is appreciated or valued by affirming strengths and finding what gives life to a situation or organisation. The second component of AI is the inquiry, which starts to open possibilities for growth by asking questions. AI is a powerful means of igniting change by using strengths and positive core values (Cooperrider *et al.*, 2008:2;

Cooperrider & Whitney, 2005:7; Gergen & Gergen, 2008:12; Reed, 2007:2; Whitney & Trosten-Bloom, 2010:3).

Another objective of the study, to determine South African MECs using a self-rated MEC gap analysis, was confirmed by the WHO framework (WHO, 2019:32) as a step that was needed. Although it is vital to delineate the landscape of current MEC in South Africa, one data source or method (self-evaluation in the quantitative gap analysis) was not deemed sufficient to compile a refined transformative framework. Furthermore, in feminist research, traditional positivist quantitative research is considered to be a replication of the regimes of power and oppressive structures (Denzin & Lincoln, 2018:270).

The term concurrent mixed-method design describes research in which qualitative and quantitative data are collected either concurrently or independently. The purpose of doing so is to produce conclusions that are more detailed, as different data sets complement each other in answering of the research question, increase corroboration, and provide a more detailed picture of the research problem (Cohen *et al.*, 2011:22; Plano Clark & Ivankova, 2016:119,120). In this research, quantitative and qualitative data were gathered and analysed independently, and both components were assigned equal importance (Grove & Gray, 2019:530; Plano Clark & Ivankova, 2016:114; Polit & Beck, 2017:584). The meta-interpretation, or inference (Grove & Gray, 2019:530; Teddlie & Tashakkori, 2009:152), culminated in the development of a transformative framework that was based on both data sets and the literature. The transformative framework was, then, refined by experts in maternal healthcare, through a non-consensus Delphi process (Keeney *et al.*, 2011:6; Polit & Beck, 2017:725). A summary of the research, including an exposition of the objectives, population, methods, analysis and products, is presented in Table 1.2.

Table 1.2 Summary of research methodology

Research question	How can midwifery educators' competencies best be strengthened to transform midwifery education in South Africa?		
	Phase 1 (Detailed discussion in Chapter 5)	Phase 2 (Detailed discussion in Chapter 6)	Phase 3 (Detailed discussion in Chapter 7)
Sub-questions	<i>What are the appreciated strengths of MEC of South African midwifery educators?(Qualitative strand)</i>	<i>What are the current self-rated midwifery educators' competency gaps of South African midwifery educators? (Quantitative strand)</i>	<i>What MEC strengths should inform a refined transformative framework that addresses the MEC gaps in South African midwifery education?</i>
Research aim	The study aimed to develop a transformative framework to strengthen midwifery educators' competencies in South African midwifery education.		
Objectives	Appreciate the MEC strengths of South African midwifery educators	Determine South African midwifery educators' competencies gaps through a self-rated MEC gap analysis	Use the MEC strengths to inform the development and subsequent refining of a transformative framework to address the MEC gaps in South African midwifery education
Target population/unit of analysis	Midwife educators at a workshop during the 15 th Annual Congress of the National Midwives Association, who attended the AI session	Midwifery educators at higher education institutions and nursing education institutions in South Africa	Selected from SOMSA executive committee, NCCEMD members, national Department of Health and regional and international midwifery experts
Eligibility /inclusion criteria	Midwife educators and education-focussed delegates attending congress workshop on midwifery education, who agreed to participate in the AI workshop	Educated to either diploma or degree level, basic or advanced midwifery programmes	Level of function: expert in maternal healthcare in education, association, practice or regulatory levels
Sampling	Nonprobability: convenient	Entire reference population: census	Non-probability: purposive
Methods	AI workshop, following the 5D process	Self-administered WHO Midwifery Educator Core Competency Gap Analysis Tool	Non-consensus Delphi process

SOMSA: Society of Midwives of South Africa; NCCEMD: National Committee on Confidential Enquiry into Maternal Deaths

Table 1.2 contain the summary of how the three phases of the research answered the research question and sub-questions and achieved the study objectives. The participants of each phase, the criteria for their selection, sampling techniques and methods are all summarised per phase of the research. Each phase will be discussed in Chapters 5, 6 and 7, respectively.

1.10 RESEARCH TECHNIQUES

The three phases of the research, as summarised in Table 1.2, involved the selection of three techniques, i.e., an AI as a qualitative method, quantitative gap analysis, and a non-consensus Delphi process. In this section, the three techniques will be discussed as individual entity, and the technique, data collection process, data analysis and rigour of each will be explained.

1.10.1 Phase 1: Appreciative Inquiry

The AI session was conducted by an experienced AI facilitator, using a guiding document, as presented in Annexure A. The steps of AI are shown in Figure 1.1.

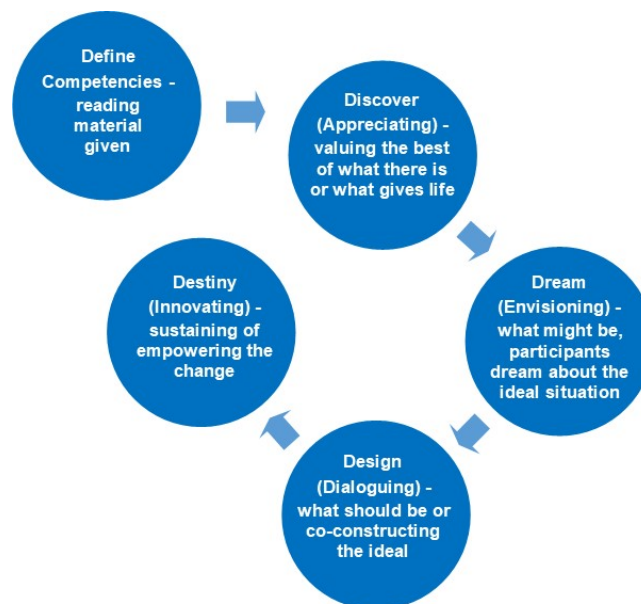


Figure 1.1 Steps in Appreciative Inquiry

Adapted from Cooperrider & Whitney (2005:5); O'Flanagan & Corrigan, (2019:87).

The steps in the AI followed the so-called 5D approach. The first D is to define the concept at the core of the AI, in this case, Midwifery Educator Competencies. This is followed by a process of Discovering, followed by Dreaming, then Designing the ideal and lastly to frame the Destiny by looking at ways of sustaining the design (Cooperrider & Whitney, 2005:5).

First, MECs were defined (as the first of 5 steps), by providing information in a short PowerPoint presentation. Due to limited time, the 5D steps were adapted by handing out reading material to participants. The reading material was bound in a separate booklet, which participants could keep. The content of the presentation was focussed on the information included in the booklet. Refer to Section 5.6 for more detail. The remaining steps were to discover what works well, develop the dream of the ideal situation, design their own ideal situation and, lastly, plan how to reach the destiny.

1.10.2 Data collection during the Appreciative Inquiry

The AI session was conducted during the 15th National Midwifery Congress of the Society of Midwives of South Africa (hereafter called the national SOMSA congress) in August 2018, in Bloemfontein. An electronic submission was sent to the Scientific Committee Chair to request permission for the AI to be scheduled as a concurrent session during the congress. An external AI expert facilitated the session, as the researcher was the president of the association at the time of data collection. As indicated in Section 4.2.2, this position of the researcher could influence data collection, and, therefore, the facilitator was involved (Savin-Baden & Howell Major, 2013:73). Further measures to address bias are explained in Section 4.5.2. The researcher and supervisor attended the session. After welcoming participants, announcing logistical arrangements and introducing the facilitator and topic, we merely observed the rest of the workshop.

A proposal document, included in the electronic annexures, was developed for the AI. A separate, anonymous demographic form was distributed, to gather demographic data of participants. Additional research documentation, such as the information leaflet and consent form, was handed out and completed before the session. The session proposal document contained information on the remaining four steps in the 5D

process. The guiding questions and space to provide answers to these questions were provided in the document.

After the initial introductions and a presentation to define and familiarise participants with the reading material, the facilitated discussion and completion of the proposal documents' questions followed. The discussions by participants, first in pairs and then in small groups per table, resonated well with the importance of dialogue, storytelling and listening in African culture (Jacobsgaard & Bukashe, 2019:6). After deep engagement with the questions at hand, each pair shared their responses at the table, after which consolidated feedback was given to the large group in a round-robin format. The facilitator guided the process and created and maintained a safe space for participants (Gadow, 2019:47).

The detailed process of the AI session is described in Chapter 5, where the logistical arrangements and report of the session are presented. The AI created an energising opportunity to capitalise on the existing strengths and contribute to transformation by creating a connection amongst the participants (Cockell & McArthur-Blair, 2012:13; Gadow, 2019:49).

1.10.3 Unit of analysis

The population consisted of all the delegates who attended the national SOMSA congress in August 2018, which was held in Bloemfontein. The sampling was non-probability, convenient sampling. As this was an event at which a significant number of midwife educators was gathered, the invitation was extended to educators and those interested in education to attend the session (Babbie, 2010:193; Grove & Gray, 2019:317). The AI session was part of the congress programme. Therefore, the venue allocation determined the maximum number of participants, based on public safety regulations of the hotel in which the congress was held. The venue allocated to the session could accommodate 30-50 participants. The unit of analysis was the congress delegates who participated in the AI workshop. A total of 32 delegates participated in the workshop.

1.10.4 Data analysis of Appreciative Inquiry

The data collected during the AI included general demographic information, the protocol books that participants completed, flip charts of the collective discussions and one video recording of a participants' exposition of a picture the group had drawn. It was essential to capture and make sense of the data and to put that in writing (Henning *et al.*, 2018:101; Reed, 2007:138,138).

A primary analysis that was done at the session by all the participants using the nominal group technique as a collaborative data analysis method was intended (Reed, 2007:27, 28). The nominal group technique, a highly structured consensus method, was to be conducted at each phase of the AI to prioritise the contributions from the participating midwifery educators about how to transform MEC (Roeden *et al.*, 2012:589). The nominal group technique process involves the generation or creation of ideas, round-robin and discussion of contributions, followed by voting for prioritisation purposes (Van Jaarsveldt & Ndeya-Ndereya, 2013:4). During the session, the completion of the nominal technique did not fully happen as planned. This is discussed in Chapter 5.

Qualitative data were analysed by the researcher under the guidance of the supervisor, firstly, by coding data. At a second opportunity, the coding was refined. After the first round, themes were developed for interpretation, and evaluation coding was considered where needed (Brink *et al.*, 2018:180; Saldaña, 2016:59). The positive propositions, themes and artwork that evolved from the AI session were also coded.

The detailed analysis is reported in Chapter 5. After a separate analysis, the AI data, together with the gap analysis data, were integrated in the meta-inference, and converged into the transformative framework.

1.10.5 Pilot considerations in the Appreciative Inquiry

Before any research is undertaken, the feasibility of aspects of the research should be scrutinised. Mixed-method research is considered to be costly, due to multiple methods being used to conduct the research. The different components are evaluated to ensure the processes, resources, teamwork and scientific content would work in the research (Grove & Gray, 2019:534; Polit & Beck, 2017:624–629).

Measures were taken to curb the cost of the AI. The logistical planning was done in collaboration with the congress organising secretariat, so that the number of participants was known; this helped to reduce fruitless expenses on workshop arrangements. During the registration, a list was provided, and interested delegates could preregister for the session. The proposal document, time management plan and order of business were evaluated and amended by the facilitator and supervisor before the session. This careful preparation contributed to ensuring the rigour of the research.

1.10.6 Rigour in the Appreciative Inquiry

Rigour in mixed-method research is described in various ways that captures quantitative and qualitative applications of rigour. The conventional measures for qualitative research rigour were selected (Teddle & Tashakkori, 2009:26). In the AI, trustworthiness was ensured by applying epistemological standards of truth value, applicability, consistency neutrality, and authenticity. Specific strategies linked to each standard and criteria ensured rigour in the research and this is discussed in Section 4.5.2 (Botma *et al.*, 2010:234,244; Brink *et al.*, 2018:111; Cousin, 2009:168; Jacobsgaard & Bukashe, 2019:6; Polit & Beck, 2017:563,564; Teddle & Tashakkori, 2009:296).

Various measures were implemented to enhance the trustworthiness of the research. Some challenges did occur, and how they limited the research is discussed in the final chapter. The next phase of the research, as summarised in Table 1.2, was the quantitative gap analysis of MEC.

1.10.7 Phase 2: Gap analysis

In the quantitative phase, as shown in Table 1.2, a gap analysis questionnaire was conducted by sending a survey participants (refer to Annexure B). The WHO Midwifery Educator Core Competency Gap Analysis Tool was developed by the consultant who had developed the WHO Midwifery Educator Core Competencies, Dr Joyce E. Thompson (2013). The competency statements and corresponding knowledge, skills, and behaviours from the WHO Midwifery Educator Core Competencies 2013 were included. The format of the tool was taken from the WHO/PAHO Strengthening Midwifery Toolkit 2011; updated by PAHO in 2013 and the ICM Monitoring midwifery competencies self-assessment tool 2013, both developed by Dr Judith T. Fullerton

(2011, 2013). At the time of requesting the questionnaire, Dr Thompson indicated that the tool had been used in workshops in Latin-America and Africa on competency based education. No formal validation of the tool was done. Analysis revolved around simple comparisons of the self-ratings of the workshop participants.

The competencies of South African midwifery educators were determined by use of the questionnaire, which comprises of two Likert scales per competency. Midwife educators could indicate their perceived level of competence, as well as their confidence on each item, as a self-evaluation. The 19 competencies are organised into domains that cover legal and ethical components, evidence-based midwifery practice, educational competencies to ensure teaching and learning with assessment and organisation of curricula. The competencies that focus on leadership, advocacy and change agents formed part of the gap analysis and gave valuable information on the level of agency of South African midwife educators. Each competency is broken down into the three components:

- Basic knowledge required to demonstrate skills/abilities and behaviours/attitudes;
- Skills/abilities; and
- Behaviours/attitudes.

The same demographic questions posed in the AI were added to two open-ended questions to ascertain what gives life to midwife educators' work and what excites them about their work. Additional questions (six) that emanated from the feminist theory and focussed on agency, were added for this study.

1.10.8 Data collection with the gap analysis tool

Dr Joyce Thompson permitted the researcher to use of the questionnaire for this research. The gap analysis was made available to participants as an electronic survey using Evasys® (Annexure B). Cues to complete the questionnaire were provided, via email, by an automated process every two weeks for the period the survey was open on the Evasys® system. A detailed explanation of data collection is provided in Section 6.2.

1.10.9 Population and sampling

The entire population of midwife educators in South Africa was targeted for inclusion in the gap analysis. Using the contact lists of the Forum of University Deans of South Africa (FUNDISA), all the nursing education institutions at universities were contacted to confirm their positions as midwife educators, and 58 lecturers who listed maternal health topics as an area of expertise were selected. Three of these lecturers indicated that they were not in clinical programmes and asked to be excluded from the invitations. Educators from the public nursing colleges listed with the office of the chief nursing officer were included. Courses listed by the colleges included R.254 Diploma in Midwifery; R.425 Education and Training of a Nurse (General, Psychiatric, and Community) and Midwife leading to Registration; and lastly, R.212 Regulations Relating to the Course in Clinical Nursing Science Leading to Registration of an Additional Qualification of Advanced Midwifery. At the time, 78 colleges offered these courses. By including all possible midwifery educators in South Africa, a census estimate was intended (Martínez-Mesa *et al.*, 2016:326). The total number of midwifery educators at nursing education institutions in South Africa were invited to complete the gap analysis. A total of 48 anonymously completed questionnaires were retrieved from Evasys®.

1.10.10 Data analysis of gap analysis

After the data had been collected, the self-rating questionnaire (gap analysis) was analysed in collaboration with the Biostatistics Department of the Faculty of Health Sciences at the University of the Free State (UFS). A simple comparison of self-ratings was made for the self-rating of confidence and competence on each item. Descriptive statistics, namely frequencies and percentages for categorised data, and means and standard deviations or medians and percentiles for continuous data, were calculated. After completion a Cronbach Alpha coefficient for internal consistency was calculated. Refer to Section 6.5.

1.10.11 Pilot study

A pilot study was conducted to refine the gap analysis (Grove & Gray, 2019:68), by asking six educators with advanced midwifery or a neonatology qualification from the institution where the researcher is based to complete the gap analysis tool, which was

shared in electronic format using Evasys®. The clarity of the instructions, estimated time to complete the questionnaire, and clarity of the questions was noted. Five educators were invited to complete the pilot study and adaptations to enhance clarity were made. The lecturers were excluded from the mailing list of the Evasys® data collection. The detail on the recommendations of the pilot study are discussed in Section 6.3.

1.10.12 Rigour

Contextualising the questionnaire for use in South Africa, contributed to enhancing rigour. The quantitative consideration of validity in mixed-method research considers whether the inferences are causal, and whether these inferences would be the same in other people and settings (Teddlie & Tashakkori, 2009:24). The consultants who developed the WHO Midwife Educators Competencies also developed the gap analysis tool, based on a used and tested format. Reliability and validity are therefore accepted as adequate by this research, although no formal testing of the tool has been done in other research. Instrument validity indicates how well an instrument measures the content in question (Brink *et al.*, 2018:151). Different types of validity are considered. Content and face validity correspond with the competencies as developed by the consultants, and contribute to validity (Grove & Gray, 2019:341; Polit & Beck, 2017:316). Internal consistency testing was done and the Cronbach Alpha coefficient was calculated for reliability testing. Details are provided in Section 6.5.

1.10.13 Phase 3: Non-consensus Delphi process

After both the AI and the gap analysis data analyses had been completed, the data sets and literature shaped the development of the transformative framework. The transformative framework is discussed in Chapter 8. The transformative framework was shared with experts in maternal care for refinement in an electronic Delphi process (Table 1.2 provides more details). The electronic questionnaire provided a platform for soliciting and receiving honest expert opinions on the transformative framework, without any power dynamics hampering the feedback (Brady, 2015:3). The non-consensus Delphi process was employed as a controlled meeting of experts, where the researcher acted as a chairperson and summarised the participants' views and comments to refine the framework (Keeney *et al.*, 2011:6; McMillan *et al.*,

2016:658). In a classic Delphi survey, the need to reach consensus is the goal. There are, however, non-consensus forms of the Delphi such as the Policy Delphi, aimed at supporting elements in the Delphi by structuring and discussing the elements. The different arguments of experts, in this case, assisted in refining the transformative framework (Keeney *et al.*, 2011:5,6). In this research the experts contributed to the refinement and was the purpose of reaching consensus as found in Delphi survey's not needed.

1.10.14 Data collection of Delphi process

A diverse group of experts in maternal healthcare was consulted to refine the transformative framework. An expert panel aims to identify broad areas of agreement, diverse views and extreme options (Avella, 2016:306; Keeney *et al.*, 2011:5,14). The Delphi process involved experts in addition to those who had the opportunity to take part in the AI. The expert group consisted of key role-players in maternal healthcare and education to enhance their contribution in implementing the needed transformation. Persons within strategic positions were included in the expert panel, to ensure that the transformative framework aligns with the current priorities of maternal healthcare in South Africa.

The co-created transformative framework was transferred to a Microsoft Word® document, as shown in Annexure C, and was sent as an electronic document to the expert panel. Consensus was not a prerequisite in this Delphi process; instead, the goal was to refine the transformative framework. All the inputs received were reviewed and considered.

1.10.15 Unit of analysis

The transformative framework was sent to a group of experts who worked in and alongside midwifery education, using a Delphi process. The experts considered in this research included (refer to Table 12 and a detailed matrix in Table 41):

- Society of Midwives of South Africa (SOMSA) executive members involved in midwifery education;
- Experts in maternal healthcare at the national Department of Health and education experts at the chief nursing officer office;

- National Committee on Confidential Enquiry into Maternal Deaths (NCCEMD), which is a ministerial committee of about 15 members on maternal health, who are national experts in maternal health;
- Selected midwife educator consultants in the African sub-region; and
- A midwife from the Nursing and Midwifery division of WHO.

The sampling was non-probability purposive (Grove & Gray, 2019:310; Polit & Beck, 2017:254). As seen in Table 1.2, the group was selected according to inclusion criteria related to their expertise in either midwifery education, practice of maternal health, the midwifery association or regulation of midwifery practice or education.

1.10.16 Analysis of the Delphi process

The contributions of the experts were all reviewed by the researcher and supervisor. The responses were triangulated with other data sets and literature. Participant responses were coded, and common concerns identified. When the experts suggested that adaptations be made or where they indicated a possible adaptation, these were considered and actioned (Brady, 2015:4). Detail are presented and discussed in Chapter 8.

1.10.17 Pilot process

After the meta-inference, the Delphi process document was developed, and comprised two sections. The first provides background information on the elements of the transformative framework, and the second section is the review section (the Delphi process document is included in Annexure C). The same group that completed the pilot study for the gap analysis also reviewed the proposed Delphi process document, by evaluating both sections of the Delphi process document for clarity and usability. The process that was followed clarified and confirmed that the content and instructions were explicit (Grove & Gray, 2019:69; Teddlie & Tashakkori, 2009:203).

1.10.18 Rigour

The quality of the Delphi process was enhanced by employing a pilot process before sending the document to the experts. The epistemological standards presented in Table 1.3 also applied to the Delphi process. Teddlie and Tashakkori (2009:296)

suggest that selecting strategies that are linked to specific criteria contributes to an enriched inference. In this research, the expert panel's comments contributed to improving inference.

The Delphi process's objective was to refine the transformative framework. Hence, confirmability and credibility were primary trustworthiness considerations. Involving some experts who had or could have participated in previous phases introduced an element of member checking. In the process of reviewing the comments, bias was reduced by involving two people, to ensure that every voice was heard and considered (Teddlie & Tashakkori, 2009:296).

1.11 ETHICAL CONSIDERATIONS: AN OVERVIEW

The ethical considerations that guided the development, implementation and eventual dissemination of the research extend further than the review process, and directed the researcher to excellence in the ethical conduct of each component of this study. The need to find credible answers to research questions is more complicated than merely ensuring the well-being of participants.

Ethical codes and guidelines from the Nuremburg Code (1949) and subsequent Declaration of Helsinki (1964), and the ethical principles captured by the Belmont Report (1979), to the Singapore Statement (2010), all have the aim of ensuring research integrity. The principles of beneficence, respect for human dignity and justice, as captured in the Belmont Report, are but a point of departure. Furthermore, the Singapore statement includes the principles of honesty in all aspects of research, accountability in the conduct of research, professional courtesy and fairness in working with others, as well as good stewardship of research on behalf of others as guidelines (Grove & Gray, 2019:130,131; *Singapore Statement on Research Integrity*, 2010).

In addition to the purpose of many ethical codes being to guide research, ethics is the backbone of research and care in health (Lategan & Van Zyl, 2017:16). However, in qualitative research, ethical reflexivity leads the researcher to ask critical questions about the research (Roth & Von Unger, 2018:3). Another position on ensuring ethical research is using a person-oriented approach that is based on respect for and

acknowledgement of the holistic being and the lived world. The researcher-participant relationship and empowerment in decision-making should inform design, selection of participants, data collection and analysis (Cascio & Racine, 2018:170). The need for reflexivity, the role of ethics in healthcare, as well as the person-oriented approach, are captured in two core ICM documents, namely the *Code of Ethics* and the *Philosophy and Model of Care*. Relationships, empowerment and partnership are described as key principles by the ICM documents. Within the *ICM Code of Ethics*, the section devoted to the advancement of knowledge in the profession states,

“Midwives ensure that the advancement of midwifery knowledge is based on activities that protect the rights of women as persons” (ICM, 2014b:2).

Similarly, in feminist research, ethical considerations are aimed at giving a voice to the silenced group, which, in this case, are midwife educators. Power inequities should be identified, and actions to reverse these inequities should be acknowledged. Taking into account that the issues of intersectionality and lack of autonomy and agency of the population were identified, sensitivity, to ensure that midwife educators were given a voice and opportunity to co-create a transformative framework, was an explicit priority (Mertens, 2015a:33; Polit & Beck, 2017:139; Teddlie & Tashakkori, 2009:198). The ethical comportment relating to core elements in the research is summarised in Figure 1.2, based on Savin-Baden and Howell Major (2013:332).

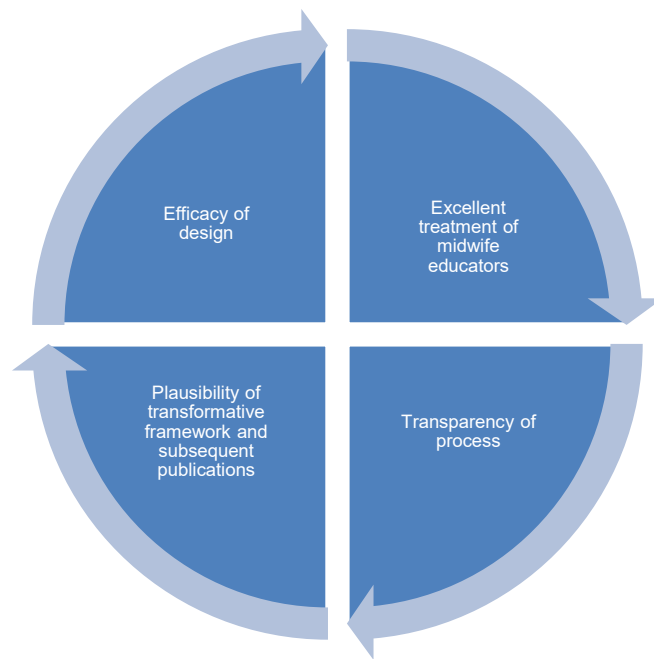


Figure 1.2 Ethical considerations

Adapted from (Savin-Baden & Howell Major (2013:332).

Savin-Baden and Howell Major (2013:332) suggest that, to transcend mere compliance with ethical review processes, a more holistic approach should be taken. These authors frame four elements that were applied in this research, namely, efficacy of design, excellent treatment of midwifery educators and experts in maternal health, transparency of the process, and plausibility of the transformative framework. Through adherence to these elements, the researcher aimed to respect and transcend standards for ethical research. A detailed discussion follows in Section 4.4.

1.12 RESEARCH FUNDING

The researcher was the recipient of the ICM Research Award in 2018. Annexure K is included with the notification of the award. The award covered the attendance and presentation of a poster (attached as Annexure L) at the Regional ICM Conference that was held in Dubai from 6 to 8 September 2018, and provided funds that were utilised for research expenses. This award enabled the development of a

transformative framework that could have a positive effect on midwifery education in South Africa, and serve as an acknowledgement of this investment in South African midwifery education. The funding for this award was provided by Johnson & Johnson.

1.13 SUMMARY

This chapter gave a short description of the problems informing the research question, which relates to the need for competent midwifery educators in South Africa. Despite global action and development of MEC by the WHO, there has been no concerted action to transform South Africa's MEC. The following research question was asked: How can midwifery educators' competencies best be strengthened to transform midwifery education in South Africa?

The research aimed to develop a transformative framework to strengthen MEC in South Africa's midwifery education. The research techniques incorporated in the transformative concurrent mixed method design included an AI, which is a qualitative method, and a quantitative gap analysis. The AI and gap analysis produced data that were converged in the meta-inference that triangulated the two sets of data and literature into the transformative framework. The framework was refined by a Delphi process. The research techniques were chosen within the transformative paradigm and framed in feminism, which, by implication, requires ethically sound practice.

The rest of the chapters to follow will cover the following topics:

Chapter 2: Perspectives from literature: midwifery education and competencies

Chapter 3: Perspectives from literature: paradigmatic foundations

Chapter 4: Research design and methodology

Chapter 5: Appreciative inquiry

Chapter 6: Gap analysis

Chapter 7: Inference

Chapter 8: Transformative framework

Chapter 9: Final Supposition

Chapter 2

Perspectives from literature:
midwifery education and competencies



CHAPTER 2 PERSPECTIVES FROM LITERATURE: MIDWIFERY EDUCATION AND COMPETENCIES

"While disruptive to the status quo, midwifery is a vital, bold, constructive solution to the challenges of providing high-quality care for all women, newborn infants, and their families" (Renfrew *et al.*, 2019:396).

2.1 INTRODUCTION

After an overview of the study was outlined in Chapter 1, this chapter reflects on the perspectives found in several literature sources on midwifery education and competencies. The status quo of quality maternal healthcare in South Africa. Midwifery and midwifery educators, as the transformative solution to meeting the needs of childbearing families, will be explored. The context of midwifery educators' competence and an elaboration of midwifery educators' core competencies, as proposed by the WHO, will be presented.

2.2 PERSPECTIVES FOUND IN LITERATURE: FOCUS

In developing an understanding of the issues influencing quality maternal health, and in pursuit of vital, bold, constructive solutions, the role of midwives and midwifery education will be discussed. The midwifery profession in South Africa, including the level of autonomy of the profession, and its compliance with core global guidelines, will be explained. Furthermore, the contribution of midwifery education to quality maternal health in South Africa will be explained. Lastly, competence and competency, as well as the WHO Core MECs, will be discussed. The focus of this literature section is depicted in Figure 2.1.

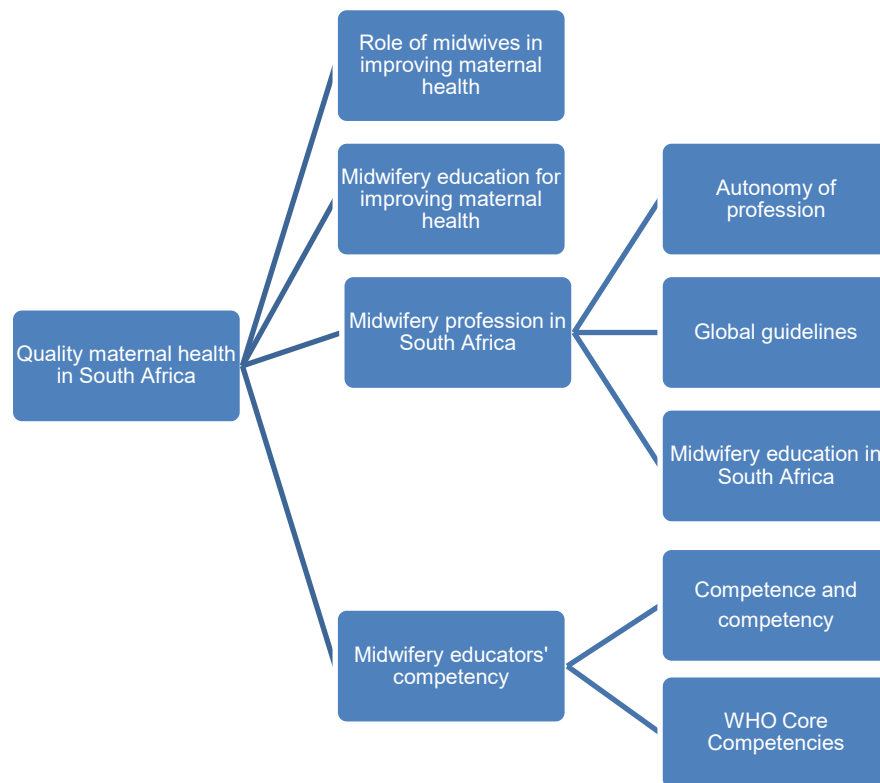


Figure 2.1 Focus of literature perspectives

An attempt was made to draw on the collective wisdom of scholars in the field, as recommended by Trafford and Leshem (2012:69), and global policies, to order to isolate what is needed to transform MEC in South Africa. A librarian used scholarly databases to search for literature on the topics listed in Figure 2.1, namely, EBSCOhost (Academic Search Ultimate, Africa-Wide Information, CINAHL with full text, HealthSource, Medline with full text, ERIC) and ScienceDirect. Literature was updated during the study period with relevant literature suggested by Mendeley and publishers, such as Elsevier.

Care was taken to focus on the essential voices and information that could contribute to the transformation of MEC. Literature of scholars in the fields, as well as documentation at policy level of bodies such as WHO, provided clarity on the use of concepts and issues, and shaped the research on MEC (Cohen *et al.*, 2011:112; Grove & Gray, 2019:199).

2.3 QUALITY MATERNAL HEALTH IN SOUTH AFRICA

MEC in South Africa cannot be investigated without considering the bigger picture of maternal healthcare. Midwives are educated as one of the core healthcare providers in maternal health and play a vital role in reaching the targets set for the indicators of maternal health.

South Africa, as many African countries has not reached the two targets set by the Millennium Development Goals to improve maternal health. The first target was to reduce by 75% the maternal mortality ratio (MMR) of 1990, by 2015. The baseline of 150/100 000 in 1990 set a target of only 38 deaths per 100 000 live births for 2015. The last estimate of MMR to measure achievement of the MDG targets was 141/100 000 in 2013 (Stats SA, 2015:vi). The second target was to achieve, by 2015, universal access to reproductive health. The indicators of meeting this target included the following: the number of births attended by skilled birth attendants; contraception prevalence rate; adolescent birth rate; antenatal care coverage (at least one visit and at least four visits) and unmet need for family planning. Refer to Table 2.1 for progress on these indicators, as tracked in the 2015 Millennium Development Goals report and the 2019 Sustainable Development report (Stats SA, 2015; 2019:63, 70, 71, 76).

Table 2.1 Indicators for universal access to reproductive health

Element of indicator	Statistics at the start	Latest statistics after measurement
Skilled attendant births	84%	96.7% (2016 District Health Information System)
	67% of public hospital births	85.6% of public hospital births
Contraceptive prevalence rate (couple year protection rate used as measurement)	27.6%	75.7%
Antenatal care	90.4% in 2012	92.9% in 2014

Sources: Compiled from Stats SA (2015; 2019:63, 70, 71, 76)

From the Table 2.1, compiled from data gathered by Stats SA, it is clear that the majority of indicators did show some progress. The contraceptive prevalence rate, for instance, shows marked improvement.

The first target of the MDG, which is part of the SDG indicators, relates to maternal mortality rate. In 1997, South Africa initiated a process of confidential enquiry and declared maternal death to be a notifiable condition. The institutional maternal mortality ratio (iMMR), as reflected by the Saving Mothers report of a ministerial committee on maternal deaths (NCCEMD) shows a general decline after a rise in maternal mortality that peaked in 2009 (Figure 2.2).

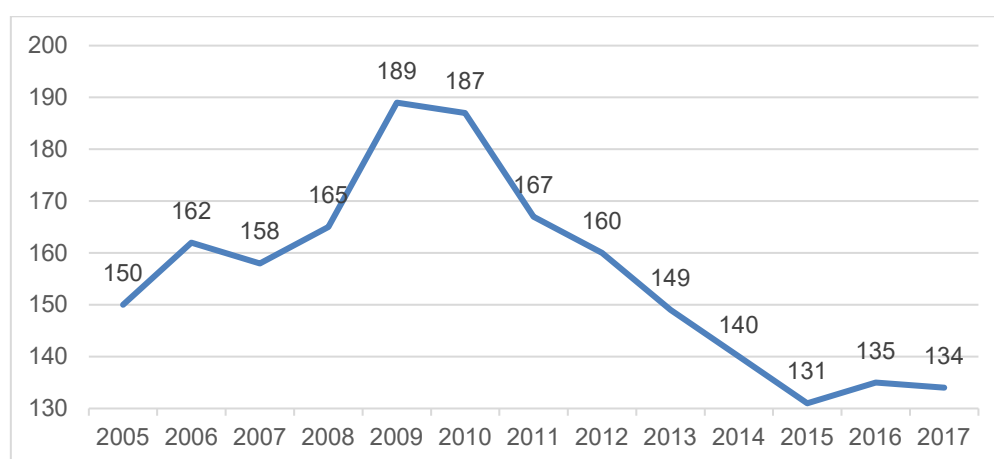


Figure 2.2 iMMR from 2005 to 2017

Source: Adapted from Pattinson and Moodley (2014:4; 2018:108)

The trend visible in Figure 2.2, shows the impact of an improved response to mothers affected by HIV and AIDS, which involves offering antiretroviral therapy after 2009. Also, a national training programme for all maternal healthcare workers on Essential Steps in Managing Obstetric Emergencies (ESMOE) was introduced. Furthermore, teams of district clinical specialists were appointed within the primary healthcare reengineering programme to strengthen the interventions from the national Department of Health. In every health district, district clinical specialists perform clinical audits to sustain the improvements made to the reduction in maternal mortality achieved to date (Pattinson & Moodley, 2014:4; 2018:106; Stats SA, 2019:63).

Compared to South African statistics as recorded from 1999, the global MMR reduced by 45% since 1990, to currently 380 deaths per 100 000 live births (Buse & Hawkes, 2015:2; WHO, 2015a:6). In Africa, South Africa is one of the countries with the lowest maternal mortality rate in comparison to the South Sudan estimated 2015 rate of 789, Malawi at 634, Lesotho at 487, Zimbabwe at 443 and Namibia 265 (UNFPA, 2017:1). However, despite a focus on maternal health by the international development arena for over 15 years, the problem persists, with the major causes of deaths being haemorrhage, hypertensive disorders of pregnancy, and sepsis. Issues such as access to and quality of care need to be addressed (Boerma *et al.*, 2018:1539; Lieberman, 2016:1146). To improve maternal health, every effort should be made to reach the targets set by the SDGs. Target 3.1 of the SDGs refers to maternal health and aims to reduce the global maternal mortality ratio to less than 70 per 100 000 live births by 2030 (United Nations, 2015:16). In a countdown report of UHC and the SDG targets, the most critical issues identified for reaching the targets were considered to be coverage and access to services, equity in the provision of services, and quality of care (Boerma *et al.*, 2018:1543).

By narrowing the focus on the issues (as also mentioned in the countdown report), the South African national Department of Health is continuously developing health policies and strategies that identify maternal health as one of the four priority areas in the burden of disease. The major disease burden in the country relates to HIV/AIDS and TB, maternal and child mortality, non-communicable disease, and injuries and trauma. Another primary concern for the national Department of Health is quality of care, as well as addressing an inefficient and ineffective health system. The high cost of private healthcare, which is only available for the minority of the population who have medical insurance was identified as another concern (Stats SA, 2019:61, 89). Therefore, despite many challenges, the formal structures of the national Department of Health keep developing national strategies that aim to address concerns relating to access to care, equity, and quality of care.

The national strategies in South Africa, however, do not formally address all issues. One problem is the medicalisation of birth. While the benefit of appropriate medical intervention, for instance, a caesarean section for women who need it, is undisputed. Interventions, such as medical treatment for complicated pregnancies and other

medical management, are an essential cornerstone of maternal health. However, unindicated interventions in normal pregnancy and birth occur often and are considered undesired. The WHO states that 10-15% of births may need intervention through caesarean section. Inequities in the South African healthcare system were exposed by a recent analysis, which found that private hospitals had a caesarean section rate of 73.6%, compared to 26% in the public sector. Although even the public sector rate is higher than the WHO target, the private sector rate is not justifiable (Solanki *et al.*, 2019:8).

The case fatality rate for mothers who died after a caesarean section had been performed, showed an increase in the last two triennial reports (Fawcus *et al.*, 2016:473). The increased caesarean section rate and the complications related to it are depicted in Table 2.2.

Table 2.2 Caesarean statistics over two triennia

	Triennium	
	2011-2013	2014-2016
Deaths n	1243	1201
Case fatality rate/100 000	190.35	169.63
South African caesarean section rate %	23.2	25.7

Sources: Adapted from Fawcus *et al.* (2016:473); Pattinson and Moodley (2018:24)

Although the deaths of mothers due to bleeding after caesarean section decreased in the last triennium, its reduction can probably be attributed to the safe caesarean section policy that was implemented. Of concern is that, in some of the deaths that occur after a caesarean section was performed; the procedure was not indicated (Fawcus *et al.*, 2016:474).

The medicalisation of childbirth is a global concern. Over time, many practices have been introduced to induce, augment, regulate and monitor labour and birth. In the ICM

Philosophy and Model of Care, the need to respect and promote the normal physiological process, and their significance, is prominently stated (ICM, 2014c:1). In 2018, the WHO published evidence-based practice guidelines to ensure a positive experience of intrapartum care. The interventions are intended to improve outcomes in relation to birth satisfaction and safety. Unnecessary interventions impact negatively on the mothers' experience of birth and undermine her ability to give birth normally (WHO, 2018a:1).

Medicalisation contributes to inequity in maternal health – equity is understood to be the absence of unfair and avoidable differences in health amongst groups of a population. The social determinants of health create subgroups based on gender, race, income, social class and education (Bergen *et al.*, 2020:1). Inequities in healthcare have an element of unethical injustice that stems from an unequal distribution of power and income. The inequities lead to inequality in healthcare services (Lindström, 2020:2). The root cause of these social determinants of health can be found in the history of colonisation. The residual effects in healthcare under colonialism include a legacy of systemic oppression, such as gender inequality, power imbalances, and the shortcomings of the biomedical model of healthcare (Chandanabhumma & Narasimhan, 2019:2). The biomedical model of healthcare creates overmedicalisation of pregnancy and birth. Inequality between well-resourced and poorly resourced areas can be expressed by a phrase that was coined as a global concern in midwifery: *too much too soon or too little too late*. The phrase describes both the unnecessary interventions in over-medicalised care, and limited access to life-saving care (Bharj, Luyben, Avery, Johnson, O'Connell, *et al.*, 2016:4; Renfrew *et al.*, 2019:397; Ten Hoope-Bender *et al.*, 2014:2).

In addition to a focus on *too much too soon or too little too late*, the Lancet series on midwifery of 2014 indicated the need for better quality and a greater number of midwives. The care should be in response to what mothers want and need, and this should inform the education of midwives (Ten Hoope-Bender *et al.*, 2014:2; WHO, 2018a:1). The gist of 2018 WHO evidence-based practice guidelines for positive intrapartum care add to the voices calling for quality of care during pregnancy, labour and birth (WHO, 2018a). Over-medicalisation jeopardises this quality of care by

reducing the innate capabilities of women, and disregards the normality of physiological labour and birth.

In South Africa, both elements, *too much too soon*, and *too little too late*, manifest due to the disparity between private and public healthcare. The public healthcare system follows a midwifery-led model, with medical practitioners ranked and positioned at different levels of care. In private healthcare, individual doctors, who work mostly in isolation, drive the system. The different models followed in private and public healthcare creates a disparity between their caesarean section rates (Solanki *et al.*, 2019:9). Midwives are a vital solution to correct this disparity. Competent midwives, educated to standards, can prevent interventions without indication, provide service in rural settings and advocate for the rights of the childbearing family (Renfrew *et al.*, 2019:397; WHO, 2016:28).

Ensuring quality maternal healthcare that is respectful to childbearing families, and which responds to what they want, is, thus, a global and national concern in maternal health and well-being. Quality midwifery care adds to a woman's confidence and empowers her to take care of her family. The ICM philosophy and model of care balances the emancipatory and human rights base of midwifery with quality care that supports the normal physiology and lack of intervention in normal processes. It also realises that referral and technology are indicated and used when needed. It states that childbirth is a significant process that has meaning for the family. Lastly, it links quality, competent care with competent, quality education at basic and continuing education levels (ICM, 2014c:2).

An elaboration of the role of midwives and midwifery education in improving maternal health, as well as the status of the midwifery profession in South Africa, will follow. Midwifery education in South Africa, as a contributor to quality maternal health, and an explanation of the WHO midwifery educator competencies will conclude the section.

2.3.1 Role of midwives in improving maternal health

An essential consideration of quality maternal health is the role of midwives, which had been described well. The 2014 Lancet series on midwifery consists of four papers that were developed as a collaboration between a multidisciplinary group that included

academics, researchers, advocates for women and children, clinicians, and policy-makers. The four papers present a framework for quality maternal and newborn care (QMNC), in which the needs of women and their newborn infants are central. The definition of midwifery that was used focussed on competence, which is made up of skills, attitudes and behaviours. The series affirms the contribution of midwifery, as captured in this powerful quote: "Midwifery is a vital solution to the challenges of providing high-quality maternal and newborn care for all women and newborn infants, in all countries" (Renfrew, Homer, *et al.*, 2014:1).

Quality midwifery care relies on the workforce, regulated and educated in compliance to global standards working within a practical environment. Health facilities should be functional, have adequate referral systems and equipped with medication, blood products and medical consumables to render the care women need (UNFPA, 2017:vi)

Earlier work confirmed that resorting to the care of other healthcare workers who are less competent, rather than midwives, is dangerous to childbearing families and communities (Fullerton, Ghérissi, *et al.*, 2011:10). Despite evidence from the Lancet series and reports, like the State of the World reports for midwifery of 2011, 2014 and the 2017 Southern and Eastern Africa reports (UNFPA, 2011, 2014, 2017), there are still misunderstandings about the role, definition and scope of midwifery. This misunderstanding and lack of clarity cause fragmentation of care that hampers health outcomes and could jeopardise progress on reaching UHC (Renfrew *et al.*, 2019:396).

The availability of a healthcare worker with midwifery skills and competencies, which include emergency obstetric care skills that can save lives in complicated births in an enabling environment, is a crucial indicator in targets for improving maternal health and reaching UHC. However, in several countries, primarily low or middle income countries, there was a surge of new mid-level cadres of healthcare workers with limited skills and practice areas to attempt reaching the millennium development goals (Fullerton, Ghérissi, *et al.*, 2011:5). To enable UHC, the midwifery healthcare workers need to have the required competencies.

Another concern is that, in many countries, including South Africa, there are gaps between international standards and birth attendants' skills and competencies. In a review of the number of births needed in African countries before registration as a

midwife, South Africa with only 15 births before registration together with Namibia and Tanzania have the lowest requirements. In Uganda 70 births are required, with Rwanda and Swaziland at 60, and Malawi and Mozambique at 50. In many African countries direct entry midwifery programmes are functional with different numbers of births required for midwifery programmes compared to nurse-midwifery programmes. Countries with direct entry midwifery include: Uganda, Malawi, Rwanda, Eritrea, Kenya and Ghana (Fullerton, Johnson, *et al.*, 2011:310; UNFPA, 2017:30). The lack of competencies, which cuts across interprofessional boundaries, is seen as a contributing factor to maternal deaths (Pattinson & Moodley, 2018:7; Schoon & Motlolometsi, 2012:784; WHO, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the ICM, the International Council of Nurses (ICN), 2018:1). In South Africa, the majority of skilled birth attendants (SBA) are midwives whose education lacks alignment with international standards.

The definitions of the midwife and midwifery, as agreed by the member countries of ICM, are clear. The ICM definition of midwife (ICM, 2011b:1) states the following:

"A midwife is a person who has successfully completed a midwifery education programme that is duly recognised in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery".

This definition indicates the need to comply with global standards and that education should be based on competencies. In Section 2.2.3.2, the global guidelines will be discussed. Upon achieving the competencies, licencing via a regulatory authority permits the use of the title of midwife. In South Africa, caring for women during pregnancy, birth and the postnatal period is, however, not provided exclusively by midwives who comply with the ICM definition. Other SBAs are also involved in the care.

The WHO SBA statement confirms that the person who provides the care should be competent and trained, educated and regulated according to national and international

standards (WHO), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the ICM, the ICN (2018:2). Having midwives with the competencies needed will contribute to improving maternal health and assist in reaching the health goals of the country. In South Africa, where midwives form the majority of the workforce in maternal healthcare, such midwives are needed. The burning question one should ask, however, is, whether the midwives that are being produced meet requirements stated in the definition.

2.3.2 Midwifery education in improving maternal health

At the time this study was being planned, the importance of midwifery as a solution to reducing maternal and child mortality and enabling the country to reach targets in the SDGs and universal health coverage had already been described (Homer *et al.*, 2014:1146; Renfrew, McFadden, *et al.*, 2014:1; Ten Hoope-Bender *et al.*, 2014:1). Against the backdrop of many global standards and guidelines that are set in midwifery education as a strategy to ensure the production of competent midwives (Luyben *et al.*, 2017:185), it is still the educator who will be the critical role-player in guiding students to competence. Having a competent educator who is able to develop curricula that include what is needed in and as a profession, within the context of the country's healthcare needs, can ensure competent midwives. Educators also need leadership skills, and should form clinical practice communities to ensure that they can provide what is needed to students (West *et al.*, 2016:19). Furthermore, these educators should guide students to competence in reducing the inequities in access and quality of care (Bharj, Luyben, Avery, Johnson, O'Connell, *et al.*, 2016:5; McNeil & Silvey, 2018:87; West *et al.*, 2016:13).

A robust education system that is competent to produce these midwives is essential (Bogren *et al.*, 2018:77; Fullerton *et al.*, 2016b:36; Fullerton *et al.*, 2011:311). The midwifery education system is complicated by several factors, some of which are systemic and others related to issues within the profession, the practice of midwifery and placement of students (Bharj & Embo, 2018a:116; West *et al.*, 2016:13).

Another two issues that threaten quality midwifery care and the practice of midwifery is respectful care and the medicalisation of pregnancy and birth, as was discussed in Section 2.2 (Bharj, Luyben, Avery, Johnson, O'Connell, *et al.*, 2016:4,5; Boerma *et al.*,

2018:1543). Midwifery educators need to teach the concepts and model to student midwives that the core of respectful care is based in a partnership relationship. This relationship should be founded on respect and understanding of human rights and how that shapes the core of midwifery practice (Bharj, Luyben, Avery, Johnson, O'Connell, *et al.*, 2016:1; ICM, 2017:1; Ten Hoop-Bender *et al.*, 2014:5). The teaching of content is likely to be consolidated into learning and acquiring competence if students can see the educator practising these competencies in caring for childbearing families (Luyben *et al.*, 2018:132).

2.3.3 Midwifery profession in South Africa

South Africa, as an African country considered having enough human resources to provide in the 46 essential interventions to improve maternal health (UNFPA, 2017:iv). However, in South Africa, the need for midwifery care is extensive. In 2015, of an estimated total population of 54.5 million, 14.7 million were women of reproductive age; the total fertility rate was 2.3. It is estimated that, by 2030, the population will have increased by 10%, to 60.0 million. To reach the targets of universal access to sexual, reproductive, maternal and newborn care, midwifery services will deal with up to 1.4 million pregnancies per year by 2030. The estimation is that there will be 91.0 million antenatal visits, 16.7 million births and 65.5 million post-partum/postnatal visits between 2015 and 2030 (UNFPA, 2017:78). To reach these numbers and have AAAQ care, competent midwives are needed.

Considering the quality of care in South Africa, we first need to acknowledge that the review of maternal deaths reflects concern about a lack of knowledge and skills, which form part of competence in medical and nursing categories. The mere fact that the midwives are labelled in the inquiries as nurses confirms as stated by international authors' work lack of identity and role clarification (Bharj, Luyben, Avery, Johnson, O'Connell, *et al.*, 2016:5; Renfrew *et al.*, 2019:397). The latest report released notes that, in 39% of all maternal deaths, a lack of knowledge and skill in medical staff was indicated as an avoidable factor that contributed to death. In 25% of all maternal deaths with avoidable factors, lack of skilled nurses (as labelled in the report) was noted (Pattinson & Moodley, 2018:7). The name confusion in referring to midwives as nurses is not an exception, and the clarity of the professional identity of midwifery is often perceived to be lacking (Gavine *et al.*, 2019:111).

The absence of an autonomous identity for midwifery, combined with confusion regarding midwifery as a subsection of nursing, create confusion about roles and responsibilities. The confusion undermines the scope of practice of midwives. As clearly stated by the 2014 Lancet series, midwives can be one of the most effective solutions in addressing adverse outcomes. Midwives who have been educated to global standards and competencies should be supported in an enabling environment, to contribute to addressing adverse outcomes (Renfrew *et al.*, 2019:397; Renfrew, McFadden, *et al.*, 2014:1,2).

In considering the ICM definition that describes *midwifery* as the profession of midwives (based on the definition of a *midwife*), only midwives should practise midwifery. The profession is based on a unique body of knowledge, skills and professional attitudes. It recognises that these traits are drawn from other disciplines and are shared by other health professions or disciplines, such as science and sociology, but practised by midwives within a professional framework of autonomy, partnership, ethics and accountability (ICM, 2017:1). As reiterated by several statements and scholarly works, the need to ensure compliance to global standards is confirmed by this definition of *midwifery* (Fullerton, Ghérissi, *et al.*, 2011:1; ICM, 2017; Renfrew, Homer, *et al.*, 2014:8; Renfrew *et al.*, 2019:397; WHO, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the ICM, the ICN (2018:1).

The issues facing South Africa, being the autonomy of midwifery in South Africa, compliance with global guidelines and standards, and its impact on South African midwifery education will each be discussed in more detail.

2.3.3.1 *The autonomy of the midwifery profession*

The first concerning issue is that, in South Africa, midwifery, although it is mentioned in the Nursing Act 33 of 2005, does not have full autonomy. Professional autonomy, which could also be seen as power or agency, and which will describe an autonomous midwifery profession in South Africa, needs midwives to determine and control the standards for midwifery education, midwifery regulation and midwifery practice (Hoope-Bender *et al.*, 2016:2; ICM, 2011c:1). Each of the three functions stated is currently performed by the SANC, as functions in education, regulation and practice

in nursing. There is no specific focus on midwifery as a separate profession, and midwifery is treated as an extension of the nursing profession, which creates confusion (Barger *et al.*, 2019:5). From experience and interaction with officials and council members of the SANC, it is known that the majority of decision-makers and SANC members have registration as midwives, but lack current competence as midwives. The concept of autonomous practice does not refer to "independent" or "private" midwifery practice (a common misunderstanding), but rather focuses on the ability of midwives to "fulfil their contract with society" by providing what women need in relation to reproductive health (ICM, 2011b:1).

Professional autonomy should not be regarded as working in isolation from the woman or other healthcare professionals. The SBA joint statement reiterates the importance of a healthcare team that addresses reproductive care. It also states that SBA groups should be competent in eight domains. The eight domains include knowledge on the scope of knowledge and scope of practice. Content on the continuum such as pre-pregnancy and antenatal care, intrapartum care, postnatal care including newborn care form domains. Care related to loss or termination is included and the final domain covers leadership. Education and regulation should comply with international standards; be based on a human rights approach and be sensitive to the socio-cultural needs of childbearing families (WHO), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the ICM, the ICN (2018:2). Autonomous midwifery practice, as a part of the interprofessional healthcare team of SBA, enables midwives to provide care to women, as set out in the ICM Definition of the Midwife (ICM, 2011b).

However, in large areas of the world, people without midwifery knowledge and skills are defining midwifery education and practice. In other places, even though midwives define midwifery education and practice, 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. In areas where midwifery autonomy is strong, the impact is visible in improved health outcomes (ICM, 2011c:1; Renfrew *et al.*, 2019:397).

Considering the impact of autonomy in South African midwifery, it is clear that midwifery is part of a generic nurse-midwife programme in both legacy and new

qualifications in South Africa. The current dispensation, where continuing professional development is not enforced by the SANC and midwifery can be taught by any person assigned to do so by an education institution, fails to determine or strengthen the competence of midwifery educators (Schoon & Motlolometsi, 2012:784). If competence of educators is not a determining factor in midwifery education, it could lead to the production of midwives without the necessary competencies (Bharj, Luyben, Avery, Johnson, O'Connell, *et al.*, 2016:5; McNeil & Silvey, 2018:87; West *et al.*, 2016:13; WHO, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the ICM, the ICN (2018:2).

The system of education currently practiced in South Africa relies on the overlap of competencies in other fields of healthcare. However, the core characteristics of midwifery, which include respect for women and their views and working in partnership with women, need to be considered if the current shortcomings regarding quality of care is to be addressed, starting with the educators (Renfrew, McFadden, *et al.*, 2014:2; West *et al.*, 2016:13). Unless midwifery programmes are offered by competent midwives with a voice to emancipate themselves and the profession, and who are competent educators, it will neither be possible to reach global standards, nor meet the needs of childbearing families.

2.3.3.2 *Global guidelines*

Global standards guide competencies, education and regulation of SBAs and midwifery. The ICM developed, via consultation with fully qualified midwives globally, core documents that are regarded as the global standard, and referred to in the core definitions. The three documents that guide midwifery education are captured in the Definition of the Midwife (ICM, 2011b:1). The global standards for midwifery education (ICM, 2013a), global standards for midwifery regulation (ICM, 2011d) and the essential competencies of the basic midwife (ICM, 2019), and the significance of these documents will be discussed next.

2.3.3.2.1 Global standards for the education of midwives

The purpose of the global standards is to set a benchmark with minimum expectations for midwifery education. Primarily, the focus is on promoting the health of childbearing women; contextual expansion to higher standards can be added to reflect country

needs. The standards are based on values and guided by principles. The values include education-focussed values, including continuous global development of midwifery education standards by midwives. Furthermore, there is a focus on integrity and a fair and equitable education process that will foster the pursuit of lifelong learning to maintain quality improvement in midwifery programmes and their outcomes. Lastly, the values are focussed on the profession, and promotes autonomy for midwives and midwifery (Barger *et al.*, 2019:2; ICM, 2013b).

The principles reconfirm that education should be in line with core ICM documents and position statements. It should be offered by fully qualified, competent midwifery educators and should fit the needs of the country.

The standards are a living document and should be utilised and updated to suit the context of each country (Barger *et al.*, 2019:2; ICM, 2013b). Six major areas are covered by the standards:

- Organisation and administration;
- Midwifery faculty (midwifery educators);
- Student body;
- Curriculum;
- Resources, facilities and services; and
- Assessment strategies.

After the global standards had been launched, a need arose to determine the extent to which it is known and utilised in the global midwifery community. Barger *et al.* (2019:5) conducted a cross-sectional, exploratory, descriptive qualitative study with participants from around the globe. The study found that the awareness of the global standards was low, with less than 10% of participants having a clear understanding. The global standards were often confused with the Essential Competencies of the Basic Midwife. Application of the standards was also limited. Challenges facing usage were similar across geographical and socio-economic divides, and included the impact of the transition of education programmes, inadequate resources to educate midwifery

students, role conflicts with nursing, which reduced autonomy, and context of care, with overmedicalisation reducing opportunities for midwifery education (Barger *et al.*, 2019:5).

The problems related to adherence to standards should not deter countries from adapting the global standards. Standards provide a useful tool for ensuring that midwives who are educated in a given country meet the definition of a midwife and can respond to the needs of childbearing families. The global standards for education are not considered or implemented by the SANC; this failure to implement the standards has a detrimental effect on the quality of midwifery education and autonomy of midwifery in South Africa.

2.3.3.2.2 Global standards for regulation of midwives

Simultaneous with the development of the global standards for education was a drive to ensure compliance with the definition of a midwife. A consensus process produced the global standards for regulation. The goal of the global standards is to promote midwifery regulation that protects childbearing families by licensing competent midwives to care for mothers and babies. The need for midwives to be supported in working autonomously within the full scope of practice will raise the status of the profession by regulating the standard of midwifery care. Table 2.3 summarises the aim of regulations, according to the purpose statements of the ICM global standards.

Table 2.3 Aim and purpose of regulation of midwifery practice

Purpose of regulation	Framework elements of regulation	Value matched to the framework element
1. Setting the scope of practice	Describe the scope of practice of a midwife consistent with the ICM definition of a midwife. Ensure that midwives can practice autonomously within their prescribed scope of practice.	Scope of practice describes autonomous clinical decisions and collaboration with other health professionals. Midwifery is an autonomous profession, separate and distinct from nursing and medicine. Only midwives can exercise the full scope of midwifery practice and provide all the competencies within this scope. Holding dual registration/qualification as a nurse and a midwife does not mean she can practice simultaneously as a midwife and a nurse. In a maternity setting, a registered/qualified midwife always practices midwifery.
2. Pre-registration education	Ensure that midwives enter the register following education consistent with the ICM Global Standards for Midwifery Education (2011).	
3. Registration	Determine who may use the title of midwife. Ensure that midwives enter the register, and are able to demonstrate the ICM Essential Competencies for Basic Midwifery Practice.	Women have the right to receive care from a competent midwife who is authorised to practice midwifery.
4. Relicensing and continuing competence	Ensure that midwives demonstrate continuing competence to practice.	
5. Complaints and discipline	Ensure public safety through the provision of a competent and autonomous midwifery workforce.	Midwives are autonomous practitioners and practice as responsible and accountable clinicians.
6. Codes of conduct and ethics	Ensure that midwives and women (as users of midwifery services) are part of the governance of midwifery regulatory bodies	Regulation supports the social contract between the midwifery profession and society. Society grants the midwifery profession authority and autonomy to regulate itself. In return, society expects the midwifery profession to act responsibly, ensure high standards of midwifery care and maintain the trust of the public.

Source: Adapted from ICM (2011d).

Regulatory councils (in South Africa, the SANC) set standards for the country's midwifery education. The SANC is also responsible for providing continuous support, monitoring and regulation of midwifery education institutions (Nyoni & Botma, 2018:117). Lack of compliance with global standards creates the risk that the licenced category of midwife would not be able to perform the full scope of practice required to produce quality midwifery care (Bogren *et al.*, 2018:74).

2.3.3.2.3 Essential competencies for basic midwifery education

The last document that followed a consultative process to update the competencies, and that is regularly updated (first developed in 2002, updated 2010, 2013 and 2019) is the description of the competencies that the basic midwife should possess. The latest version of the competencies, published in 2019, sets out the minimum knowledge, skills and professional behaviours required for registration as a midwife.

Previous versions had seven competencies and, in the latest update, it was changed to a framework of four interrelated categories. The first category is a broad set of competencies that apply to all aspects of a midwife's practice, whereas the other three categories are specific to

- care during pre-pregnancy, antenatal,
- labour, birth and
- the postnatal period (ICM, 2019).

The four categories group the content of the seven competencies in the previous version into an organised set of competencies.

Complying with global standards is mentioned as a critical step in ensuring that midwives can respond to the needs of childbearing families. Yet, the question remains, how is the South Africa midwifery profession responding to the call to produce competent midwives?

2.3.3.2.4 Midwifery education in South Africa

Considering the international guidelines and definitions, the situation in South Africa is alarming. The current programmes are categorised as legacy programmes, and the

South African Qualifications Authority declared 2019 as the last year in which these programmes could be offered. Education as a midwife formerly took place at either college or university level. At public nursing colleges, students followed either a four-year diploma (with professional registration as a general nurse, midwife, community health nurse and psychiatric nurse) or a one-year midwifery diploma following a bridging course, after completion of general nursing qualifications. These colleges functioned under the auspices of the Department of Health. The universities offered a Bachelor's degree leading to professional registration as a general nurse, midwife, community health nurse and psychiatric nurse. Some colleges and universities provided the option of advanced midwifery qualifications as a post-basic diploma or Master's degree. The legacy programmes favoured a practitioner (nurse) who should be employable in a variety of settings including maternal and newborn care.

In South Africa, the regulations for a majority of the current programmes date back to 1985. At the brink of the new dispensation that is to commence in 2020, there are many unresolved issues. Now is the opportunity to align qualifications to comply with global standards. In the last quarter of 2019, the regulations for midwifery content had not yet been published for the postgraduate diploma. The draft for public comments was only published in October 2019, and many institutions still awaited approval from the three authorities, that is, the SANC, the South African Qualifications Authority and the Council for Higher Education. Furthermore, in discussions about the process, the need was indicated that public nursing colleges are expected to convert to higher education, though the nature of this process seems unclear. The slow and haphazard processes are frustrating to the profession, education institutions and prospective students.

At the same time, the new qualifications offer the opportunity to convert and comply with international standards. However, if the post-nursing diploma (advanced diploma) is considered, the global standards recommend 18 months minimum duration, whereas the proposed new qualification is set as a one-year diploma. At the time of approval of the global standards at the ICM Council (2011), the documents were shared with the SANC. Several meetings and discussions followed, yet full acceptance and application of these standards in 2020 is not evident in the new qualifications.

Other countries share the concerns of non-implementation of global guidelines. The consequences of non-compliance with the global standards are that countries, like South Africa in this case, may produce midwives who do not have the competence to render the quality of care that is needed (Luyben *et al.*, 2017:185; McNeil & Silvey, 2018:87; Schoon & Motlolometsi, 2012:784). In the South African nursing education system, which includes midwifery, the individual nursing education institutions govern the allocation of staff and develop their own micro curricula. As global standards are not adopted and supported by all in the profession, there is the possibility that individual interpretation and needs can systematically create a disempowered situation for midwifery education. The education of midwives, in addition, relies on the competencies of the educators, which will be unpacked in the next section.

2.3.4 Midwifery educators' competency

Competence and competencies are leading concepts in healthcare worker education. In maternal and child health, the two statements in the 2018 SBA of the WHO, and the 2019 updated ICM Competencies both reflect the competence expected of a competent practitioner. The WHO statement is enriched with a competency map that clarifies international standards and interprofessional boundaries (WHO, 2018b:1–5). Educators should continuously engage with competence and competencies, as this is a core construct in healthcare and the midwifery profession.

2.3.4.1 *Competence and competency*

The definitions of competence and competency, as a key focus of this research, and presented in the concept clarification section of this study, are evolving. Continuous change is attributed to an increased focus on competency and competency-based education in many areas.

In a quest to improve knowledge acquisition, towards the end of the previous century, industries established training units and started focussing on competence. These training units aimed at increasing efficiency and improving the tasks of different jobs. The needs of industries and vocational training expanded to education institutions, which developed education based on competencies that were to be achieved, also in professions such as the healthcare professions (Fullerton, Ghérissi, *et al.*, 2011:5).

There is a debate about the focus on competencies in healthcare education. Critics see competencies as reductionist behaviourism, which hamper the development of professional expertise and lead only to measurable, practical skills learned. Supporters acknowledge that a narrow understanding can lead to this perception (Fernandez *et al.*, 2012:358); however, the value of competencies can be appreciated if it is investigated.

As differentiated in the conceptual clarification of this research, another perspective considers competence and competency as two distinct concepts that capture complex elements. Competence is defined in relation to behavioural tasks, whereas competency includes the personal traits that are at the foundation of the tasks (Fullerton, Ghérissi, *et al.*, 2011:6).

Three main approaches to competence are found, namely, behavioural, generic and holistic approaches. In the **behavioural approach**, competence is defined by identifying actions that can be demonstrated and assessed. The actions are founded on knowledge that is understood well. Building on the behavioural approach is the **generic approach**, which defines clusters of abilities that are paired with the knowledge needed for the abilities, and the critical thinking required to bring about expert performance. Criticism of the generic approach is that it does not consider the context, which can influence performance. A solution to the critique is found in the **holistic approach**, which combines the attributes of the person and the context in which a task is performed. The values of the person and the ethics of the profession are integrated into competence (Fukada, 2018:1; Fullerton, Ghérissi, *et al.*, 2011:6). By expanding the approach to capture not only the behavioural tasks and personal traits, but adding the context, provides a comprehensive picture of competence.

In addition, Fernandez *et al.* (2012) confirm the importance of competence by conceptualising it as more than education that focusses only on mastering the concepts. If the concept of competence includes the integration of components, the synergy of the components in clinical situations will ensure education that is focussed on the attainment of synergy (Fernandez *et al.*, 2012:357). The synergy, according to Fernandez *et al.* (2012), confirms the view expressed by Fukada (2018) and Fullerton *et al.* (2011), that context, values and traits should be combined with the professional task at hand.

Furthermore, competency is a complex integration of knowledge, and includes professional and clinical judgment, psychomotor skills, values and attitudes. Competency requires adaptation to circumstances and is determined by professional responsibilities in a specific context (Fukada, 2018:1, 2).

In 1984, Patricia Benner developed a theory for skills acquisition in the context of nursing practice (*From Novice to Expert*) using skills acquisition models of Dreyfus and Dreyfus, of 1980 and, later, 1986, that studied chess players. Alligood (2014) reports that Benner identifies five stages, starting at novice, followed by advanced beginner, competent, proficient and, finally, expert. The third level of competence is a progressive level within a larger model that is situation-based, and not trait-based. Benner describes performance (competence) as a function of the nurse practitioners' familiarity with a given situation and the educational background. Her model does not refer to psychomotor skills performed outside the context of nursing practice (Alligood, 2014:122, 123).

Competency is a more complex construct. Alligood (2014) reports Benner's description of competency as "an interpretively defined area of skilled performance identified and described by its intent, functions and meanings" (Alligood, 2014:125, 126). The construct is multidimensional and implies synergy between the cognitive processes and the actions at a specified level of performance in a given situation (Fullerton, Ghérissi, *et al.*, 2011:6).

The competencies for midwifery educators capture the synergy between knowledge, skills needed and the behaviour of a midwifery educator in all contextual areas of midwifery and midwifery education. The competencies and continued growth in competency should be seen as a continuous cycle that can inform professional development.

2.3.4.2 *WHO Core Midwifery Educator Competencies*

Moving from understanding the concepts of competence and competencies, the global movement to strengthen midwifery as a way to improve maternal health contributed to a collaborative effort to address MEC. The team included the ICM, UNFPA, ICN, WHO Collaboration centres for Nursing and Midwifery Development, and Jhpeigo. The group compiled a list of the competencies needed by midwifery educators. A

consultative process was followed to produce competencies that are comprehensive, relevant, adaptable and accessible, to ensure that educators are prepared to meet the needs of their counties (WHO, 2013:5).

The development of the list of these competencies included a literature review, which was followed by global consultation in a meeting with global technical experts in midwifery and education that produced a second draft set of competencies. The draft was then shared in a global Delphi survey with several networks, including associations, United Nations groups and web-based discussion groups. The 287 replies conveyed strong support for the competencies. After the original consultancy group gave inputs again, the validation was done in two countries, Rwanda and the Kingdom of Bahrain. Their final inputs consolidated the competencies.

In total 19 competencies were identified, which were organised into eight domains, each with corresponding competencies. The domains that were created and the competencies comprising each domain are presented in Table 2.4.

Table 2.4 Competency domains of WHO Midwifery educators' competencies

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.

Domain	Competency
	Competency 7: Recognise 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 individualised, 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. Organisation, management and leadership	Midwifery educators participate in formulating the policy and programme outcomes and in designing and implementing curricula.
	Competency 12: Actively participate in organising and implementing a midwifery curriculum.
	Competency 13: Implement and revise midwifery educational courses/programmes.
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 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.

Source: WHO (2013:8, 9)

The eight domains cover areas captured in the discussion about competence and competencies, and focus on the aspects related to the context of midwifery, education of the midwife, leadership roles and scholarship. The following section will summarise the eight domains and provide detail on the competencies, by linking the knowledge, skills and behaviour to each, as stated in the WHO core competencies.

2.3.4.2.1 Ethical and legal principles of midwifery

This first domain covers two competencies that refer to the way educators utilise and promote ethics and legal issues in their educational practice. Primarily, they need to be role models regarding ethical conduct, and must adhere to regulatory and legal frameworks. The importance of ethics in midwifery is captured in the ICM core document, International Code of Ethics for Midwives. The code describes the expected ethical comportment in four main areas, namely, midwifery relationships, professional responsibilities of midwives, midwifery practice and how the practice and profession should be advanced (ICM, 2014b:1, 2). Section 1.1.3 alluded to the human-rights-based foundation of midwifery, and the link between quality midwifery care and respectful care was explained in Section 2.3. As shown in Table 2.5, the elements of Domain 1 and the two competencies of the domain rests on human rights and elements flowing from it, such as respectful care. It is crucial for educators to have this competency if they are to improve the quality of maternal healthcare, and ensure that it is founded on human rights.

Table 2.5 Ethical and legal domain of MEC

Domain 1: Ethical and legal aspects of midwifery					
Competency 1: Behaviour reflects ethical standards of teaching and midwifery profession			Competency 2: Demonstrate an understanding of legal and regulatory statutes of teaching and midwifery profession		
Knowledge	Skills	Behaviour	Knowledge	Skills	Behaviour
International and local ethical responsibilities concerning teaching and practice	Use knowledge of ethical issues as the basis to influence, design, implement and evaluate policies and procedures in education and practice	Incorporate respect and responsibility	Laws and regulations applicable to teaching and midwifery	Utilise legal and regulatory requirements of teaching and midwifery in teaching and learning	Act in line with legal and regulatory standards
		Protect women's rights in teaching and rendering care			Ensure compliance with legal and regulatory standards by a student
		Identify ethical issues			

Source: WHO (2013:12)

The elements of the two competencies and the first domain of ethical and legal aspects of midwifery urge a competent midwifery educator to utilise and teach the ethical standards of midwifery to students. The knowledge, skills and behavioural components of both competencies require the midwifery educator to model how human rights can shape and guide practice of education and relationships. Compliance with the legal framework that regulates the profession is a crucial element that can guide students to increased professionalism.

2.3.4.2.2 Midwifery practice

The second domain of midwifery practice, captures two components, namely, the need for clinical midwifery competence, and using evidence-based practice. Both these components are included in the core ICM documents, which include the International Code of Ethics for Midwives and the midwifery Philosophy and Model of Care. The Code of Ethics, in the sub-section on midwifery practice, indicates the need for competent practice informed by the latest evidence-based practice guidelines.

Evidence-based practice relies on peer review and research that form part of the subsection on the advancement of the profession, in the Code of Ethics (ICM, 2014b:2, 3). The philosophy statement says: "Ethical and competent midwifery care is informed and guided by formal and continuous education, scientific research and application of evidence" (ICM, 2014c:2). In addition to using evidence in their own practice, the model of care following the philosophy, confirms the need for midwives to maintain their competence and develop the next generation of midwives, with a focus on lifelong learning (ICM, 2014c:3). The domain includes theory and practise of midwifery. Table 2.6 lists the elements contained in this competency.

Table 2.6 Midwifery practice domain

Domain 2 Midwifery practice					
Competency 3 Maintain competence in midwifery practice			Competency 4 Practice midwifery in ways that reflect current, evidence-based care		
Knowledge	Skills	Behaviour	Knowledge	Skills	Behaviour
Total theoretical midwifery curriculum	Provision of safe, competent and effective care	Participate in professional development	Research process	Implement and interpret research	Ability to conform practice to new evidence
All areas of clinical practice	Application of research findings	Practice in line with code of ethics	Local epidemiology, health needs	Review literature to inform evidence-based practice	
Evidence-based care content	Reach requirements of the regulatory body	Provides high-quality care			
		Values life-long learning			

Source: WHO (2013:13)

The knowledge, skills and behaviour needed in the domain on clinical competence and use of evidence-based practice covers the content of midwifery and research competence to utilise evidence and inform practice. Self-directedness and lifelong

learning will help the practitioner to maintain clinical competence. The focus shifts in the following domains, from clinical expertise to education expertise.

2.3.4.2.3 Theoretical learning

As the expectation is that a midwifery educator should be a competent midwife as well as competent as an educator, this domain covers two competencies related to education. In the journey to becoming a midwife educator, there is progress, from a high level of clinical functioning, into education. The transition into the role of educator involves a change in the functions and scope of practice, for which preparation in the science of education is needed (Thompson *et al.*, 2001:xv, 17). Competencies 5–13 cover content related to education and curricula, which are required to develop as an educator (Benner *et al.*, 2010:19).

The first competency in this domain, Competency 5, describes the knowledge, skills and behaviour needed to incorporate educational strategies to promote learning through the teaching strategy.

Knowledge required includes theories of learning that will result in the acquisition of competency, and competency-based education.

Skills needed include the ability to work with adult learners, to use teaching strategies founded in evidence-based teaching, and to create opportunities for students to develop critical thinking, clinical reasoning and innovative thinking. The list of educational approaches to be used includes the following:

- Problem-based learning;
- Narrative and case-based learning;
- Group work and discussion;
- Seminar presentations;
- Experiential learning, including role-play, simulation and simulated women;
- Workshops;
- Projects;
- Active participatory lectures;

- Effective use of audio-visual material, and
- E-learning.

Lastly, the **behaviour** that a competent midwifery educator should exhibit includes modelling critical reflective thinking, showing enthusiasm for teaching, learning and midwifery, and motivating students within a relationship of respect and trust.

Competency 6 links to Competency 5, as effective teaching and learning resources and material must be selected. The knowledge required to do this includes the evidence base of educational and learning resources. Skills needed include the evaluation of material and resources to make appropriate choices and to develop educational material. Educators should also use information technology to support teaching and learning. Lastly, educators should advocate for conducive classroom conditions, or utilise available resources to enhance teaching and learning (WHO, 2013:14).

Competency 7, which is focussed on the unique learning needs and learning styles of students, concludes the domain. **Knowledge** elements needed are the theory and methodology of an educational needs assessment, the social and human relationships and counselling principles that form the base for interactions between educators and students and determining conditions for learning. **Skills** that form part of Competency 7 are the ability to individualise provision of resources and to use counselling to ensure students meet their learning goals. Educators should be able to create a learning environment that enhances the socialisation of a student midwife via self-reflection and setting goals. The ability to foster cognitive, psychomotor and affective development via self- and peer-evaluation is needed. The educator must recognise the influence of teaching styles and interpersonal interactions on a student. **The behaviour** required for this competence is an interest and respect for learners. Educators should support the learner and their own lifelong learning and use attributes, such as caring, confidence, patience, integrity, flexibility, to enhance learning (WHO, 2013:15).

The following domain revolves around clinical learning, which would also be a generic competency in other healthcare professions.

2.3.4.2.4 Learning in the clinical area

The value of clinical teaching to develop midwives, who are competent and caring in the presence of a real woman who needs midwifery care, creates new opportunities for learning. In clinical teaching, the educator facilitates the transfer of knowledge and application of theory (Thompson *et al.*, 2001:119). The two competencies in Domain 4, on clinical learning are summarised in Table 2.7.

Table 2.7 Competency 8 Clinical learning environment

Competency 8: Facilitate a safe and effective clinical learning environment	Knowledge of	Clinical environment and structures governing it
		Competency-based clinical learning
		Integration of students in a clinical setting
		Evidence-based practice
		Supporting informed choice and ethical expectations of midwifery practice
	Skills	Facilitation of active learning by teaching assessment, planning, implementing and evaluating midwifery care and documenting the care
		Create a climate of fostering, evaluating and disseminating practice development
		Demonstrate relationships with childbearing families that are effective
		Obtain free, informed consent for student involvement in care
		Protect women and babies from harm
		Bridge theory-practice gap by encouraging reflective thinking
		Build and maintain collegial relationships with staff from clinical placement areas
		Demonstrate principles of delegation and supervision
	Behaviour	Demonstrate effective interpersonal skills

		Seek clarification or assistance from staff if needed
		Create a dynamic and constructive relationship with students with professional boundaries
		Use effective communication to foster professional growth and personal development
		Facilitate and develop interprofessional learning and working ethos
		Identify clinical teaching opportunities
		Set boundaries for safe practice

Source: WHO (2013:16)

In addition to the general focus of Competency 8 on clinical learning, Competency 9 narrows the focus to individualised, experiential learning. The elements that make up this competency are summarised in Table 2.8.

Table 2.8 Individualised experiential learning elements

Competency 9: Foster individualised experiential learning	Knowledge of	Experiential learning
		Diversity of learning processes
	Skills	Design, deliver and assess practical learning settings to support a range of students
		Assist students in creating, developing, identifying and using opportunities to meet their learning needs
		Provide positive feedback and constructive criticism to students
		Support and advice students if changes are required
	Behaviour	Assess the ability of students to integrate their professional role – their knowledge base of identity and performance of the role must be intermeshed
		Act with respect in the best interest of students
		Demonstrate patience

Source: WHO (2013:17)

The role of clinical teaching in shaping competent and caring midwives by asynchronous teaching that applies all the theory taught in the classroom requires the midwife educator to use knowledge and skills and model behaviour. The role is more comprehensive than only that of an expert midwife or the competencies of a classroom educator.

2.3.4.2.5 Assessment and evaluation of students and programmes

Domain 5 captures competencies that refer to evaluation and assessment of programmes and students. Midwifery educators should be able to monitor and evaluate the students, as well as programmes that they are teaching, regularly. Assessment provides the opportunity for achievement and performance, to measure if competence has been reached. Assessment should be a positive experience that measures if student outcomes or programme outcomes have been achieved (Thompson *et al.*, 2001:108). Table 2.9 captures the elements comprising Competency 10.

Table 2.9 Competency 10 elements: Assessment

Competency 10 Monitor, assess and evaluate the effectiveness of programmes		
Knowledge	Skills	Behaviour
Theory and methodology of assessment	Use assessment tools linked to learning goals	Ethical intent and objectivity in assessment
	Use and develop tools	
	Construct assessments	
	Set standards for pass or failure	
	Keep records	

Source: WHO (2013:18)

In following the general programme assessment of Competency 10, student competence and its assessment is the focus of Competency 11. The knowledge

component relates to assessment procedures, while skills capture the development, implementation and adaptation of assessment tools and documents in reference to clinical practice. Plans to assess student progress, and the ability to judge the competency of a student, including cultural competence and respectful care, are required. Ways to provide constructive feedback and support unsuccessful students should be mastered. Lastly, confirming competence according to the standard competencies should be actioned. The behaviour elements are the ability to act as a role model, and to complete assessments with objectivity and ethical intent (WHO, 2013:18).

Domain 6 focusses on the organisation, management and leadership abilities that a competent midwifery educator should have.

2.3.4.2.6 Organisation, management and leadership competence of midwifery educators

Competent midwifery educators should be taking the lead in the design and implementation of curricula, and should participate in policy development and programme planning. Competency 12 focusses specifically on the role of midwifery educators, who should participate in organising and implementing curricula. A sound knowledge base that covers education management theories, teaching and learning methodology and curriculum design, is necessary. Also, the ability to curriculate should be informed by the national health priorities and should ensure that adequate time is scheduled and tabled for a programme. Skills to develop the ability of an educator to work in a multidisciplinary or interprofessional team and to develop curricula are also essential. Time resources and other resource planning are elements needed by this competency. Lastly, the behaviour that will facilitate this competence is the ability to work as part of a team and to make inclusive decisions (WHO, 2013:19).

Competency 13 takes the midwifery educator to the level of implementation and revision of programmes. The knowledge needed includes curriculum evaluation and revision, quality assurance and monitoring and evaluation of organisations.

The implementation and revision of programmes require a variety of skills, such as,

- Curriculum revision and the implementation of revised curricula by using change management strategies;
- Continuous improvement of student performance, student evaluations, peer review graduation and registration success;
- Compliance with national health needs; and
- Quality assurance, which is embedded in the evaluation of organisational effectiveness in midwifery education.

Behaviour that involves keeping accurate records and maintaining integrity in monitoring covers the personal attributes needed (WHO, 2013:20).

The organisation, management and leadership competence of midwifery educators in Domain 6 are expanded in Domain 7, which focusses on communication, leadership and advocacy.

2.3.4.2.7 Communication, leadership and advocacy

The need to transform the profession from within relies on constant improvement. Relevant curricula and assessment of programmes are the first steps of transformation. Educators need to engage with regulators, policymakers and administrators of education to ensure midwifery education complies with global, national and community priorities (Benner *et al.*, 2010:214). This domain and the four competencies that comprise it focus on the need for midwifery educators to be advocates, change agents and leaders who can communicate effectively. Competency 14 emphasises using various methods and adapting to diverse settings, to enable effective communication. Table 2.10 lists the elements of this competency.

Table 2.10 Elements of Competency 14

Competency 14 Communicates effectively using a variety of methods in diverse settings		
Knowledge	Skills	Behaviour
Communication techniques	Effective communication, oral, written, report writing	Awareness of self and others
Presentation methodologies and report writing	Demonstrate effective communication skills at all levels of interaction	
	Conflict resolution skills	

Source: WHO (2013:21)

Competency 15 refers to cultural competence and how that should be included in the planning and implementation of midwifery education. In the context of South Africa, cultural competence is crucial and, hence, every midwifery educator should know that human rights is the basic start of cultural competence. Midwifery and nursing literature contains the golden thread of cultural competence. Both the ICM Midwifery Philosophy and Model of Care and ICM Code of Ethics refer to the importance of culture in midwifery practice. The Code of Ethics stipulates respect for cultural diversity. In addition, the ability to identify and address possible harmful practices is emphasised – a South African example of harmful practices would be to apply cow dung to a newborn baby's cord. The Philosophy and Model of Care require midwives to respect cultural diversity, and links respect for diversity to the ethical principles of equity and justice (ICM, 2014c:2; 2014b:2).

In addition to a focus on midwifery practice, ethnic and cultural beliefs and norms influence the teaching and learning environment. If a deliberate focus on inclusivity, and respect for age, race or ethnic origin, culture, gender and sexual orientation is lacking, the unconscious constructions might be that of the educator only (Thompson *et al.*, 2001:78,79).

From nursing theories, Madeleine M. Leininger developed the culture care theory of diversity and universality in 1991. This theory is focussed on nursing care for individuals and groups. It incorporates social structure, generic emic and professional

etic care in a variety of environmental contexts. Culturally-based care is responded to within a participatory relationship (Alligood, 2014:424, 425). Leininger's theory inspired the work of Josepha Campinha-Bacote who, in 2007, described how cultural constructs and cultural skill emanate from cultural encounters. She places cultural competence as a commitment to social justice. She also links culture to more than ethnicity and includes religion, physical size, gender (feminism in this research), sexual orientation, age, socio-political aspects, geographical space and occupations (midwifery educators in this research) as cultural groupings (Campinha-Bacote, 2002:181–183; 2008:144).

The skills needed include facilitating culturally appropriate care and embracing multicultural expression, views and experiences in teaching. Midwifery educators should foster the ability in students to protect human rights in action and words. The behaviour needed from the midwife educator is to model cultural sensitivity and inclusion and to be accountable for the protection of human rights (WHO, 2013:21).

Competency 16 deals with the ability to act as a change agent and leader. The need for midwives to act as change agents advocates, and the leadership ability to do that is captured in the core documents of ICM. The emancipatory and empowering opportunities for midwives to ensure that women can receive care for a normal birth from a midwife is captured in many elements in the Philosophy and Model of Care and all in four of the sections of the Code of Ethics (ICM, 2014b:2,3, 2014c:1–4). See Table 2.11 for the elements of Competency 16.

Table 2.11 Competency 16 Change agents and leaders

Competency 16 Function as change agents and leaders to improve midwifery education and practice		
Knowledge	Skills	Behaviour
Change management	Act as custodian of safe, competent respectful midwifery care	Use personal values of respect, collegiality, professionalism and caring to create a climate that strengthens the development of students and educators
Leadership theories	Create and maintain partnerships in clinical environment and community that supports education within the interprofessional team	Demonstrate integrity, courage, perseverance, creativity and vitality
Interdisciplinary collaboration	Midwifery educator role to be integrated, so that it is innovative and creative	Develop and maintain collegial working relationships with students, peers and clinical staff to strengthen positive learning environments
	Implement organisational change strategies	Use self-reflection to improve teaching practices that improve learning
	Utilise organisational leadership skills to enhance the midwifery identity and the academic contribution of midwifery	
	Provide leadership in institutional governance	
	Improve role effectiveness by using feedback from self, students, peers and administration	
	Mentor and support colleagues	

Source: WHO (2013:22)

The importance of the human rights base of midwifery care and respectful care was discussed in Section 2.3.2. The knowledge, skills and behaviour of Competency 16, as listed in Table 2.12, cover all the elements needed for midwifery educators to function as change agents and leaders who can shape the profession.

The last component in Domain 7 refers to advocacy. Competency 17 expects a midwifery educator to use various advocacy strategies to promote human rights, the

profession, communities and midwifery education. Special mention is made of structural advocacy, which is seen as a way to provide respectful maternity care. To be competent as an advocate, the midwife educator needs knowledge on advocacy strategies and organisational functions. The skill of demonstrating leadership on all levels will be enhanced by the ability to present an argument confidently while communicating effectively (WHO, 2013:23).

2.3.4.2.8 Research

Domain 8 captures two competencies dealing with research. Midwifery educators should promote and use research to inform their education, content and practice of midwifery.

The importance of research is inherent in the academic environment, with an essential requirement for all professions being that academics are involved in education, practice and research. Research responds to an academic quest and commitment to discovering truths and understanding while enhancing society's well-being. In the education of midwives, the educator has roles and responsibilities as an educator and as a scholar. Scholarly tasks are various, including formal research, writing, representation and presentation at professional meetings and in the policy environment (Thompson *et al.*, 2001:166,167). Table 2.12 contains a summary of the elements of the last two competencies.

Table 2.12 Competency 18 and Competency 19 Research domain

Competency 18 Use research to inform education and practice		
Knowledge	Skills	Behaviour
Evidence-based care and hierarchy of evidence	Use electronic resources to find research and clinical guidelines	Model and encourage inquiry
Resources available for research	Rate the quality of evidence	
Research approaches like quantitative and qualitative	Utilise research in education and practice	
Competency 19 Cultivate a critical inquiry culture and support evidence-based practice		
Knowledge	Skills	Behaviour
Evidence-based care and hierarchy of evidence	Create a climate to implement research in midwifery practice	Model critical thinking
Critical inquiry	Positive feedback for research endeavours	Give priority to reflection and questioning

Source: WHO (2013:23)

2.3.5 Conclusion regarding midwifery educators' competencies

The WHO core competencies for midwifery educators covers the areas of education, midwifery practice, leadership and research, which build up collectively to ensure competence. Using these competencies as a diagnostic tool to strengthen midwifery educators was confirmed in the 2019 WHO framework for strengthening midwifery education (WHO, 2019:32), of which the implementation depends on the availability of resources. Strengthening the midwifery workforce relies on educators being competent (Bharj, Luyben, Avery, Johnson, O'Connell, *et al.*, 2016:4; Renfrew, Homer, *et al.*, 2014:2; WHO, 2013:23).

2.4 CONCLUSIONS FROM LITERATURE PERSPECTIVES

In reviewing the dilemma facing the provision of quality maternal healthcare in South Africa, the importance of a midwifery profession that complies with global standards was described. The status quo in South Africa, which is characterised by the midwifery profession facing limitations and challenges relating to the transformative ability of midwifery education to meet the needs of childbearing families, became clear. An exposition of competence and competencies provided a background for the steps needed to transform MECs in South Africa. If the perspectives from the literature are considered, it is clear that midwifery education in South Africa has an important role and that optimising the competencies of midwifery educators can contribute to improving maternal health. In this research, the perspectives from literature clearly show the need for transformation, in this case, to strengthen MECs.

Theoretical perspectives found in midwifery and midwifery education, and the way the research and choices were guided by the need to transform midwifery education within this landscape, will be explored in Chapter 3.

Chapter 3

Perspectives from literature: paradigmatic foundations



CHAPTER 3 PERSPECTIVES FROM LITERATURE: PARADIGMATIC FOUNDATIONS

"A lot of the time, it is hard to see gender norms because they seem like they have always been there. And even when we see them, it is easy to assume that they are impossible to change – that they are a 'natural' part of the social landscape, as immovable as mountains" (Gates, 2019:2373).

3.1 INTRODUCTION

Having surveyed the landscape pertaining to quality maternal healthcare, midwifery education and MECs in the previous chapter, the surrounding mountains of gender norms will be illuminated in Chapter 3. Feminism, as a grand theory, will be contextualised in relation to midwifery and this research, after which the theoretical grounding of the qualitative component of AI will be discussed. The chapter will conclude with an exposition of the intertwining of the grand theory and theoretical foundations of AI in a quest to achieve sustainable and deep change.

3.2 GRAND THEORY: FEMINISM

Gender inequity in maternal health care and health systems stems from androcentric philosophy, which flows into practices and produces a systematically uneven quality of care. The assumptions and biases that result in disempowering inequities that infringe on the human rights of women and childbearing families need transformation (Brisolara *et al.*, 2014:4; WHO, 2015a:25). A transformative paradigm (discussed in Section 1.7) responds specifically to the various levels of social change, including issues of race, gender inequality, disability, sexual orientation and oppression (Mertens, 2015a:21). In this research, the focus on MEC, as a component of the midwifery profession, carries an element of gender inequality.

Three variants are identified by the transformative design that is based on the particular lens, that is, the feminist, disability and socioeconomic lenses. The transformative design addresses power imbalances that are present and need to be changed. The specific causes of the power imbalance should be understood through

a lens that magnifies the issue at hand best (Creswell & Plano Clark, 2011:99, 100). The best fit for midwifery educators relates to gender, because they share a similar social standing and a racial distribution, which is representative of the South African population. Although disability could be considered, the practical nature of the discipline limits the probability of this issue as a common trait amongst midwifery educators. The power imbalance that is relevant to issues in midwifery education is, therefore, gender inequality.

Intersectionality and the importance of recognising the issues of differences and diversity is core to understanding gender inequality. Problems related to the theoretical hegemony of gender have practical implications, which present as gender inequality (Lutz *et al.*, 2011:46). The ramifications of gender inequality block progress towards achieving quality maternal healthcare, due to disempowerment within patriarchal structures and systems. Professional, sociocultural, and economic barriers that were created by gender inequality have a negatively impact on the profession and practice of midwifery (Renfrew *et al.*, 2019:396). Even the discourse in narratives of childbirth is dominated by a medicalised perspective, which reflects the disempowered position of women and midwives (McKenzie-Mohr & Lafrance, 2014:44). Feminism, therefore, elucidates gender inequality and promotes women's priorities, concerns and perspectives.

3.2.1 Feminism unpacked

Feminism, as grand theory in this research, is represented by many and diverse views and different applications, which serve as theory, philosophy or lens. The views evolve as more insight is found, and depend on the scholar using feminism (Brisolara *et al.*, 2014:5). Essentially, feminism envisions encouraging action against a blueprint that is based on gender. It seeks to understand and resolve social issues, which relate to the consequences of androcentric philosophies or practices that lead to the disempowerment of women (Brisolara *et al.*, 2014:4; Eagleton, 2003:1). Unfortunately, scholars of feminism are often reduced by critics to being man-haters. Other scholars who understand how gender influences society might, consequently, shy away from feminist research. Moreover, trivialising feminism as representing only radical views does not respect the ethos, which is grounded in changing the position of women in society (Jensen *et al.*, 2001:141; Yuill, 2012:36).

The common concern of feminism involves many plural and diverse applications that can contribute to a paradox of partialities and selectivity. Theories and philosophies are often categorised according to the nation of origin, for instance, German-inspired, French, or Latin-American originated work. Marxist and postmodern feminism follows a categorisation by philosophical traditions. At the same time, the stages of Western feminist movements are described as waves, which describe how the popularity of certain ideas increased and decreased over time (Brisolara *et al.*, 2014:5; Pilcher & Whelehan, 2017:166, 167). Cutting across all philosophical traditions, theories and waves of feminist research is a primary focus on issues related to knowledge. Typical considerations relate to how this knowledge was obtained, by whom, and with what purpose. Marginalised groups, such as lesbian, Black, Coloured, Indian or disabled women, have individual foci. Within the context of this research, the influence of history, social context and patriarchal systems in midwifery brings a specific feminist focus (Denzin & Lincoln, 2018:265; Renfrew *et al.*, 2019:396).

If the thoughts of Michel Foucault on the archaeology of knowledge are considered, the construction of knowledge and science is influenced by several factors that he describes as episteme. He postulates that a worldview at a given time influences all science and imposes the same norms, discussions and systems on science.

"The episteme is not a form of knowledge (connaissance) or type of rationality which, crossing the boundaries of the most varied sciences, manifests the sovereign unity of a subject, a spirit, or a period; it is the totality of relations that can be discovered, for a given period, between the sciences when one analyses them at the level of discursive regularities" (Foucault, 1989:211).

The importance of relationships and how they shapes structures and discussions within structures has led to many different theories within feminism.

3.2.1.1 *Theories within feminism*

A common thread that crosses different streams and concepts evolved in feminism on the basis of relationships. A summary of the key concepts in different streams of feminism theory is presented in Table 3.1.

Table 3.1 Key concepts in streams of feminism theory

Streams within feminist theory	Key claims and concepts
Feminist empiricism	• Focusses on measurable concepts in the social and natural world • Combines positivist practices with feminist perspectives • Critiques scientific practice as insiders • Adds value judgement in rigorous inquiry to limit androcentric views and biased results
Standpoint feminism	• Focusses on the importance of context and social position • Critiques positivism and role of androcentrism-shaped research practices and institutions • Holds the belief that different standpoints provide unique findings • Combines political advocacy with research
Critical feminism	• Critiques positivism • Focusses on power, domination and exploitation • Seeks social transformation • Focusses methodological choices on lived experiences of women
Postmodern post-structural	• Critiques positivist research but reconsiders the need for objectivity • Requires reflexivity in language and scepticism • Critiques the ability of social theory to bring social change • Favours deconstruction of knowledge, social institutions and modernity
Global and postcolonial	• Examines how dominant discourse shapes reality • Examines the interaction between gender and other levels of oppression • Considers Western assumptions and the effect of the colonial past • Recognises that areas of oppression can be areas of resistance • Confirms gender power and its advantages and disadvantages

Source: Brisolara *et al.* (2014:15,16)

In addition to the streams of theory in Table 3.1, there are race-based and indigenous feminist movements, as well as sex, sexuality and queer theories that do not form part of the focus of this research. Race-based and indigenous movements are increasingly receiving attention, as a need to "endarken" or decolonise feminism to ensure that research can transform to gendered social justice for women. As research evolves, other perspectives emerge; the feminist agenda is diverse and dynamic, and as new

perspectives are born, others fade or disappear (Denzin & Lincoln, 2018:264). The dynamic nature of feminism means that the theory can be used to suit the perspective and context of specific research issue that is embedded in gender inequality.

3.2.1.2 *Power/agency*

A cross-cutting issue in all feminist research is power. Foucault states that the foundations of thought are based on knowledge, power and the self (Kritzman, 1988:xxiv). Power is not a substance, but is based on relationships in which one person can determine another persons' conduct. The relations are not based on exchange, communication or production, but in power, some of the elements of relationships can be found. The relations do not involve instrumental violence, and are more subtle, with a sense of perceived rationality. Foucault states that any protest against power is not only based on blaming or critiquing the institution, but rather questioning the rationality at stake (Kritzman, 1988:83, 84). Agency is lost when the voices of women are excluded, silenced and marginalised. Domination of relations by men should not be the only association with agency; instead, agency should be viewed as an opportunity for women to reclaim the relation (Charrad, 2010:517, 518).

Another component of agency or power and the self, which is a confirmation of Foucault's concepts around power, is suggested by Mackenzie (2019). She describes autonomy as a capacity and a status with multiple dimensions. Firstly, self-determination implies the absence of interference and freedom from domination and subjection to arbitrary power or interference. The second element is self-autonomy, which represents the ability to make choices and act on them in line with one's identity, values and commitments. Self-autonomy implies not only authenticity to one's values, but also the competence to carry out the actions. Lastly, self-authorisation is the ability to set the direction for one's life, and implies ownership and accountability to oneself and others. These abilities are often found in the capacity for reflexivity and appropriate levels of self-respect and self-esteem (Mackenzie, 2019:148, 149).

In addition to the relationships and autonomy of power, it is essential to note that power is vested in religious, ideological, or political systems. In feminism, power is often regarded as patriarchal, where even the most disenfranchised man is likely to have more power than women (Pilcher & Whelehan, 2017:114). An androcentric philosophy

leads to practices that perpetuates oppression of women (Brisolara *et al.*, 2014:4). The power of men is evident in the issue of toxic gender constructions, such as gender-based violence. Men dominate the statistics of perpetrators of gender-based violence and benefit from unequal gender structures, because the gatekeepers of social-political institutions are men (Mwatsiya, 2019:1). After all, men blame women for dressing inappropriately or being in the wrong places, thereby instigating acts of rape or abuse.

Although concerns of power imbalances between men and women are well described on a global level, the power balance between men and women is unique in Africa.

3.2.1.3 *African men and women*

The impact of colonisation on Africa was that it changed the traditional ways in which societies worked. Mwatsiya (2019), a South African author writing from a social work perspective, explains that, after colonisation, the traditional masculinity markers, which were cattle and land, were replaced with Western ideologies, such as economic and political agendas. Colonisation led to the creation of more violent ways of attainment of masculinity for men in Africa, which is now often characterised by a hegemonic masculinity that is dominant in nature (Adamson, 2017:28; Mwatsiya, 2019:1).

Mwatsiya (2019:1, 7) continues that the African way of defining power differs from Western contexts. Motherhood, which, in many African cultures, is seen as a compelling position, is presented as an example. In contrast, Western feminism often views motherhood as a position of subordination and loss of agency. In considering the issues of feminism in Africa, it is, therefore, crucial to understand that the reality for African women might be different (Mwatsiya, 2019:1, 7).

Furthermore, Mwatsiya (2019) postulates that women in African culture are often treated differently from men and women in other cultures. Men have more power and privilege and less accountability and responsibility. Women are still perceived to be weaker, vulnerable, and less suited for the workplace. They carry a more substantial responsibility for household work and have less sexual agency. Nonconformity to sexual gender norms that are based on cultural or religious bias creates conflict for some women. Often, non-conforming women are dealt with in very violent ways (Mwatsiya, 2019:7,8).

Despite a liberal constitution, cultural, societal and religious influences and patriarchal institutions are still evident in many levels of South African society. When reflecting on Foucault's construction of the foundations of thought that are based on knowledge, power and the self, and based on power that rests on relations between individuals, (Kritzman, 1988:83), it is clear that there is still inequity in South Africa. Moreover, patriarchy influences midwifery and midwifery education.

3.2.2 Feminism in midwifery

The impact of gender inequality in midwifery is clear. Renfrew *et al.* (2019) link the delayed progress regarding improving maternal health issues at a global level with gender inequality, which disempowers midwives and women. Patriarchal structures create barriers that influence the profession of midwifery and exacerbate sociocultural and economic disparities (Renfrew *et al.*, 2019:396).

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 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" (ICM, 2017:1).

If the disempowering inequality in midwifery is considered against the backdrop of the reality in South Africa, the question that arises is whether the lack of autonomy that midwives face can be the result of gender inequality. The majority of midwives are female (see numbers in Section 1.2), and they care for women. Considering that the continuum of pregnancy and birth is positioned at a vulnerable time for the childbearing family, the question arises whether this vulnerability perpetuates power imbalances.

The status and development of midwifery and midwifery education are influenced by the gender-specific nature of the discipline, which is embedded in disrespect for women's and human rights. UHC and reproductive health issues, which are founded on human rights (see Section 1.1.3), are underpinned by elements such as gender inequality. Even in a country with a constitution that supports equality, gender is still an organising principle that shapes the conditions of the lives of South African women and midwives. Effective measures to change systemic barriers, among which the low status of women and midwives, are crucial for strengthening midwifery care (Ten Hoop-Bender *et al.*, 2014:2).

3.2.3 Reflexive stance: Role of feminism in this research

Considering the general premises of feminism and its application in this transformative paradigm, it is essential to explore the fundamental principles of feminist research.

Concepts identified by Brisolara *et al.* (2014) clarify the nature of knowledge. In the first place, knowledge is contextual. Time and place and sociocultural context influence the data knowledge that is gathered, which is filtered through the knower (researcher). Historical identities and realities of the researcher and participants are interpreted and can influence the knowledge that is captured in a specific context. The importance of personal stance, positionality and reflexivity, as discussed in Section 4.2, is significant (Brisolara *et al.*, 2014:23–25).

The second concept relating to the nature of knowledge is that it is a resource that should serve a purpose. Research participants are the primary owners of knowledge and should be able to influence the utilisation of the knowledge. The ethical responsibility to share the possible utilisation of the knowledge, that is constructed, should be stated clearly. Dissemination of the knowledge should be mindful of the relationships that form the foundations of power and knowledge. Thirdly, evaluation is seen as a political activity that is influenced by relationships of power. Methods chosen in inquiry can be influenced by bias in relation to race, age, gender and social class. The fourth principle confirms that research methodology, practice and research institutions are social constructs that are influenced by ideology, culture, time and academic traditions. Patriarchy, in particular, is considered as influence in quantitative

research. Lastly, a feminist research principle confirms that there are multiple ways of knowing – intuition and emotions are embraced (Brisolara *et al.*, 2014:24–27).

If feminist principles are compared to the principles of AI as depicted in Table 3.3, the ability of inquiry to bring about change resonates with the power of knowledge. AI principles also tie in with the third principle, which sees evaluation as a political activity, and which acknowledges the possibility of change that is linked to the inquiry process of AI. Furthermore, the principle that the chosen methodologies are social constructs and can, as such, be influenced by androgenic perspectives, is real. Feminist researchers should respect that the principle that multiple ways of knowing exist, and should embrace more ways of accepting information. Sound methodological choice in research can enable a researcher to incorporate emotion and intuition to provide richer knowledge for the inquiry. The reality of gender inequalities reflect society at large and cuts across race, class and culture. Discrimination is often structural and systemic and requires action from the researcher (Brisolara *et al.*, 2014:26–30; Jensen *et al.*, 2001:154; Weber *et al.*, 2019:2455; Yuill, 2012:39).

The identified inequity of gender (Creswell & Plano Clark, 2011:99) as central component shaping consciousness, which is the fundamental departure of feminist research and the focus that this lens brings, questions several issues in midwifery and midwifery education, including the competencies of the midwifery educators. The following questions that frame gender inequity in research and its application in this research confirm the applicability of feminism for this study.

- Does the unequal social position of women create invisibility and distort issues affecting women? In this research, the clear, unmet need for maternal and reproductive health and the lack of autonomy of the midwifery profession can influence midwifery education and the competencies of educators directly.
- How can collaborative and non-exploitative relationships be created to transform, in this case, midwifery education and educators' competencies?
- How can the transformative agenda protect indigenous knowledge and intersectionality? Inequalities in South Africa's dispensation should be considered in relation to MECs.

- How does the social devaluation and powerlessness of women, as caregivers and as care recipients, influence the agency and autonomy of midwifery educators?
- How does gender as a social construct determine the power relationships that affect social position, also for midwifery educators (Creswell, 2013:25–27; Creswell & Plano Clark, 2011:99)?

Safe, effective, and respectful care can take place if the transformation to broaden the meaning of health, to ensure the improvement of the social, economic, and political determinants of healthcare, is achieved. One determinant in midwifery is the role of women, both as receivers and givers of care (Ceschia & Horton, 2016:2065).

For this research, it was essential to acknowledge that my personal support for feminism cannot not be separated from my cultural background. As a white, Christian, South African, middle-aged woman, I grew up in a sociocultural environment that was influenced by religion, and at a time when the political regime moved from apartheid to full democracy. My personal experiences as a widowed single mother of patriarchal systems in a heteronormative society, while practicing, first, as a midwife, and then midwife educator, shaped my perspectives on how women and, specifically, midwife educators are viewed. Reflexivity will be discussed in Section 4.2. Despite being active in association leadership for many years, and gaining national and international exposure, the inability to address crucial issues in midwifery and midwifery education confirms my own experience of patriarchal systems that reduce agency for midwives and midwifery educators.

3.3 THEORETICAL GROUNDING OF APPRECIATIVE INQUIRY

The centrality of gender issues in midwifery directed the research towards empowering, rather than disempowering midwifery educators. In AI, midwifery educators are respected as co-constructors of their destiny, and within the grand theory of feminism, allows the principles discussed in Section 3.2.3. The approach of AI, that is, to appreciate what works well and to focus on the positive core of human systems, creates an orientation that leads to more innovation and creativity for solving problems, and the participation in and contribution of the group to sustainable and

deeper change processes (Barrett & Fry, 2008:17; Gergen & Gergen, 2008:58; Thatchenkery *et al.*, 2010:1). The respect as co-constructors of the transformative framework links well with giving a voice people who are disempowered by systems, as a primary transformative impetus.

Social constructionism is the theory that lies at the foundation of AI. It postulates that a social system creates or determines its reality (Cooperrider *et al.*, 2008:438; Gergen & Gergen, 2008:8). Creswell (2009:234) distinguishes between social constructionism and social constructivism. In social constructivism, individuals develop subjective meanings (originating from hermeneutics) of experiences in a quest to understand the world in which they live (Creswell, 2009:234; Mertens, 2015a:16). Authors, such as Denzin and Lincoln (2018), however, do not distinguish between the concepts in theory or as paradigms; instead, they see the dynamic development situated in researchers. They argue that social constructionist or constructivists have authenticity that is founded equally in many different paradigms. The impact of qualitative research on social issues through meaning-making by those around the phenomenon is key in social constructionism (Denzin & Lincoln, 2018:219, 220). AI generally refers to the concept of social constructionism.

In AI, the central premise, built on social constructionism, 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 reality (competent educators for the education to ensure the provision of quality midwifery care). Actions are not constrained by what we used to know and do; instead, as people speak together, listen to new insights and discuss new questions, new meaning is created together. Hence, co-creation is the basis of social constructionism. Our knowledge, views, insights, language and values are limited, but, in interaction with others, a new reality is created (Cooperrider *et al.*, 2008:14; Cousin, 2009:170; Gergen & Gergen, 2008:12). Social constructionism principles is founded on the idea that people control their destiny. Their vision of what they want to achieve control and guide the development of action steps to move towards a defined destiny (Cooperrider *et al.*, 2008:14; Cousin, 2009:171). It also encourages multiple methods and values, expanding forms of expression, and using other forms of media to capture new knowledge (Gergen & Gergen, 2008:72, 73). The theory of social constructionism

supports the process of inquiry of AI, and does not focus on what is considered to be factually correct, instead, on exploring the positive. The focus on what gives life through connection of the positive core can contribute to development and sustainable change (Gadow, 2019:49; Reed, 2007:40). The nine principles of AI that are foundational to the process are summarised in Table 3.2.

Table 3.2 Principles of AI

Constructivist principle	Confirms the process of construction that shapes thoughts and actions (closely related to the social constructionist theory)
Simultaneity	Implies that inquiry and change are simultaneous
Poetic principle or narrative principle	Confirms peoples' ability to author their worlds 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	Recognises that wholeness, co-creation and inter-connectedness of people reduce fragmentation and enhance cooperation
Enactment principle	Embodies our future by practising new behaviour
Free choice principle	Confirms that power is liberated if we choose how and what we contribute and increases self-knowledge
Awareness principle	Implies the ability to keep reflecting on our actions, words and relationships, reduces assumptions and increases general awareness

Sources: Compiled from Barrett *et al.*, 2008; Reed, 2007)

Although the grand theory of feminism is not directly linked to AI, many principles of feminist research resonate with the principles of AI. In AI, the recognition of strengths confirms the view of feminist research that women have agency and can make choices and resist oppression (Creswell, 2013:25–27). Both AI and feminist research place the solution in the hands of the affected group, in this case, South African midwifery educators. Figure 3.1 in Section 3.4 enlightens the linkages in the research.

AI assumes that, in every situation or group, something works. Appreciation of what works is vital in a profession that is often scrutinised for what is wrong. Maternal death

inquiries and similar processes focus on what went wrong. As these inquiries are common in midwifery practice, the negative focus should not be perpetuated in this research, which was focussed on transforming midwifery education. Focus becomes a reality (refer to principles of AI in Table 3.2), and the existence of multiple realities can be created in the moment. In AI, asking questions influences outcomes and the process to value differences in groups. The language and disposition of democratic discussion create reality with respect to intersectionality and marginalised groups (Reed, 2007:27, 28).

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 competency that can quantify competence (Sakraid, 2014:123).

- **Strengths-based:** In feminism, the constructs of powerlessness based on gender are addressed by recognising that all human systems, including midwifery educators, already have strengths (Barrett & Fry, 2008; Creswell, 2013). One of the central themes in the ICM Philosophy and Model of care is empowerment, which refers to respect for women and their capabilities, which links it to feminism (ICM, 2014c: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 imagine the possibilities of the element being appreciated (in this case, MEC) (Barrett & Fry, 2008:26). In the ICM Philosophy and Model of care, creating a new generation of competent midwives is placed in the hands of midwives and by extension, midwifery educators (ICM, 2014c:4).
- **Collaborative:** The focus on current successes and past strengths leads to the collective discovery of a new destiny (in this research, a transformative framework to enhance MEC) (Barrett & Fry, 2008:26). The collaborative nature of midwifery care is expressed by emphasising the partnership relationship between women, childbearing families, communities and other healthcare providers (ICM, 2014c:2, 3, 4). The partnership relationship is based on respect and preserving human rights, which lies at the core of feminism.

- **Inclusive:** Inclusivity creates the opportunity to hear everyone's voice, to co-discover, co-imagine and co-create their reality in order to improve it (Barrett & Fry, 2008:26). The partnership elements and respect for women implied in the ICM document and feminism also allude to inclusivity.
- **Generative:** The co-creative element places the solutions for improving current context (MEC) in the hands of midwifery educators themselves (Barrett & Fry, 2008:26).

The AI principles of incorporating strengths in a creative, artful way to generate and create, in a collaboration with everyone who should be included, a solution that might work were well suited to research into MEC, and finding ways to transform it in South Africa. The research process allowed the midwife educators to co-create the solutions, which respect their agency and autonomy.

3.4 THE UNIQUE CONTRIBUTION OF THIS RESEARCH BY COMBINING OF APPLICABLE THEORIES

As illustrated in Chapter 3, the importance of recognising the impact of gender inequality in the midwifery profession is evident. The principles of feminist research that are related to the nature of knowledge, and the nature of inquiry as tools to increase social justice, as described by Brisolara *et al.* (2014), links well with AI. In AI, which is grounded in social constructionism, finding a solution for a phenomenon is placed in the hands of those around it, in this case, midwifery educators. The principles of AI, as summarised in Table 3.3, link with the research principles of feminism on many levels. The principles of both feminist research and AI resonate with the ICM Philosophy and Model of Care. The ICM midwifery care model is based on partnership relationships. Empowering childbearing families and the profession, by creating the next generation of midwives, is the focus of midwifery education. In Figure 3.1, the links between the principles of AI and the elements of feminist research they resonate with, are presented. The core ICM documents, such as the ICM Philosophy and Model of Care, ICM Code of Ethics and Definitions of the Midwife and Midwifery, blend seamlessly into the stated principles.

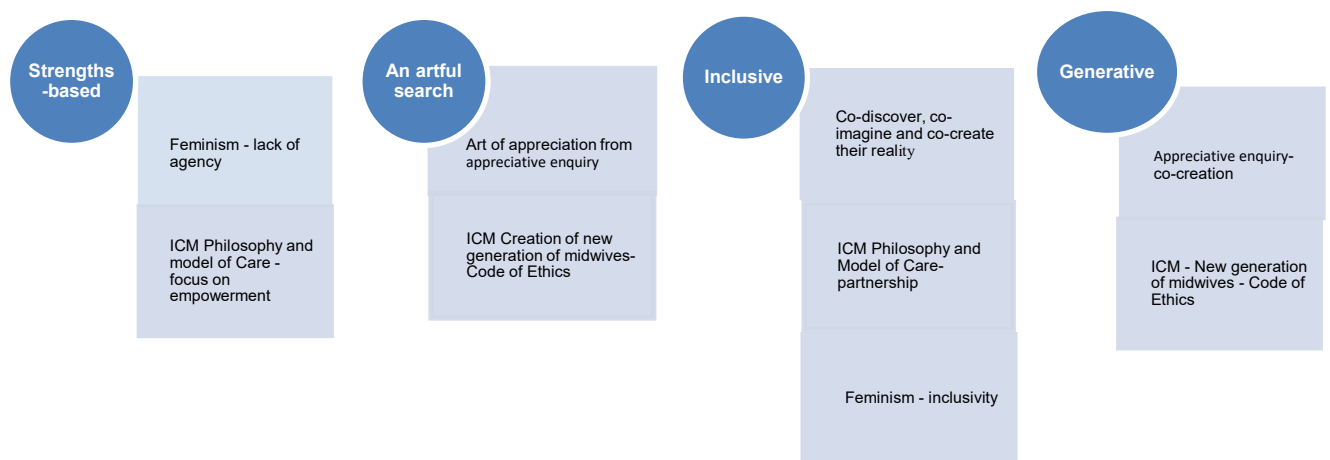


Figure 3.1 Linkages between feminism, Appreciative Inquiry and midwifery education

The way that core ICM documents blend into the principles of feminist research and link with the AI principles, flowed from the paradigm and application of theory. As depicted in Figure 3.1, the researcher matched the principles of AI with elements of feminist research and related them back to the ICM core documents. The synergy between the theoretical foundations, methods and defining documents of the profession shaped the research and contributes to providing a unique solution to the research problem. The significance of these linkages will be elaborated in Chapter 9.

3.5 CONCLUSION FROM PARADIGMATIC PERSPECTIVES

The importance of gender inequality in midwifery illuminates the need for the transformative paradigm in this research. Within feminism, the landscape of inequality and disempowerment, and the lack of agency of women as care recipients and in a female-dominated profession, motivates the need to empower midwifery educators, midwives and the women they serve, by confirming the requirement of respecting human rights. Respect for human rights intertwines with AI, which places the solution to research needs in the hands of the participants to co-create a new reality. The

interrelated theories of feminism, the principles of AI and the ICM Philosophy and Model of Care all are linked in the theoretical foundation of this research. Ways of applying research methodology to contribute to transformation and social change will be mapped out in Chapter 4.

Chapter 4

Research design and methodology



CHAPTER 4 RESEARCH DESIGN AND METHODOLOGY

"[A]s researchers, we have the potential to contribute to social change in a more conscious way if we view mixed methods as a tool for such change"

(Mertens, 2011:195).

4.1 INTRODUCTION

In considering the landscape of gender inequality and how women's lack of agency impacts on midwifery and midwifery education, as illuminated in Chapter 3, the linkages between AI and core midwifery documents within the theoretical foundations of the research will now be followed by an exposition of research methodology choices. The solution to co-creating transformation and social change in MEC was found in research methods that could be consciously mixed to address the priorities. A broad overview of methodological processes applied for the different phases of the research will be described and motivated. The research question that this research aimed to answer is,

How can midwifery educators' competencies best be strengthened to transform midwifery education in South Africa?

The sub-questions are:

- i. What are the appreciated competency strengths of South African midwifery educators?
- ii. What are the current self-rated midwifery educators' competency gaps of South African midwifery educators?
- iii. What midwifery educators' competency strengths should inform a refined transformative framework that addresses the midwifery educators' competency gaps in South African midwifery education?

The research report does not follow the traditional conventions for theses, with a complete chapter on research methodology, followed by another for data analysis. In this chapter, overarching components of the methodology will be presented and the different phases will be discussed as entire entities, with the interface as a separate chapter. (A visual representation of the distribution of content is captured in Figure 4.1.) The researcher believes that structuring the chapters in this unique order created an opportunity to express and report the research in a more authentic way. Mixed-method research is complex and the opportunity to express nuances that are unique to this study (Plano Clark & Ivankova, 2016:11) was realised by this structure.

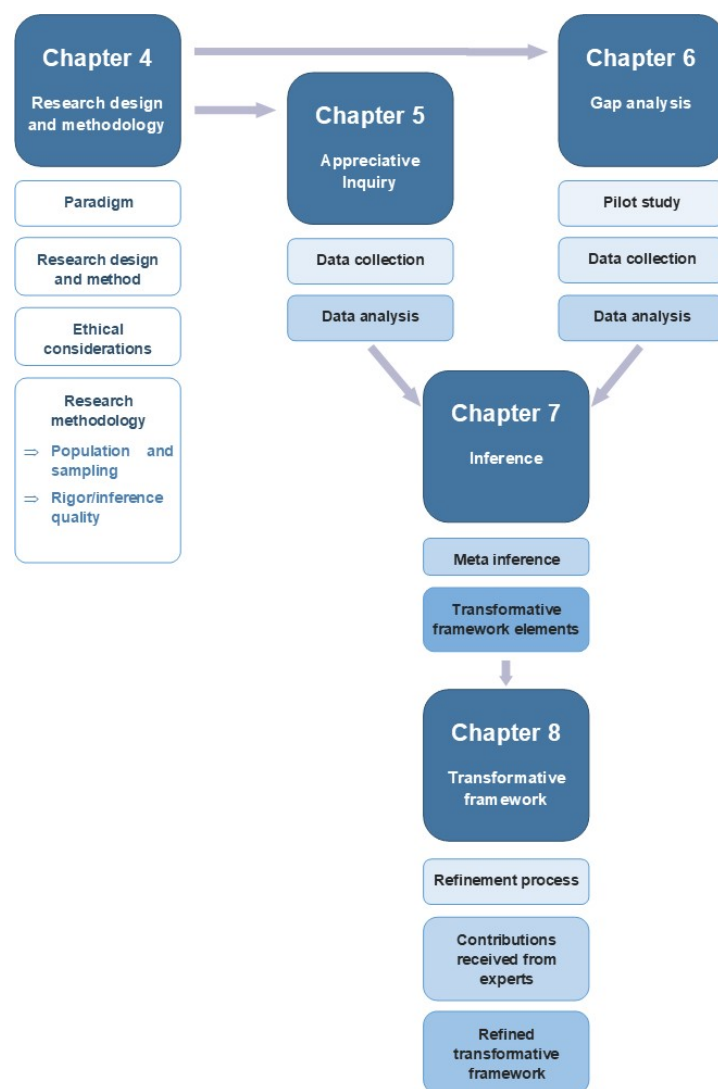


Figure 4.1 Ordering of methodological elements

The intention of the order and structure of the research report in the thesis is to honour the conceptualisation and execution of each phase of the research (Bergman, 2008:2). First and foremost, the research paradigm, as essential foundation of how the research was planned and conducted, will be explained. The rationale for the chosen research design and method will be presented. Flowing from and feeding back to the paradigm and the philosophical foundations of the research, the ethical considerations grounded the research methodology, and preceded the incorporation of rigour.

In Chapters 5 and 6, the research process, actual data collection and analysis of the respective data sets will be discussed. The inference will be presented in Chapter 7, with the final phase of the refinement being presented in Chapter 8, as indicated in Figure 4.1.

4.2 RESEARCH PARADIGM

The transformative paradigm, which grounded the research, and the way the landscape and context flowed from the paradigm was discussed in Section 1.6. My worldview encompasses axiology, ontology, epistemology, and methodology. Axiology captures ethical behaviour and includes elements such as aesthetics and religion. Within a transformative paradigm that seeks to address inequalities and power imbalances, cultural and societal norms are central to respecting human rights. Reciprocity was enhanced by the addition of qualitative research methods which also respected the agency of midwifery educators. In AI, appreciation is a central premise. The appreciation of what works in relation to MEC reciprocates the value of aesthetics, which refers to the appreciation of beauty. The beauty of what works, and gives life to MEC feeds back in the axiology of respect and ethics of the transformative paradigm (Denzin & Lincoln, 2018:229; Mertens, 2015:11, 2016:256; Savin-Baden & Howell Major, 2013:58; Watkins *et al.*, 2011:113).

The ontology or the nature of reality is traditionally on a continuum between realism and idealism. In the transformative paradigm, the nature of reality is considered to have many facets – these include socio-cultural time and place as considerations.

Conversely, realism as found in positivist thinking often views a unimodal reality, which is linked to patriarchal dominance. In this research the reality that midwifery educators are facing a specific power-imbalance based on gender is noted. Therefore, it was essential to account that the reality of midwifery educators within a woman-centred profession, and the agency they have could influence the reality they have (Brisolara *et al.*, 2014:23,24; Denzin & Lincoln, 2018:229; Mertens, 2015:11, 2016:256; Savin-Baden & Howell Major, 2013:58).

Epistemology reflects the nature of knowledge and implies a specific relationship between the knower and what would be known. In the transformative paradigm, power and trust are important, as power imbalances drive the need for transformation. In transformative work, knowledge is regarded as a resource and, therefore, clarity on purpose, as well as the intended use of knowledge should be explicit. In this research, an insider perspective influenced both the nature of knowledge and the relationship with participants. As I am a midwifery educator myself, that role shapes how I look at what is presented. I am involved in the profession and the area of maternal health on a national level, which could have contributed to the relationships and perceived power within the relationships (Denzin & Lincoln, 2018:229; Mertens, 2015:11, 2016:256; Savin-Baden & Howell Major, 2013:58).

Within the transformative paradigm, the methodology that flowed naturally had to give agency to the midwifery educators and respect their ability to co-create the needed solution. The paradigm motivated me to include qualitative components in the research. The gap analysis is a quantitative method that could be perceived as an interrogation of MEC. Because the ideological influence of patriarchy is often associated with quantitative methods, the two qualitative components were added to respect the voice of midwives and generate knowledge with the power to transform MEC. The intentions of the qualitative components were, therefore, to appreciate the current competencies and to refine the transformative framework through a Delphi process. To utilise the power of the knowledge created, and to facilitate transformation by the implementation of the research recommendations, vital stakeholders in maternal health were included in the Delphi process (Brisolara *et al.*, 2014:23,24; Denzin & Lincoln, 2018:229; Mertens, 2015:11, 2016:256; Savin-Baden & Howell Major, 2013:58).

Research, evaluation, and the knowledge created from the process are filtered through what Mertens (2015:23) describes as the knower. The values, or axiology, brought to and respected by the research and the researcher, and the language, or rhetoric, can influence the creation of knowledge, which makes self-reflection essential for the researcher (Maree *et al.*, 2012:53; Mertens, 2015:23). To provide clarity regarding my convictions, and my position and role in the research, and to explain in depth my understanding of how being and thinking influenced this research, I will share my stance (conviction), positionality and reflexivity.

4.2.1 Personal stance

The paradigm that guided the research and shaped the methodology and the findings also reflects the researcher's own frame of reference (Savin-Baden & Howell Major, 2013:71). In this research, I made choices that are congruent with my development and current position.

One of the factors that influenced my choices in the research, is that I am approaching 50 years of age. I was born and grew up in a rural environment in South Africa. I spent my childhood in the time of apartheid, while most of my adulthood was spent in the post-apartheid period. My upbringing was in a nuclear family with a present father and mother and a wide range of relatives. Both parents had university education, which created a climate that welcomed discussion of topics and valued scholarly work. We were raised in line with our parents' Christian faith, which I embraced and confirmed as my own at age 14.

My value system was shaped by embracing nature and the fundamental conviction of the Christian faith, that is, to love and serve the Lord and to show love in my relationship with all people. The choice to become a nurse was confirmed by prayer. As an undergraduate student in nursing (training that included midwifery), compassion and caring for people in need developed as a confirmation of the serving love that is part of my faith. From my first exposure to midwifery, I knew that this was my vocational calling within the profession. The awe of being the first person to touch what the Almighty Lord knitted together (Psalm 139) still touches me today. As a Christian midwife, I realised early in my career that families are prepared at birth, and the way I

can empower a woman can assist her to be the best mother possible to her newborn baby.

Furthermore, my values are based on a deep-rooted devotion as a Christian. The central message of love for the Almighty Lord of lords and creator of the universe, and for everyone He created, provides my moral compass. As a midwife, I view pregnancy, birth and parenthood through the lens of how the Lord created these processes. We understand so little about His work. I frame normality in childbirth within a process enabled by the Almighty Creator and, therefore, I believe I should only intervene if risks and complications arise.

This passion serves as not only a caring driving force, but also a protective one. In addition to progressing safe motherhood, the passion also extends to saving my profession in South Africa, which is captured as a way to serve the Lord, like the Hebrew midwives, Sifrah and Pua. My personal choices regarding childbirth were shaped by my profession, and inversely, my birth experiences also shaped my profession. My daughter was born in a hospital, as there were no other options available at the time, and my son was born by means of a water birth. These personal choices confirmed the normality of birth on a personal level. In addition, partnership and choices are essential components of midwifery care.

Moving to my reflexivity regarding midwifery education, I have been involved in midwifery education since 1995: first as preceptor, then as part-time theory lecturer and, since 2007, as a full-time midwifery educator at a university. The passion for my profession resonates with my value system and faith. Clinical competence as a midwife, with intrapartum care, high-risk maternal care and independent midwifery practice as focus areas, enabled me to shape students in clinical, and later, in formal education. The passion for sharing with new midwives the awe of birth, how it was created to empower a woman to be the mother of this baby, and respect for the process created by God, still energises my midwifery education.

In addition to my involvement in clinical and theoretical aspects of midwifery, I am actively involved in a professional association for midwives, of which I was a founder member in 2001. At that time I was active on a provincial level and, in 2004, I was elected to the national executive committee. I have served as secretary, vice president

and, currently, as president. The Society of Midwives of South Africa (SOMSA) is an association member of the ICM. Through my involvement in the association I was selected to undergo a leadership development programme offered by the ICM. Being highly exposed to the ICM, I saw the positive, and some negative, factors within the organisation. I have voiced that ICM has individuals at many levels who disregard and disrespect midwives in developing areas, especially Africa. Despite leadership traits, formal development and further engagement as a faculty member on a Sigma Theta Tau leadership programme, agency is still problematic for me. In the international community, we are treated differently because we are Africans.

Notwithstanding my abilities as an academic, my socio-political awareness, and my leadership role in the professional association, the systemic barriers within the institution where I work and the regulations of the profession often disempower and leave me without agency. The exposures and activities I have had, influenced my position in the field and shaped my position in this research.

4.2.2 Researcher positionality

As a midwifery educator, I am familiar with systems and situations that midwifery educators face on a daily basis. It has given me an insider view that influenced my choice of the topic of this study. My personal experiences and growth do not tolerate discrimination, disempowerment or lack of agency. The socio-political environment of midwifery educators is well known to me. Because of my involvement in the profession and my leadership roles and responsibilities, there was a possibility that participants in all three phases of data collection could know me. The fact that I am a midwifery educator is, on the one hand, an advantage, but also creates the possibility for bias, as I could interpret data to confirm my views on a conscious or subconscious level (Grove & Gray, 2019:251).

Two elements impacted on my relationship with participants. First, as a midwifery educator, I was an insider researcher and, second, my role in the professional association shaped my position. Being conscious of the elements that could impact on my relationships with the participants, I selected platforms for data collection that reduced the possible impact of my profile in the field. To mediate the issue I utilised

and created platforms to allow participants to voice their views without exposing their identity, thoughts and situations (Savin-Baden & Howell Major, 2013:71–73).

Although my initial contact with midwifery was via the nursing degree, my growth opportunities within the professional association provided clarity on the need for an autonomous profession for midwives. The lack of autonomy led me to understand how patriarchal systems and colonisation affects midwifery negatively. At the same time, I do cherish many male midwives, colleagues, as well as current and former students, whom I count as friends. Men working with and as midwives are generally sensitive to gender inequality. The influence of feminism in my thinking is, subsequently, balanced by respect for all individuals, and is driven by the need for agency and equality.

My personal stance and positionality influenced many aspects of the study. This consideration can strengthen reflexivity on how the researcher shapes research. The choices made in the research were indicated in Section 1.10.

4.2.3 Reflexivity

Reflection, as a primary re-thinking activity, has many levels. To learn or understand more, involves more than a non-conscious reflex in a given situation. Critical reflection, of which the highest level is critical self-reflection, leads to meta-reflection and reflexivity and the gaining of new insight (Zuber-Skerritt *et al.*, 2015:76). The difference between reflection and critical reflection accentuates what is needed to reach metacognition or reflexivity. Reflection can include reflective learning, while reflective practice is focussed on finding links, causes, and reasons for bringing about new appreciation of insights. Reflexivity, where critical self-evaluation is added, is valuable for promoting equality and social justice (Savin-Baden & Howell Major, 2013:76).

Critical reflection is a personal and focussed activity that involves reviewing yourself and investigating your beliefs about "us" and "them". Critical reflection analyses power, control, and the influence of power relations. This focus enables greater emancipation (Zuber-Skerritt *et al.*, 2015:79–81).

In research, the continuous reflection that, over time, increasing insights, can lead to transitions in views. Reflexivity allows the researcher to consider methodological choices founded in the theoretical perspectives and context of the field. Reflexivity

contributes to social learning, action and social transformation (Popa & Guillermin, 2017:22; Savin-Baden & Howell Major, 2013:75–77). It was important to appreciate differences and similarities and to critically reflect on the power relations in midwifery education. The influence of my stance and position shaped paradigmatic elements, such as how I "know" the world as a midwifery educator. It also shaped my relationship with midwife educators and other participants in the research and, therefore, the methodology was tailored to mitigate the fact that participants could know me in certain capacities.

Axiology elements, such as my values and faith, shaped how I listened to participants and allowed every voice to be heard. The aesthetics of appreciating beauty led me to methodological options and the choice of AI (Denzin & Lincoln, 2018:247; Savin-Baden & Howell Major, 2013:76, 77).

Having chosen a topic close to my heart and world, methodological choices were made to limit my involvement to that of researcher only. The theoretical perspectives that shaped the research are rooted in part of myself and my lived experiences as a woman and midwife. Fundamentally, I know that women were created as exceptional beings. The disregard that systems often place on gender, even calling women the weaker gender, disrupts how I see and experience womanhood. Birth itself shows the abilities and power all women have. Difficulties I had to navigate at a personal level also showed me that women are indeed stronger than what society in general might declare. Reflexivity is an ongoing process and, on conclusion of this research, and in my journey onward.

4.2.4 Metacognition of paradigm, the role of the researcher, and context

The paradigm, personal value and development, my positionality and ability to continue being reflexive, shaped the research process and products. Considering that metacognition should be guided by literature, the socio-ecological conceptual framework by Plano Clark and Ivankova (2016:15) was adapted for this study. The framework indicates the different elements to be considered in the dynamic synergy between individual and contextual factors (refer to Figure 4.2).

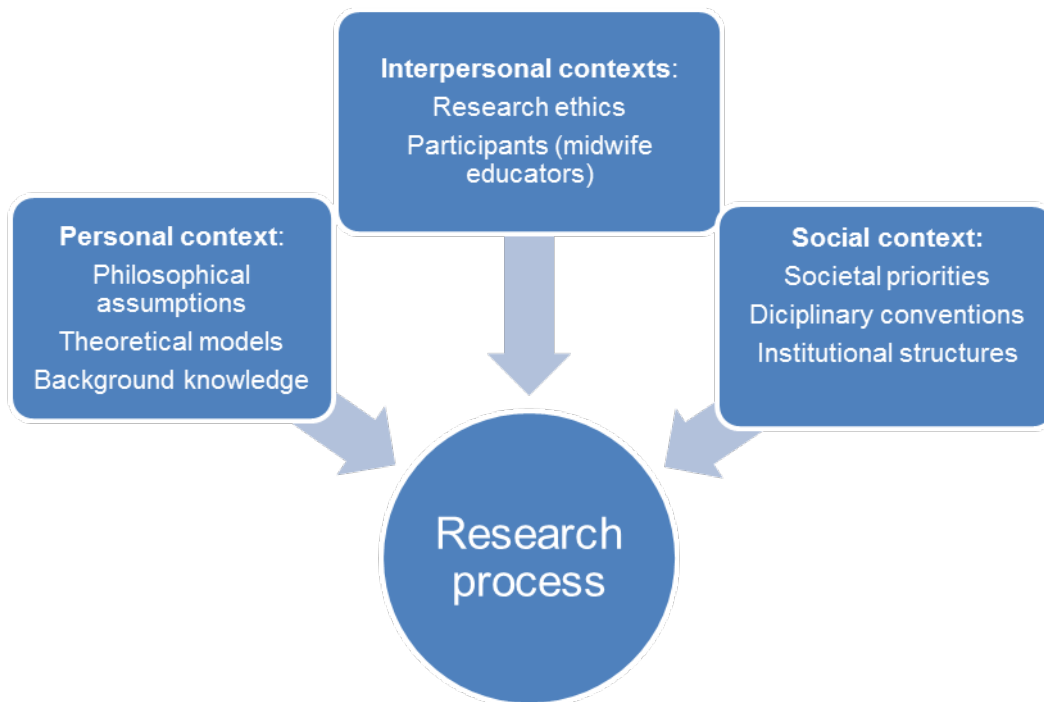


Figure 4.2 Socio-ecological framework of paradigmatic elements

Adapted from Plano Clark and Ivankova (2016:15).

The ability of the knower to optimally balance the personal, interpersonal and social contexts of the midwifery educators, as well as her own, within the current structures and conventions, was supported by the choice of processes applied in this research.

Personal context refers to the philosophical assumptions of the paradigm and subsequent choice of theories. Background knowledge of a lifetime contributes to how research is shaped (Plano Clark & Ivankova, 2016). For me, the importance of advancing the midwifery profession was driven by my development, values and passion.

In this study, the roots of the profession in feminism, and how it affects the profession, were explored. The backdrop of a disempowered profession – the disempowerment caused by a lack of agency – dictated the need for transformation. On the other hand, social constructionism, according to which midwifery educators are regarded as co-constructors of the transformative framework, and the strengths that maintain midwifery education, are identified and appreciated in the transformative framework.

Interpersonal context encompasses ethical issues and the researcher's relationships with participants, which, in this research, included midwifery educators and selected stakeholders in midwifery education and maternal health. The positionality and role of the researcher shaped decisions, thereby mitigating possible adverse effects on interpersonal relationships (Plano Clark & Ivankova, 2016). An often daunting, but necessary, process of obtaining gatekeeper permission and access to the individual participants complicated the entire research process. Unless the ethical boundaries were respected, the interpersonal, and disciplinary, context could have been harmed. Ethics will be expanded on in Section 4.4.

Social context recognises that research happens against the backdrop of institutional policies, disciplinary conventions and social context, including national values (Plano Clark & Ivankova, 2016). Quality maternal health, with a global focus of normalising birth and respectful care, are important considerations at this stage. In addition, the international midwifery community increasingly objects to gender inequality, with its negative impact on midwifery, as well as the conflation of nursing and midwifery.

Given the complexities of the personal, interpersonal and social contexts and their impact on the research question, the research design had to integrate all the diverse methods determined by the context (Plano Clark, 2019a:4).

For giving coherence to research, Trafford and Leshem (2008:85) advocate ensuring "the practical relevance" of conceptual frameworks. In this research, the socio-ecological conceptual framework acted as a signpost, to ensure that data collection and analysis were congruent with the personal, interpersonal and social contexts of the study.

4.3 RESEARCH DESIGN AND METHOD

A transformative concurrent mixed-method research design was chosen to co-construct the transformation of MEC. In Section 1.10, more detail was provided about the choices that were made. The integration of qualitative and quantitative methods of data gathering and analysis allowed and required the context-specific elements of the personal, interpersonal and social context of the researcher (Plano Clark & Ivankova,

2016:5). The transformative paradigm (as indicated in Section 1.6) allowed the complexities of the human rights and, in this case, the lack of agency of the women focussed profession to be captured (Creswell & Creswell, 2018:39; Mertens, 2015a:21). Mixed-method research promotes the ability to address the research question, and ensures that the design, implementation and combination of methods is creative, logical and leads to defensible conclusions (Plano Clark, 2019a:5). By working within a transformative paradigm, decision-making in mixed-method research is based on how these methods contribute to strengthening human rights and social justice. In this study, issues around a disempowered midwifery profession were the focus (Creswell, 2014:571; Mertens, 2016:256).

The data were systematically integrated in a transformative concurrent design, in which the quantitative and qualitative components had equal priority (Creswell, 2014:570; Creswell & Creswell, 2018:42; Plano Clark & Ivankova, 2016:114). The appreciated strengths, constructed within the qualitative strand, and the gaps that were identified shaped and informed the transformative framework. The integration of both sets of data, against the backdrop of the autonomy of the profession, ensured that the transformative framework could address the MEC comprehensively, and maintain respect for participants.

Creswell (2014:570) and Creswell and Plano Clark (2011:74) identify the following four critical decisions relating to selecting the appropriate mixed-method design. Elements that need consideration are the level of interaction, priority, timing, and interface of the different components. If the mixing of the strands is not adequately planned and executed, the research is a mere multimethod, as one of the strengths of mixed-method research is the interface of data and interpretation integration. The selections in this research are summarised in Table 4.1.

Table 4.1 Selection of mixed-method design

Element	Description	Application in the study	Final selection
Level of interaction	Interaction between the strands at the level of the research question, data collection and data analysis	Two strands mixed without direct interaction	Convergent
Priority	The strand with more emphasis	Both strands were equally important, as the AI and the gap analysis informed the transformative framework	Addressing the identified competencies was a crucial element of framework development. The co-creation in the AI was a critical emancipatory element
Timing	Time of data collection and the order in which the results would be incorporated	Two strands ran separately to confirm priority	Sequential
Mixing of strands	Combining and integrating the data from the two strands: <u>determined by the following:</u> <u>Point of interface</u> refers to the stage of integration. <u>Mixing strategies</u> involve merging the two data sets, connecting one data set to the next data set	Design, data collection, data analysis or interpretation	In this study, the interpretation was the point of interface. The entire process was based on the grand theory of feminism, to emancipate educators

Adapted from Creswell (2014:570); Creswell and Plano Clark (2011:74).

The analysed data of the AI and gap analysis converged in an interface. The gap analysis and AI had equal priority and ran separately. Interpretation of the two primary sets of data, which will be discussed in Chapter 7, created the interface for mixing the strands.

In summary, the transformative concurrent design was chosen to answer the research question in a way that was consistent with the paradigm and theoretical underpinnings.

Ethical considerations shaped the research processes and how they were conducted. The rest of the methodology was shaped by the ethical considerations.

4.4 ETHICAL CONSIDERATIONS

The transformative need and nature of the research were based on a power imbalance, which implies that ethical considerations were at the core of every step of the research. Furthermore, human rights are central to both feminism and social constructionism. According to the core ICM documents, as explained in Section 1.11, the profession, including research, is grounded on a Code of Ethics and the Philosophy and Model of Care (ICM, 2014b:2, , 2014c:2,3). As co-creators of the solution, the participants were able to address the research phenomenon is a central premise of AI. The ethical considerations, as discussed in Section 1.11 shaped every step and process of the research. Figure 4.3 indicates how the efficacy of a design promotes excellent treatment of midwife educators and other participants through a transparent process. Consequently, the processes and methods chosen provide products of the research. In addition, the credibility and use of the products of the research are bound by the ethical approach.

Consideration of ethical research, as framed by Savin-Baden and Howell-Major (2013:332), means an effective design will ensure that the treatment of research participants is excellent. A transparent process will enhance the final step, which is to ensure the plausibility and credibility of the products of the research. These considerations are illustrated in Figure 4.3.

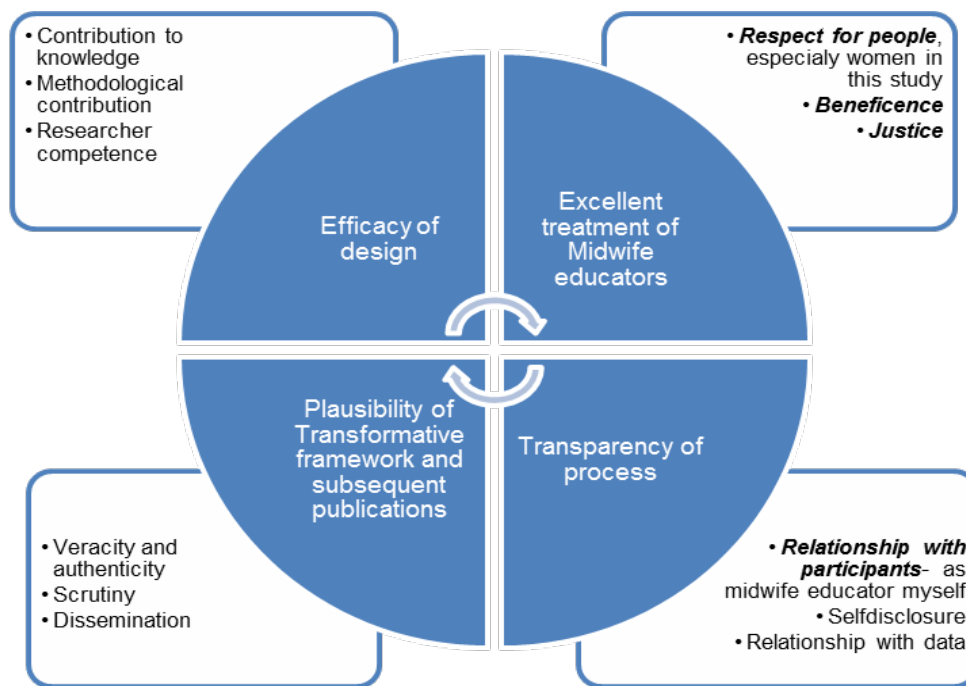


Figure 4.3 Ethical considerations applied in the research

Adapted from Savin-Baden and Howell Major (2013:332).

The discussion that will follow the way these elements were respected and implemented in this research further.

4.4.1 Efficacy of design

This study was sensitive towards women and midwifery educators, as members of oppressed/marginalised groups, while envisioning to address a real and serious problem concerning midwifery education. Therefore, the focus was not only on the gap analysis of MEC in South Africa, but appreciated the strengths of midwifery educators and worked with them to develop a transformative framework to address MEC gaps.

The study **contributed to knowledge**, as the transformative framework was co-created by midwife educators and refined by experts, thereby enhancing the ability of the framework to facilitate change in midwife educators. Feminism, as grand theory, enhanced sensitivity to the inequalities that might exist within systems and structures. With a precise aim and objectives, as stated in Section 1.5, this research contributed to knowledge (Savin-Baden & Howell Major, 2013:333).

Effective design of the research provided a **methodological basis** that provided reasons for using certain methods. Choices were clear and defensible. As it was unlikely that the research question could be answered by using only one method, the bigger picture of MEC was explored by using both the AI and the WHO Midwifery Educator Core Competency Gap Analysis Tool. The ability to have the midwifery educators co-creating the transformative framework, based on what works, ensured that the design respected midwifery educators (Savin-Baden & Howell Major, 2013:333).

Researcher competence in the chosen methods and the ability to complete the research was crucial in ensuring that the research remained ethical (Savin-Baden & Howell Major, 2013:333). In this regard, the ability and position of the researcher were established through formal education. Moreover, long-standing involvement in the profession at national and international levels ensured sensitivity and insight in midwifery education and practice. The supervisor guided all steps of the study, and she possesses significant research competence.

4.4.2 Excellent treatment of midwifery educators and participants

In a quest to enhance the integrity of the research process, many approaches emerged. The most dominant is a principle-based approach, which is guided by adherence to ethical rules, duties and responsibilities linked to the approach. The Nuremberg Code (1949) was the first guideline for research with humans, and contained basic directives. The Helsinki Declaration expanded on the code, by listing 35 ethical principles to protect humans in medical research. Thereafter, the Belmont Report (1979) focussed on three principles, and the Singapore Statement on Research Integrity (2010) identified four principles and 14 responsibilities that should guide ethical conduct in research across disciplines (Polit & Beck, 2017:139; Resnik, 2012:329).

MacFarlane (2008; 2010) criticises principle-based approaches for failing to guide ethical decision-making, and proposes a virtue-based approach that fosters moral development. The virtue-based approach finds its origins in Greek philosophy and the work of Aristotle, which valued the development of good character traits, instead of focussing on compliance with rules and principles. Resnik (2012) elaborates on the

work of Aristotle, which explores happiness in humans and linked it to excelling in performing functions, rather than fulfilling desires. Human functions that contribute to satisfaction are rooted in rational thought and action, which qualify human behaviour (Resnik, 2012:332, 333). Virtue ethics also revolves around a positive view of human nature, recognising excellence in others and navigating to them as role models, and finding fulfilment in living virtuously (Morris & Morris, 2016:202, 203). Virtues, according to Aristotle, are found in humans on a continuum, from excess to deficiency, and are practiced and imitated until they are developed and achieved (Morris & Morris, 2016:203; Resnik, 2012:334). Savin-Baden and Howell Major (2016:333) identify striving for excellence as an important element of ethics. Reaching excellence suggests that basic standards will not satisfy, instead, there is a striving to be unusually good (Savin-Baden & Howell Major, 2013:333).

There are two options for constructing research ethics; the one option is to replace the principle-based approach with a virtue-based approach. The augmentation approach, where the principles are enriched by virtues (Resnik, 2012:334), aligns better with the paradigm and philosophies framing this research. There is choice implied in choosing the augmentation approach by the researcher, to reach for excellence, and also by participants, who make choices about their involvement and contribution, to reach excellence in MEC.

MacFarlane (2008) identifies scientific virtues, and these, as well as traits identified by Resnik, are tabulated in Table 4.2, to expand the virtues and the traits or behavioural components that can be linked to it.

Table 4.2 Virtues and traits in virtue-based ethics

MacFarlane virtues	Explanation	Resnik traits	Explanation
Courage	Having the resolution to stand up for your beliefs, despite potential personal implications or cost	Integrity	Acting in accordance with values, avoiding hypocrisy
Respectfulness	Treating all people with respect	Fairness	Treating people fairly
		Resourcefulness	Using and finding new resources effectively
Resoluteness	Staying committed to the work, despite difficulties, if reasonable to continue	Conscientiousness	Being meticulous in work and research
Sincerity	Being truthful and honest	Openness	Sharing resources and knowledge, when appropriate
Humility	Giving due cognisance to your strengths and weaknesses		
Reflexivity	Being critical and understanding bias in your own life and work		
		Flexibility	Being adaptive and changing plans when necessary

Sources: MacFarlane (2010:24–25); Resnik (2012:334).

The virtues and traits summarised in Table 4.2, make it clear that ethical comportment and how research participants are treated involve much more than compliance with institutional review. The value of institutional review is ensuring that all research at a given university complies with the requirements of ethical comportment. Table 4.3 gives a summary of ethical principles and their corresponding rights, and the matching virtues and traits, with an explanation of how the rights, virtues and traits were applied in this research.

Table 4.3 Ethical principles and application in research

Ethical principle	Rights	Virtues	Traits	Application in this research
Beneficence	Right to freedom from harm and discomfort	Sincerity	Fairness	Confirmed by ethical review process and AI evaluation of process by expert and supervisor
	Right to protection from exploitation	Reflexivity	Fairness	
Respect for human dignity	Right to self-determination	Respectfulness Humility	Integrity	Informed consent, with information and right to withdraw
	Right to full disclosure		Openness	
Justice	Right to fair treatment	Courage	Integrity Fairness	Compliance with requirements for institutional review, no incentives, and data protection
	Right to privacy		Integrity	

Sources: Polit and Beck (2017:139–142); Resnik (2012:334).

In this study, human rights that are captured in the ethical principles and rights were protected by obtaining informed consent from all participants. All three research components, had information provided in written format. Participants had the opportunity to clarify information to ensure that they understood the aim, objectives and process, and they could choose to continue or withdraw at any time (Brink *et al.*, 2018:32). The purpose of the informed consent was to state the risks and benefits and ensure that the groups are protected (Savin-Baden & Howell Major, 2013:323). An opening clause was placed on Evasys® to provide participants with full information on the self-rating questionnaire. Their completion of the questionnaire served as implied consent (Polit & Beck, 2017:146). Adhering to the virtues and traits, thereby allowing and respecting these processes, are key to ensuring excellent treatment of research participants. The potential risk and benefits should be considered, so that the researcher can move towards kindness and clarity (Brink *et al.*, 2018:35; Savin-Baden & Howell Major, 2013:334). Approval was obtained from the Health Sciences

Research Ethics Committee of the UFS, on condition of adherence to national standards, to ensure compliance. The principles of AI, as discussed in Table 3.2, ensured kindness, clarity and drawing on positive psychology of the group that was part of the AI.

Justice was ensured by treating everyone as equals. No incentives were given. Similar to the delegates of the congress, the participants received meals and refreshments during the AI session.

The required permission process was followed for the AI and gap analysis. The individual participants in the Delphi process International Confederation of Midwives. 2011b. International Definition of the Midwife. https://www.internationalmidwives.org/assets/files/definitions-files/2018/06/eng-definition_of_the_midwife-2017.pdf Date of access: 24 July 2020 provided individual consent as experts.

The **AI participants** all signed an informed consent document after receiving and allowing time to read the information document. (Refer to Annexure D.) Institutional permission for the **gap analysis** was obtained to include the midwife educators in service of the Department of Health. Provincial gatekeepers, as stipulated per province and facility were contacted. At the UFS, the dean of the Faculty of Health Sciences, vice rector: Academic, provided permission for UFS staff to take part in the pilot study. Implied consent was obtained by individual participants' completion of the questionnaire form. Permission was granted by FUNDISA to contact educators at universities; for which FUNDISA provided a contact list. At each data collection event, participants received information about all the phases of the research and specific detail on the phase they were involved in. Information regarding the right to withdraw from the research was given. Refer to Annexure D for more detail.

4.4.3 Transparency of the process

The researcher's **relationship with participants**, based on **self-disclosure**, is an essential element of ensuring transparency (Savin-Baden & Howell Major, 2013:335). The Scientific Committee for the congress was comprised of members of the provincial organising committee and selected national executive committee members. Their role included the blind peer review of submitted abstracts and drafting of a preliminary

programme for the congress. Both the committee and AI participants were made aware of the fact that I am a midwifery educator who is also serving in a vital position of the professional association. Approval for the AI session at the congress was granted through a blind peer-review process, of which I was not part. (Refer to Section 4.5.2 for an elaborated discussion.) In addition, the AI session was facilitated by an external expert, to decrease the risk of bias. Congress delegates were given the option to attend the session as one of many concurrent sessions and hence no participants were coerced to attend the session. The plenary hall and two larger rooms had other sessions continuing at the same time.

The **relationship with data** refers to ownership and clarity regarding the subsequent use of data, and remaining critical of how the researcher's philosophical stance might have influenced the analysis of data (Savin-Baden & Howell Major, 2013:335). Permission to use the questionnaire was given by Dr Thompson in person. The researcher considered her role as a woman and someone who is passionate about midwifery. She is involved in the professional association for midwifery at national and international levels and works in an official capacity to strengthen the profession and promote autonomy in the profession. Balance was brought by the fact that the supervisor is not part of these structures, and her involvement ensured that possible bias was addressed. The traits and virtues, as summarised in Tables 4.2 and 4.3, guided the researcher's relationships with participants and the way the data were collected, analysed and respected.

4.4.4 Plausibility of the transformative framework and subsequent publications

The development and sharing of research products should proceed in an ethical fashion. Application of the three considerations identified by Savin-Baden and Howell Major (2013:335, 336) enhanced the plausibility in this research:

Veracity and authenticity – The transformative framework is an authentic and genuine product, co-created by participants in the AI, interfaced by the gap analysis data, triangulated with literature, and then refined by experts in the Delphi process. The links with the traits and virtues are listed in Table 4.2.

Scrutiny and accountability – Feedback to the HSREC review committee ensured accountability. In addition, scrutiny by peer review, in this case, through the Delphi

process, enhanced the ethical quality of the transformative framework. As indicated in Table 4.2, the biggest drivers of the application of ethical principles are the traits and virtues of the researcher. The level of virtues is related to the level of ethical comportment found in the processes (Morris & Morris, 2016:203; Resnik, 2012:333).

Dissemination – The research succeeded in contributing to the body of knowledge. Components of the research were shared with the professional community in research presentations. This transformative framework, as well as the methodological applications and processes, can be shared in articles and presentations to national and international audiences in midwifery and AI.

4.5 RESEARCH METHODOLOGY

An AI, as a qualitative research method, suited the paradigm and philosophical foundation of the research. (Refer to the discussion of the different phases in Section 1.10 and the summary in Table 1.2). AI is a solution-oriented option which combines an exploration of empirical facts with envisaging ability, to co-create a solution based on strengths (Cousin, 2009:167). The origins of AI was in organisational development, however, due to its evolution, it can be regarded as a methodologically fluid process that can leverage perceived strengths, and to integrate them into the change needed. It is a principle-based intervention that is focussed on using stories and dialogue to construct a new reality (Watkins *et al.*, 2011:32, 33). In this research, a so-called 5D process was chosen – each step was discussed as it happened during the session. In Section 5.2, the logistical arrangements and the data collection during the AI will be elaborated.

Chapter 6 will report on the gap analysis, that is, the self-evaluation of midwifery educators on an electronic questionnaire developed by the consultants that worked on the WHO competencies for midwifery educators. Refer to Section 6.2 for a detailed discussion. Self-reporting through quantitative methods provides an opportunity to gain insight into the beliefs of and the way people think. It provides a quick way of accessing a group (in this case, midwifery educators) and is, therefore, a cost-effective strategy for gaining information. The anonymity of an electronic questionnaire on Evasys®, like the one of this study, enabled participants to give honest answers, although offered limited opportunity for participants to ask probing or clarifying

questions if anything was unclear to them. One of the difficulties with questionnaires is that the response rate might be low, although using electronic questionnaires improves the response rate. Especially if the questionnaire is long, as was the case in this research, participants tend to fail to complete all questions (Brink *et al.*, 2018:142; Grove & Gray, 2019:356).

Participants should find questionnaires understandable and easy to complete, and the questionnaires should be easy for the researcher to administer and score. A questionnaire should meet the objective of the enquiry, in this case, to ascertain the gaps reported by midwifery educators, to inform the elements of the transformative framework to strengthen MEC. The questionnaire had a number of closed-ended questions and open question items. The competency elements were placed on two scales, one for competence and one for confidence (Brink *et al.*, 2018:141; Grove & Gray, 2019:357).

Refining the transformative framework was done via a non-consensus Delphi process, which will be described in detail in Section 8.3. Many modifications have been made to the classic consensus Delphi. In this research, the Delphi process did not aim to achieve consensus among the experts on the transformative framework; instead, their input was solicited to refine the framework and enhance the implementation. The experts were invited to provide their diverse views based on experience and knowledge of different areas in maternal healthcare. Inclusion of the views of experts shaped the framework to suit the context and professional needs of midwifery educators (Brady, 2015:3; Keeney *et al.*, 2011:5–7; McMillan *et al.*, 2016:658).

Criticism against the Delphi centres around the involvement of experts, as there is concern is that, even though the so-called experts might be within a field, they might not be true experts. It is recognised that willingness to take part as an expert might be greater by people who might be affected by the focus of the Delphi process (Keeney *et al.*, 2011:8). Compiling a balanced expert panel is crucial, as is ensuring anonymity of the expert participants, to limit power inequities (Brady, 2015:3) and selecting a heterogeneous group, to allow multiple views to be elicited (Keeney *et al.*, 2011:8).

4.5.1 Population and sampling

The target population of each phase of the research is summarised in Table 1.2. The population, as entire group of persons of interest linked to the research topic (Brink *et al.*, 2018:131), is not always available. Hence, the target population is identified by using eligibility criteria. The accessible population is the group of participants to which a researcher has access (Grove & Gray, 2019:293). In quantitative research, sampling from the population should be considered carefully, as the results drawn from samples will have an impact on the generalisability of the findings. Conclusions drawn and the use of statistical inference could be considerations linked to sampling (Grove & Gray, 2019:294; Martínez-Mesa *et al.*, 2016:326). As the aim of this research was not to generalise any of the findings, but rather to integrate all the data gained in triangulation of literature, the statistical power was not a driving consideration.

Sampling bias, which refers to the use of flawed selection procedures, and non-response bias, where a limited number of participants respond to quantitative research, were considered in the quantitative phase (Martínez-Mesa *et al.*, 2016:326). Therefore, an automated reminder system was set up to send an email fortnightly to persons who had not yet participated.

The topic area of MEC in South Africa concerns all the midwifery educators in the country. The entire population of midwifery educators, at either universities or colleges offering midwifery education, was therefore included in the AI and gap analysis. The Delphi process relied on experts who were chosen because of their strategic involvement in maternal health and midwifery education.

A discussion of the detail pertaining to each phase will follow.

4.5.1.1 Selection of the AI population

The qualitative phase had a **target population** of delegates attending the national SOMSA congress. Delegates from other countries also registered and attended the congress. One congress delegate from Turkey attended the AI workshop. The AI session was a concurrent session in the congress programme and an invitation to preregister on-site was extended to the delegates. **Eligible participants** were congress delegates who either were midwifery educators, or had an interest in

education, and who provided written informed consent to be part of the research. The **sampling** was non-probability convenient sampling as, in qualitative research, the accessible population is often guided by the willingness of eligible target population participants to take part in the research. Willing and able participants provide high quality information (Brink *et al.*, 2018:125). Considering the logistic constraints facing accessing all midwifery educators for an AI summit, the national congress provided an opportunity to access them as a group. The number of participants were limited by the congress venue room allocation, as guided by fire and safety regulations. Detail on the demographic information of the participants and a detailed discussion will be presented in Sections 5.2.

4.5.1.2 Selection of the gap analysis population

As it was important to include the total **population** of midwifery educators in the research, a census was attempted. Using the entire population is always the ideal in any research, especially if the population is known and the size is not too large (Martínez-Mesa *et al.*, 2016:327). All the educators involved in midwifery education at all the universities and colleges in South Africa offering midwifery education were targeted for the census. The educators were involved in diploma, degree and/or advanced/specialist midwifery programmes. In order to ensure that the criteria that qualifies a member to be part of the target population is followed and clearly stipulated, the **eligibility criteria** were determined (Brink *et al.*, 2018:131; Grove & Gray, 2019:294). The whole population was targeted, using a census rather than sampling (Martínez-Mesa *et al.*, 2016:326). The participants who were eventually included considered themselves to be midwifery educators and, as the questionnaire is a self-evaluation intended for midwifery educators, all qualified as part of the census domain.

Many challenges needed to be navigated, however, to reach the population for the gap analysis. Gatekeepers prevented the participation of midwifery educators at colleges in an entire province. Furthermore, electronic distribution questionnaires was difficult, because, despite repeated follow-up, the email addresses of some educators could not be attained, nor could or did all the heads of departments confirm who the midwifery educators at their institutions were.

4.5.1.3 Selection of experts for the Delphi process

The last phase of the research that of refining the transformative framework, was completed via a non-consensus Delphi process with one round of input from experts. To ensure a heterogeneous group that had the ability to also enable implementation, the expert panel included not only experts in midwifery education in South Africa and the sub-region, but also members from the ministerial committee on maternal health – the most authoritative structure on maternal health. Key officials of the national Department of Health, including the office of the chief nursing officer and the maternal child-health division were included. A medical specialist with obstetric and rural healthcare expertise was selected to include a focus on community-based midwifery care.

Although **eligibility criteria** can include the number of publications in a field, or qualifications, it was not required in this expert panel, as the level of the representation on national and regional committees implied the expertise of the panel members (Keeney *et al.*, 2011:8,9; McMillan *et al.*, 2016:658).

The **size** of an expert panel is not prescribed. To ensure that the group is well composed carries more significance than mere numbers. Inviting between 15–25 participants is often advised, and if larger panels are involved, greater expertise could be countered by diminished returns (Keeney *et al.*, 2011:8,9; McMillan *et al.*, 2016:658).

Therefore, the selection technique was **nonprobability purposive sampling**. As the intention was to include participants who had the capacity to refine the framework, representation of and generalisation to the total population of maternal health experts were not pursued (Martínez-Mesa *et al.*, 2016:327, 328). By purposively selecting key stakeholders in maternal healthcare, valuable input refined the transformative framework.

4.5.2 Rigour and inference quality

Another overarching element that flowed from the ethical comportment as described in Section 4.4 was to ensure that the research findings were based on quality data. Scientific rigour was incorporated in the development of the transformative framework

to ensure that credible findings would be presented (Grove & Gray, 2019:119). In mixed-method research, the quality considerations of the qualitative, as well as those for quantitative components, are incorporated in addition to elements that ensure inference quality (Creswell & Creswell, 2018:246; Polit & Beck, 2017:597).

4.5.2.1 Rigour in the AI

The qualitative component followed epistemological standards to reach trustworthiness. The elements considered and followed are summarised in Table 4.4.

Table 4.4 Trustworthiness standards, strategies and criteria in the study

Epistemological standards	Strategies	Quantitative analogue	Criteria to be utilised
Truth value (confidence in the truth of the findings)	Credibility (how the constructors of the multiple realities interpret the credibility)	Internal validity (validity of inferences – degree of accuracy of inductive and deductive conclusions)	- Triangulation (data, method and person triangulation): Data from various methods were triangulated. Findings were triangulated with literature. The Delphi process provided method and person triangulation. - Investigator: After planning and organising the AI session, an experienced AI practitioner facilitated the session. - Member checking: Part of the AI-process was through a consensus-building technique. - Peer debriefing: The AI process relies on the discussion and making sense of elements in groups, where the focus was on what gives life and works well. - Group discussion: The AI process is embedded in group discussion as a confirmation of African culture. A voice was given to disempowered people, to co-create change.
Applicability (degree to which findings could apply to other contexts)	Transferability (transferring inferences from one context to another)	External validity (degree of generalisability)	- Rigour in the selection of data sources: In AI, the inclusion of the "whole" is essential. Therefore, all stakeholders were included. A wider stakeholder group of experts participated in the Delphi process. - Thick/dense description was maintained as the proposal books of AI session are analysed and thoroughly discussed in the thesis.
Consistency (stability of findings with replication)	Dependability (consistent results)	Reliability (extent of freedom from measurement error)	- The dependability audit process, procedure and data analysis were audited by the supervisor. - Thick and dense description of the methodology: The AI process was run using a protocol document as described in 1.10.6 and gave detail of the process and additional data.

Epistemological standards	Strategies	Quantitative analogue	Criteria to be utilised
			- Cronbach Alpha was calculated for gap analysis question items
Neutrality (freedom from bias)	Confirmability (the product is grounded in data, and is logical and free of bias)	Objectivity (extent to which independent researchers would come to similar conclusions)	- Confirmability audit, triangulation and reflexivity - Neutral facilitator for AI session , as I was the president of the professional association, a neutral facilitator was involved in the AI.
Authenticity (fairness and faithfulness in showing a range of different realities)			- Involvement of the "whole" provided the reality for midwifery educators, their future students and the practice of midwifery. All delegates were invited to the session. The facilitator ensured full participation during the AI session.

Adapted from Botma et al. (2010:234,244); Brink et al. (2018:111); Cousin (2009:168); Jacobsgaard and Bukashe (2019:6); Polit and Beck (2017:563, 564); Teddlie and Tashakkori (2009:296).

In addition, to ensure that the collected and analysed data were trustworthy, the following measures were incorporated. An abstract for the AI workshop was submitted and formed part of the peer-review system of the national SOMSA congress. A scientific committee completed a double-blind review. Reviewers were allocated by the congress secretariat software, and the abstract was accepted. After the double-blind peer reviews, the programme population process involved the national executive and scientific committees. As I was the president of the association and chairperson of the meeting, the committees were made aware of my involvement and I withdrew from decision-making of the particular session. For the same reason, the session was facilitated by an independent AI expert, to mitigate possible bias.

The AI proposal document, which was provided to the participants as a booklet to complete during the AI session, was refined by the expert and supervisor. The paradigmatic perspective enhanced the trustworthiness of the AI and respect for the participants, as the majority was women from Africa. Participants allowed the AI process to flow, and this enabled them to be part of the solution; their contributions co-

created the transformative framework in the meta-inference (Gadow, 2019:47; Henning *et al.*, 2018:101; Teddlie & Tashakkori, 2009:296).

4.5.2.2 *Rigour in the gap analysis*

The quality of the quantitative component of a mixed-method research project contributes to the ultimate inference quality. Traditional considerations include internal validity, statistical conclusion validity, construct validity, and external validity (Polit & Beck, 2017:216). Application of the validity measures is less restrictive than in quantitative research. In mixed-method research, internal validity measures allow for possible explanations for results, rather than a restrictive application that alternative explanations for findings can exist. Threats to internal validity in classic experimental research, such as selection of participants, maturation, regression, attrition, testing and instrumentation errors, were not applicable in this mixed-method research (Bergman, 2008:107; Creswell & Creswell, 2018:246; Teddlie & Tashakkori, 2009:297–299).

Statistical conclusion validity and construct validity were, consequently, pursued. Statistical conclusion validity refers to the degree to which the researcher can render evidence of the relationship between inferences (Polit & Beck, 2017:216). In addition, appropriate procedures were followed to ensure quality results of the statistical analysis. Quality results can be jeopardised if the statistical power is low (Teddlie & Tashakkori, 2009:298, 299). In this research, a census was targeted, so, selection threats to validity were not applicable.

Construct validity, which refers to the adequate measurement of the constructs that are being researched, was considered (Brink *et al.*, 2018:154). The measured outcomes should match theoretical constructs and the inferences should align with the theory and measured data (Bergman, 2008:107; Teddlie & Tashakkori, 2009:297–299). In this research, applying an instrument that originated from the team of consultants that developed the original WHO Midwifery Educators Competencies provided a reassuring measure of construct validity. In addition, questions that were added, on what excites the participants as live-giving elements, corresponding with the AI theoretical foundation, contributed to adequate inference. The addition of

questions on gender also ensured quality inferences on the underlying issues of gender inequality.

External validity is the degree to which inferences drawn from this research can be generalised to other settings (Bergman, 2008:107; Teddlie & Tashakkori, 2009:297–299). The research was focussed on South African midwifery educators, and is context specific. The purpose was never to generalise the findings to other populations and, therefore, external validity was not relevant in this research.

4.5.2.3 *Rigour in the Delphi process*

A non-consensus Delphi is regarded as a qualitative technique and, hence, elements of trustworthiness, as captured in Table 4.4 are also applicable to the Delphi process. In addition, it is important to understand that, in a Delphi process, the aim is to gain a valid opinion from the expert panel. Keeney *et al.* (2011) describe a valid opinion as an opinion that could or could not be backed up by evidence. The opinion is neither a correct nor incorrect answer, but a definitive view held by the participant (Keeney *et al.*, 2011:9).

Anonymity of the Delphi experts is an important consideration, as power balances might influence the opinion given (McMillan *et al.*, 2016:660). In this case, using an electronic platform, Evasys®, allowed experts to provide their input without perceptions of influential experts' views on comments. Because the researcher knows who the experts are, full anonymity was not achieved; however, panel members did not know who the other members were. Each contribution was received and analysed independently, so that each valid option could be respected (Keeney *et al.*, 2011:9).

4.5.2.4 *Inference quality*

In mixed-methods research, a final level of rigour is in the quality of the inference, which refers to the quality of conclusions drawn from the findings of the research (Bergman, 2008:101; Plano Clark & Ivankova, 2016:163; Polit & Beck, 2017:216, 597). Quality considerations in mixed-method research usually relate to inadequate conceptualisation and theoretical grounding of the research. The expectation is that, in quality mixed-methods research, there should be an epistemological and ontological grounding. A research question should be posed and be informed by a theoretical

framework. The sampling strategies and interpretations should be conducive to both qualitative and quantitative research conventions (Bergman, 2011:273; Creswell & Creswell, 2018:246). A distinction is made between the quality of data and the quality of the inference. Inference quality refers to the process of making meaning of the data, and it is appreciated as both a process and an outcome (Bergman, 2008:102, 103). Inferences represent the conclusions and interpretation of the data and captures both the process of interpreting the findings and the outcome or product of the interpretation (Bergman, 2008:103). Two major components of determining inference quality are design quality and interpretative rigour. Design quality is applicable to qualitative and quantitative components of the research, and influence the quality of the inferences directly. Interpretative rigour is focussed on the credibility of the interpretations made (Bergman, 2008:113,114). The application of the components in this research is summarised in Table 4.5.

Table 4.5 Criteria for design quality and interpretative rigour in the research

Component of inference quality	Criteria	Audit of this research
Design quality	<u>Design suitability</u> (translation fidelity) Consider the methods chosen and the ability to answer research questions	The research sub-questions matched the methods
	<u>Design fidelity</u> Ensure rigour of methods	Refer to 4.5.2.1, 4.5.2.2 and 4.5.2.3
	<u>Design consistency</u> Seamless fit between components	Live-giving elements were identified in AI and the gap analysis and gender empowerment components captured in both AI and the gap analysis
	<u>Analytical adequacy</u> Appropriate and adequate techniques	Analysis of AI and Delphi process done with supervisor Gap analysis done with biostatistician
Interpretative rigour	<u>Interpretive consistency</u> between data and interpretations	Triangulation with literature

Component of inference quality	Criteria	Audit of this research
	<u>Theoretical consistency</u> Explanation credibility Findings consistent with theories in field and other research	Triangulation with literature and theoretical constructs considered
	<u>Interpretative agreement</u> Peer agreement	Refinement confirmed interpretations
	<u>Interpretative distinctiveness</u> Strong and plausible conclusions	Refinement and triangulation with literature confirmed interpretations
	<u>Integrative efficacy</u> Each phase's inference integrated in meta inference	Information from AI and the gap analysis included in transformative framework

Adapted from Bergman (2008:113–115).

In this research, design quality was enhanced by aligning the methods chosen with the research question and sub-questions. Rigorous implementation of quality measures in an integrated research project is key (Bergman, 2008:101; McCusker & Gunaydin, 2015:12; Polit & Beck, 2017:597). Appreciating strengths and identifying gaps provided the data, which could, after appropriate analysis, be incorporated to make inferences. The interpretations of the data sets had to be triangulated with literature to ensure that interpretations were consistent and congruent with midwifery education. To ensure that inferences were in agreement with the scientific community, and that strong, distinctive conclusions were drawn, the triangulation and refinement ensured that the meta-inference was plausible. Both datasets were integrated in the meta-inference.

Final considerations for inference quality are **inference transferability** and **legitimation**. If the inferences and quality of data are poor, the relevance to the context might be insufficient and not well understood. Legitimation is a process of evaluation of the purpose of the research and the meta inference (Plano Clark & Ivankova, 2016:167,168). Considering the way design quality considerations and interpretative rigour were respected, coupled with continuous triangulation with literature, the

refinement of the Delphi process provided another opportunity to ensure the quality of the meta-inference.

4.6 SUMMARY OF CHAPTER

This chapter provided a map of the way social change was achieved through a convergent transformative mixed-method design. Within the frame of the transformative paradigm, methodological choices that were informed by the paradigm and ethical considerations vested in the person of the researcher, the participants and rigorous processes were described. The story of the journey according to this map of the methodology will be told in the following chapters: 5 for the AI, 6 for the gap analysis and 8 for the Delphi process, in which the detailed discussion of the data collection and analysis will be expanded.

Chapter 5

Appreciative Inquiry



CHAPTER 5 APPRECIATIVE INQUIRY

"If we appreciate our strengths, this will affect the way we move forward" (Reed, 2007:56).

5.1 INTRODUCTION TO AI, PHASE 1

The map that plots research as a tool for social change will now be continued by the description of how appreciating the strengths of MEC can co-create the transformation of moving midwifery education forward. In this chapter, the data collection and analysis of the qualitative phase of the research (AI) will be described (refer to Figure 4.1). The content reported in this chapter was obtained from anonymous demographic information forms, the AI process booklets that participants completed and left behind, flip charts of group feedback sessions, and photographs.

5.2 DATA COLLECTION LOGISTICAL ARRANGEMENTS OF AI

The AI workshop was a concurrent session during the national SOMSA congress that was held from 28 to 31 August 2018 at the President Hotel in Bloemfontein. The workshop was submitted to the blind peer-review system, approved, and placed on the programme (refer to the programme, Annexure E). The workshop was scheduled on the second day of the congress and, to optimise time, special arrangements were made to serve lunch and tea during the workshop. Congress delegates registered for the workshop, as the venue had limited space. Delegates had other concurrent sessions in larger venues to also choose from to ensure that no participant felt coerced to attend the workshop. Logistical arrangements for lunch were announced.

The session preceding the workshop was a plenary panel discussion, in which the provincial member of the executive committee of Health was a panellist, because her participation, as the political head of health, was needed. However, the dignitary arrived late, which caused the workshop to start an hour late.

I introduced the facilitator to the delegates who participated in the workshop. The research information documents, consent forms and anonymous demographic forms were distributed and signed during lunch. Any participant that after the informed consent process wanted to attend another session of the congress could do so. Lunch and tea were served in the venue, to allow the session to progress during lunch and teatime on the congress programme. Participants were seated at round tables. Each received a copy of the AI process document booklet (refer to Annexure A) as well as a second document containing reading material (refer to Annexure F).

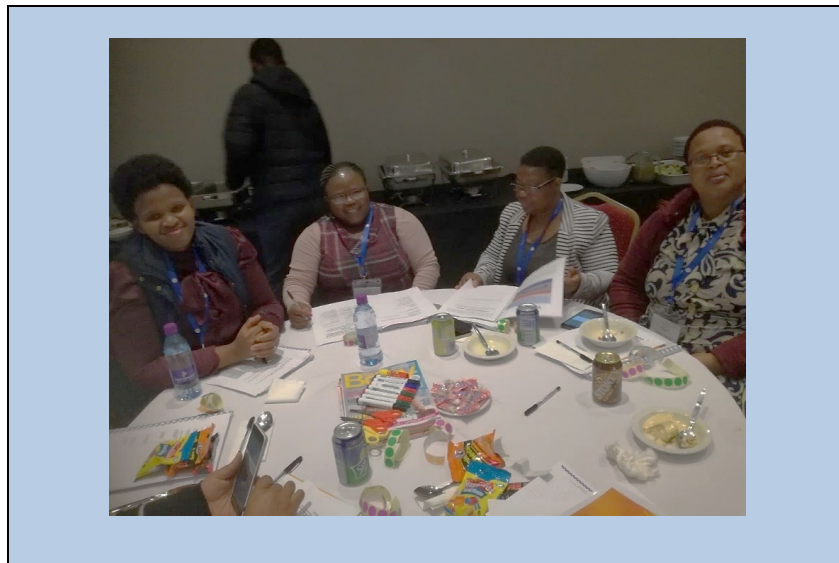


Image 5.1 Seating during the AI session A



Image 5.2 Seating during the AI session B

The room was prepared with the theme, sunflowers, and a multisensory experience was created. The tablecloth on the lectern, for instance, had a sunflower pattern and fresh sunflowers were used for the floral arrangement. A perfume, *Sunflowers* by Elizabeth Arden, was sprayed in the room as participants entered to emulate the experience of being in a field of sunflowers after the rain. The reading material had a sunflower design on the front page. The choice of sunflowers was inspired by a personal appreciation of crops grown in the Free State, including the farm where I lived for many years. Sunflowers are a signature plant of the region, where large farming areas are covered with fields of sunflowers at certain times of the year. Sunflowers are an excellent example of plants that grow in the direction of light, a trait that was shared with participants in the introductory presentation. David Cooperrider, who is regarded as the father of AI, made the following seminal statement to elucidate AI:

"Implied in... scholarly research... is the intriguing suggestion that human systems are largely *heliotrophic* in character, meaning that they exhibit an observable and mostly automatic tendency to evolve in the direction of positive anticipatory images of the future. What I will argue is just as plants of many varieties exhibit a tendency to grow in the direction of sunlight, there is an analogous process going on in all human systems" (Cooperrider in Watkins *et al.*, 2011:191).

The purpose of multiple sensory repetition of sunflowers was to create an ambience concerning this concept, as described by David Cooperrider. Pictures of sunflowers from photos that I had taken on the farm were inserted in the PowerPoint presentation (refer to Annexure G) and repeated in the document design.

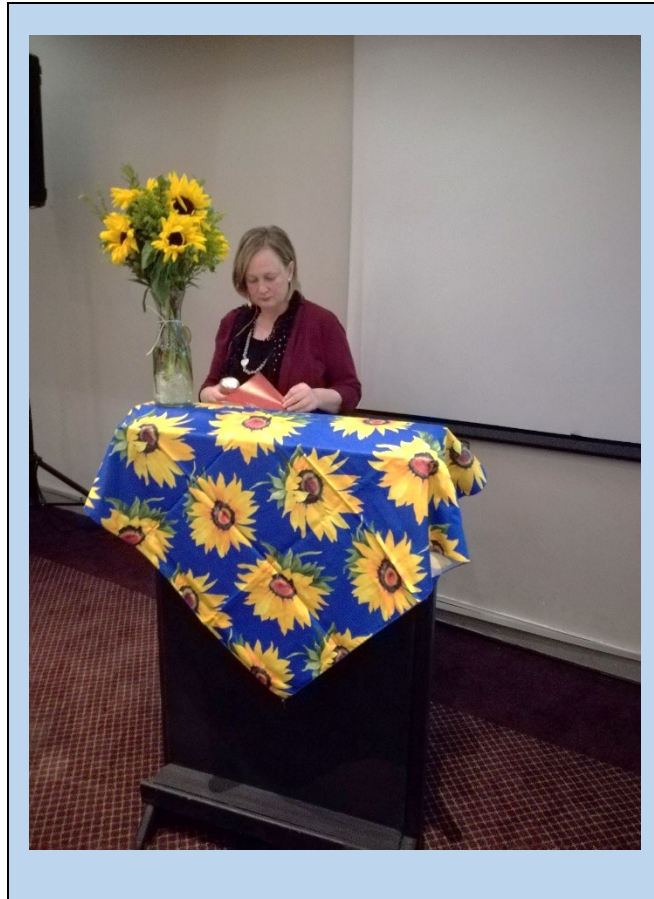


Image 5.3 AI facilitator at lectern prepared with sunflowers

Despite the logistical arrangements made to save time, the delay in the onset of the workshop had a detrimental effect on the anticipated process and the energy levels of the participants. Fatigue slowed the progress and some of the groups were unable to complete all of the activities.

The estimated time needed to complete the steps was adapted by the facilitator. Some tables, at times, needed more time for tasks, and mental and physical fatigue increased towards the end. It was, however, admirable that, despite the perceived complexity of the task and their low energy levels, the participants did not leave, but stayed and contributed to the process.

5.3 ELIGIBILITY CRITERIA

Participants were all registered delegates at the congress, and had the option to register for the AI as a concurrent session in the congress programme. The invitation to the workshop targeted midwifery educators and delegates interested in midwifery education. Venue capacity was limited to 50 persons due to the fire and safety regulations of the facility.

5.4 DEMOGRAPHIC DETAILS OF AI PARTICIPANTS

The demographic information of participants was captured on an anonymous form; however, not all the questions were completed fully. Some participants did not complete the form, which explains the difference in numbers: there were 27 demographic forms and 32 completed participant AI process booklets.

All the participants in the groups were female and their age distribution is indicated in Table 5.1.

Table 5.1 Age distribution of AI participants

20-30 years	31-40 years	41-50 years	51-60 years	61+	n	N
1	3	5	14	4	27	32

The majority of participants were close to retirement, with 18 of the 27 participants being at most 15 years from the retirement age of 65. The generational classification of the group included Baby Boomers (born between 1946 and 1964), Generation X (born between 1965 and 1980), and Millennials or Generation Y (born between 1981 and 1997). It is important to remember that current midwifery students are likely to be mostly Post Millennials (Generation Z, born after 1997) (Stutzer, 2019:79). The characteristics associated each group are summarised in Table 5.2.

Table 5.2 Generational differences

Generation	Characteristics
Baby Boomers (born between 1946 and 1964)	• Work is linked with personal worth and satisfaction • Idealistic • Workaholic • Non-conforming to old rules – questions authority • Enjoys recognition • Team player
Generation X (born between 1965 and 1980)	• Short-term employment • Leadership positions are filled by Baby boomers, so there are limited growth opportunities • Driven by job satisfaction and the need to make money • Cautious, self-reliant and independent • Comfortable with technology
Generation Y (born between 1981 and 1997)	• Technologically sophisticated • Achievement oriented • Motivated and group oriented • Able to multitask • Strives to achieve work-life balance • Respects different values and diversity
Generation Z (student population) (born after 1997)	• Confident and cautious • Information is at their fingertips • Not aware of a time without computers and mobile phones • Reads less, sleeps less • Preserves family ties

Compiled from Stutzer (2019:79).

Although there may be contextual differences among countries and regions, one cannot contest the influence of technology in daily life, including education. The generational gap, therefore, deserves consideration.

Considering the highly clinical subject content of midwifery, it is preferred that an educator should be a clinical expert before they enter into an educator role. Clinical expertise develops over time, while working as a midwife. Thompson *et al.* (2001:16) describe this process as a transition that takes time. The time needed to become competent can explain why the group which was interested in and active as educators were mainly older than 41.

The majority of participants indicated that they possessed graduate and postgraduate qualifications, as shown in the pie in Figure 5.1.

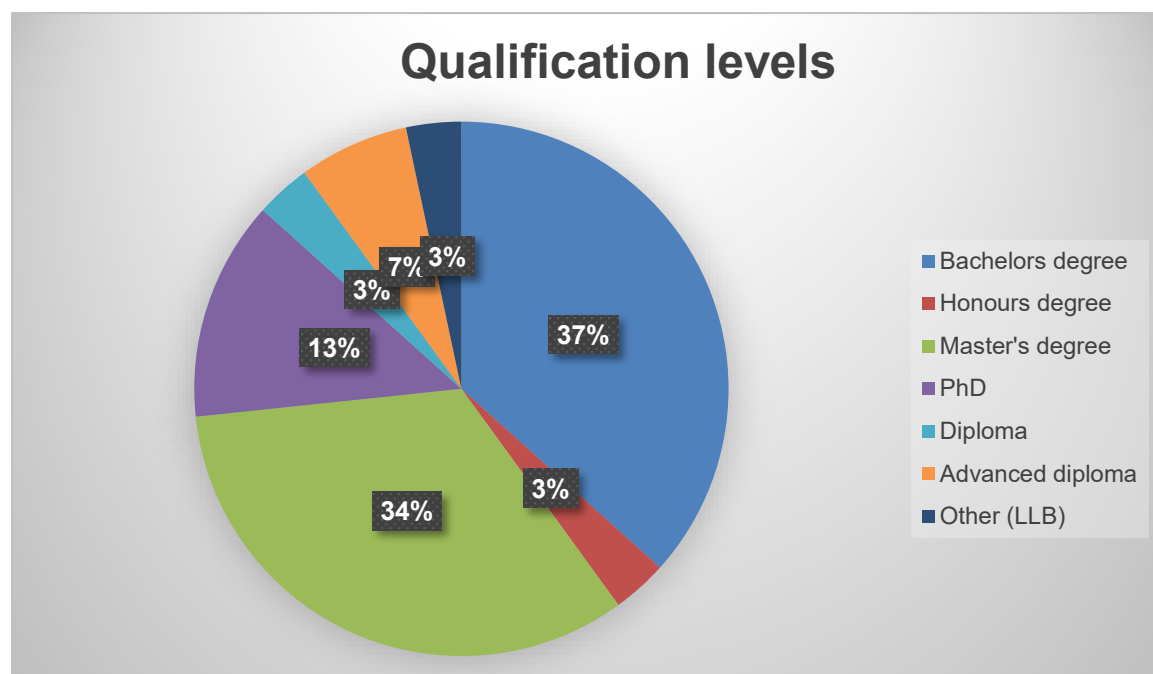


Figure 5.1 Qualification levels of AI participants

The participants indicated that they had furthered their education to higher qualifications. The majority had achieved advanced diplomas and degrees after Bachelor degrees. One participant listed an additional qualification, in this case, LLB.

The professional registrations held by participants were diverse and, as expected, the majority were registered with the SANC for midwifery, advanced midwifery and education (Figure 5.2).



Figure 5.2 Professional registrations held by AI participants

As depicted in Figure 5.2, the professional registrations held by most participants, except for general nursing and midwifery, was for education (which is often obtained together with a management qualification) and advanced midwifery. Eight participants indicated that they had an additional registration as assessor and moderator, which is ideal for educators. One participant who attended the session was from Turkey. She presented a peer reviewed paper in the programme and worked as a midwife educator in Turkey. It is possible that her registrations might be different but as the demographic forms were anonymous, it is not confirmed.

Participants indicated in which programmes within midwifery education they were involved. At college level, there are combined programmes with nursing registrations that include basic midwifery as part of a combined four-year programme, one-year basic midwifery qualifications following nursing, and advanced midwifery programmes. Universities mostly offer a generic Bachelor programme that includes midwifery as part of the four-year programme, as well as advanced midwifery qualifications and postgraduate degrees.

Figure 5.3 shows that the majority of participants were involved in a four-year diploma that is offered at colleges.

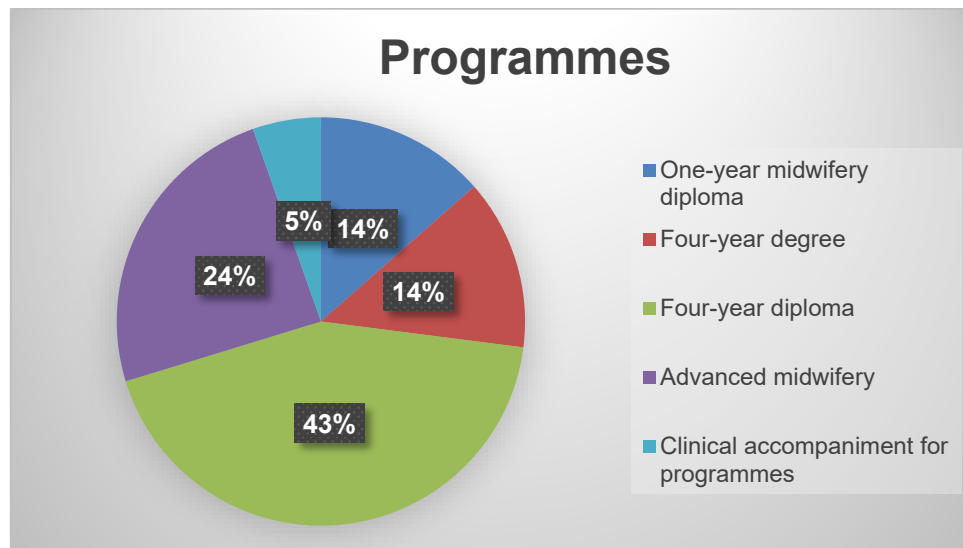


Figure 5.3 Programme involvement of participants at AI session

In addition, participants had to indicate what their role was within the programmes offered. Among the participants who were not working as educators, but who had a keen interest in education, there was a manager of a maternity section, and an advanced antenatal care practitioner (a particular programme of enhanced antenatal care in the Free State province). In addition, one of the participants was an advanced midwife who was part of the district health specialist team (functioning in the health districts of South Africa). An independent midwife also joined the session.

The participants who were involved in education on a daily basis specified their roles in the programmes, as shown in Figure 5.4. Participants could list more than one role covering theoretical teaching, practical supervision and accompaniment. Depending on the education institutions' capacity, some were involved in research supervision, simulation activities or were engaged in administrative functions.

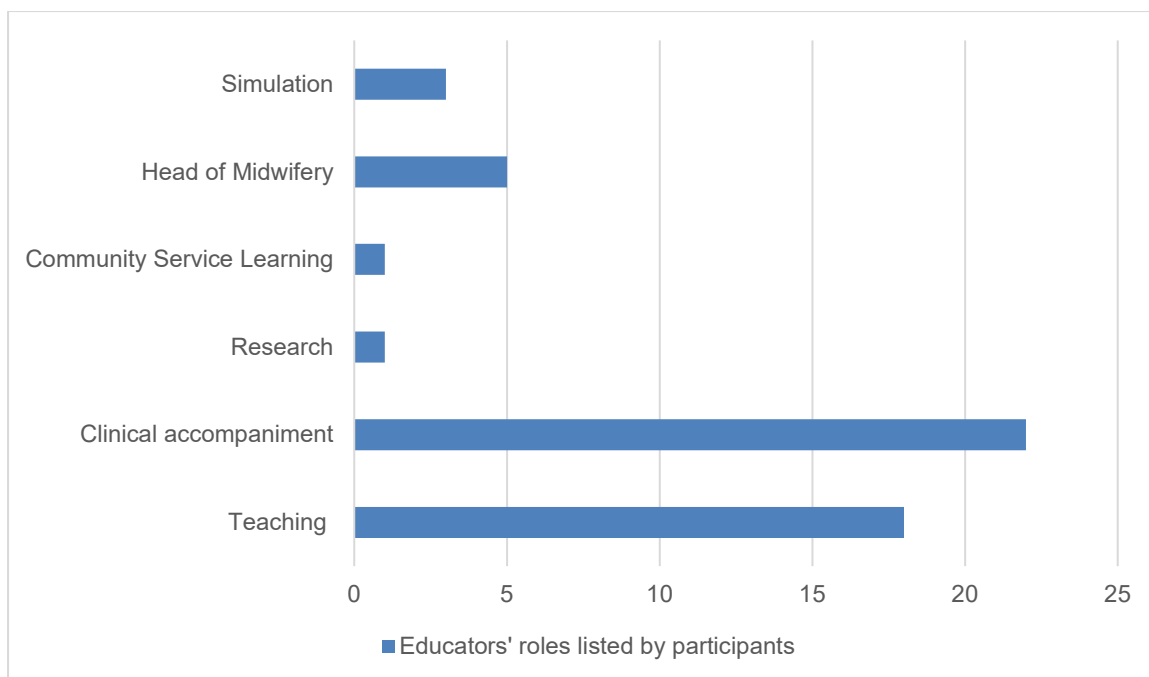


Figure 5.4 AI participants' roles in education programmes

From the data gathered and presented in Figure 5.4, it can be deduced that the majority of educators were involved in both teaching and learning components, as well as clinical accompaniment. Some participants brought wisdom from other roles in education, such as a managerial role, research involvement and simulation activities.

It was important to know how much clinical experience the participants had before becoming educators, because clinical competence as a midwife can only be gained in clinical practice.

Table 5.3 Number of years of clinical midwifery experience of AI participants

0-5 years	5-10 years	10-15 years	15-20 years	20-25 years	25+ years	n
2	8	9	5	4	1	29

The number of years of teaching experience is captured in Figure 5.5. The majority of participants had clinical experience that matched their age group, as captured in Table 5.3. As the participants were mostly older than 50 years, this data confirms the notion that most educators could have had a journey through clinical and educational preparation, which took time.

A large number of participants started their teaching journey outside midwifery. Although the majority had a midwifery specialist qualification, it raises concern if educators are not allocated to programmes according to their clinical expertise, but rather departmental needs. The participants were, however, not explicitly asked to confirm placement in other programmes.

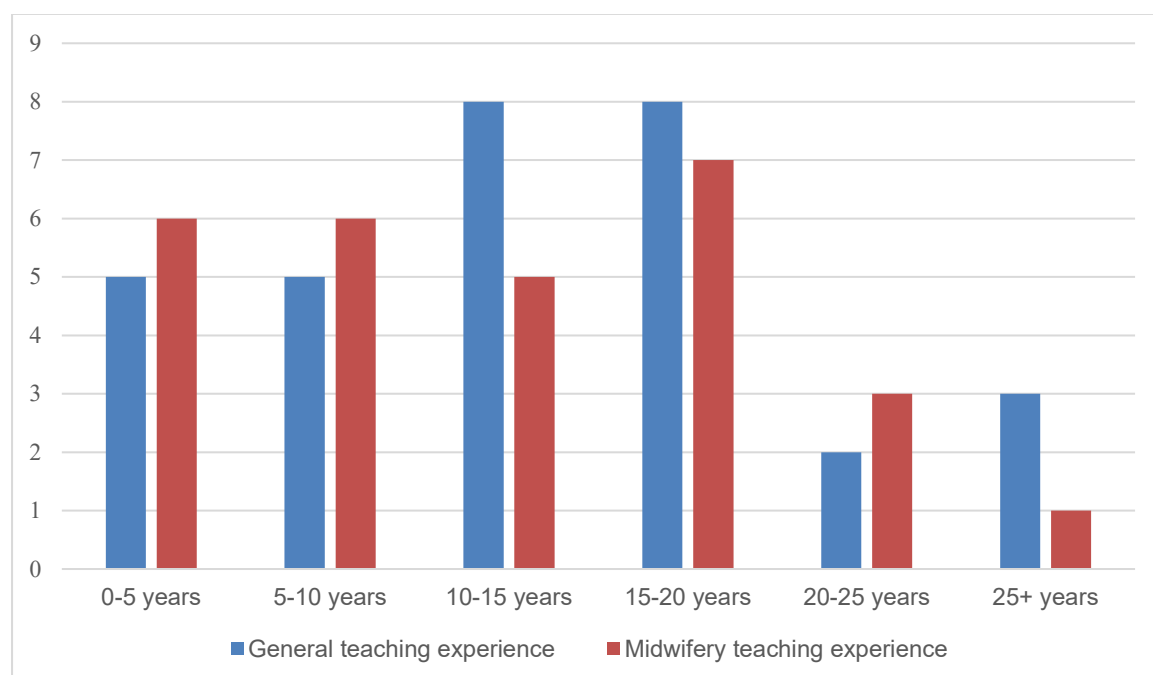


Figure 5.5 General teaching experience and midwifery teaching experience of AI participants

Another important consideration was the clinical exposure and competence of midwifery educators. To ensure that students' education is relevant to the current context and treatment protocols, educators should participate in practice regularly, to

build relationships with clinical staff and to support the clinical learning of the students. Closing the theory-practice gap is, however, a challenge in education. The 2019 action plan of the WHO for the strengthening of midwifery education to reach UHC by 2030 reaffirms the importance of integrating theoretical, simulation and clinical teaching (WHO, 2019:32).

At an international workshop, participants from around the globe identified theory-practice integration and clinical involvement a major challenge in the practical placement area (Bharj & Embo, 2018b:117). In addition, South African researchers Vuso and James (2017) identified concerns about the quality of clinical supervision, especially inconsistent supervision, as a factor that limits the acquisition of midwifery competence. Clinical educators who are appointed but not competent in midwifery education were found to contribute to less reliable clinical evaluation. The value of educators being in the clinical environment is also connected to the educators being more up to date with new developments in clinical field (Vuso & James, 2017:138).

In relation to the importance of clinical involvement by midwifery educators, the hours spent by educators in clinical practice, as reported by this group, is captured in Figure 5.6.

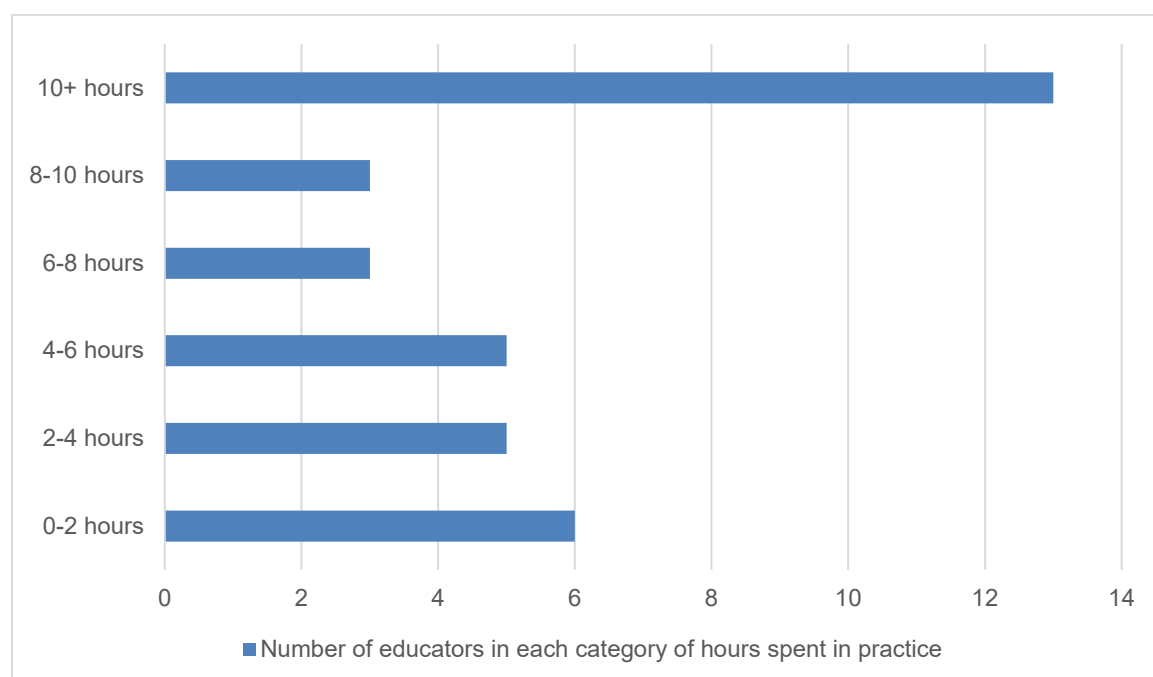


Figure 5.6 Hours per week in practice- including student supervision

The majority of the participants who provided responses spent more than 10 hours per week in clinical practice. Some colleges use a block system, with certain weeks allocated to only teaching theory, and other weeks dedicated to clinical practice. The block week system might contribute to the high number of hours reported by some participants - their only role is clinical accompaniment. Having become more acquainted with the background of the participants, their appreciated strengths can be understood more clearly.

5.5 PROCESS OF DATA ANALYSIS

AI is considered to be a relatively new addition to qualitative research methodologies. Therefore, it is recommended that the data analysis should be a shared activity, and should involve more people – not only the researcher – to enhance rigour (O’Flanagan & Corrigan, 2019:90). As it is a collaborative method embedded in social constructionism, knowing in AI is socially constructed (Cooperrider *et al.*, 2008:14; Nel & Govender, 2019:337). In the transformative paradigm, and from the theoretical perspective of feminism, the methodological choice of AI in this research, during which participants co-create and analyse the data in a collaborative process, therefore, respected the value and role of the participants (Mertens, 2007:213; Nel & Govender, 2019:342; Savin-Baden & Howell Major, 2013:270). Involving the participants in the analysis confirms the need to be consistent with the philosophical underpinning of the research, in this case, feminism, which appreciates inclusivity and acknowledges the voice of the educators (Grove & Gray, 2019:116).

The process, which involve the participants and a second coder during the final analysis, optimally respected the essence of AI as a strength-based approach that strives to elicit co-constructed ideas. The participants contributed to amplifying their contributions by validation of their stories and added rich contributions with the aim of strengthening MEC in pursuit of transforming midwifery education in South Africa (Cousin, 2009:179; Reed, 2007:146, 148).

In AI, one of the steps, after initial interviews in pairs, is a round-robin sharing of interviews that were held in pairs at each table. Collated feedback from each table was then shared with the entire group in a round-robin fashion. This process resembled the first phases of a nominal group technique, i.e., generation, round-robin, listing, and discussion of ideas. Although the limited time did not allow voting, apparent similarities emerged and were confirmed in the analysis of items captured on the flip charts.

The completed AI process booklets contained portions of text and, in some cases, collages created during the course of the AI session. In addition, there was a short video in which a participant explained an artwork. This recording was transcribed (Saldaña, 2013:5). Tables summarising the data have been added as Annexure H and I.

After the AI session, the information gathered and the co-created ideas were sorted, organised and accounted for, to make sense of and fully understand the contributions by participants. Time was devoted to reflecting on the data, making connections and eliciting meaning, to ensure that, by immersing them in the data (Brink *et al.*, 2018:180; Polit & Beck, 2017:530–531; Savin-Baden & Howell Major, 2013:420), the wisdom of midwifery educators could be harnessed to co-create a transformative framework for MEC. In addition to breaking information down into usable units, reflexivity and interpretation was needed to purposefully review contributions, and convert into the synthesis of meaning (Cohen *et al.*, 2011:537; Cousin, 2009:179; Reed, 2007:137, 138). The data were coded to assist in classifying it and identifying similarities and differences (Grove & Gray, 2019:117; Saldaña, 2013:10).

Analysing data by validating and refining categories and themes through dialogic exploration and reflection was a valuable exercise (O’Flanagan & Corrigan, 2019:90). In the final analysis of the data, the researcher and supervisor worked together. A qualitative content analysis was performed as a sense-making effort, “to identify core consistencies and meaning” (Polit & Beck, 2017:537; Saldaña, 2013:5). We manually coded all the responses captured in the AI process booklet to find patterns and explanations, using inductive and deductive processes to understand the participants’ contributions (Creswell & Creswell, 2018:254). The supervisor brought expertise in qualitative data analysis from transformative education, and my own strengths in midwifery and midwifery education contributed to rich dialogue and exploration of the

data, to ensure that different perspectives were considered and that analysis remained centred on the appreciative nature of AI (Brink *et al.*, 2018:180; Mertens, 2015a:442; O'Flanagan & Corrigan, 2019:90).

Reflexivity is needed to ensure rigour in the analysis of the data, so that the researcher critically reflects on data and ensures that new ways of thinking are embraced. Inherently, AI is designed to appreciate strengths, and a sole focus on the positive could carry the risk of negative elements being "swept into the shadows" (Mace & Hocking, 2015:201,202). The reflexivity of the participants and research supervisor added to my own reflexivity, and counteracted any possible bias that my insider position could bring to the analysis (Mace & Hocking, 2015:202; Nel & Govender, 2019:341, 342).

Visual data were analysed in relation to textual data, as recommended by Roos (2016:120; also Saldaña, 2013:4). Collier (2013, cited in Roos, 2016:120) aptly describes the creation of images as a process of giving birth to the stories of the images. The creation process and subsequent analysis should, therefore, be sensitive to self, and the paradigmatic and theoretical underpinnings of the research in triangulation with the textual data and literature (Banks & Zeitlyn, 2015:12-13; Roos, 2016:120).

In order to maintain synergy in the data, the final analysis codes, which were words or phrases that summarised data, captured salient meanings of the data (Saldaña, 2013:4). Saldaña regards coding as a cycle that has the intention to link it to a heuristic discovery, not merely to label data (2013:9). The first cycle, as a collaborative process in the AI, was followed by a number of rounds, which created fragments for synthesis into subcategories, categories and emerging themes (Saldaña, 2013:10). To generate natural units of meaning and to classify and order the categories and themes, the data were analysed into parts to enhance understanding (Cohen *et al.*, 2011:555). The data analysis was framed with the heliotrophic principle described by David Cooperrider (Watkins *et al.*, 2011:191) in mind. The focus of positive strengthening of the future (in this instance, MEC), guided the analysis (O'Flanagan & Corrigan, 2019:90; Watkins *et al.*, 2011:192).

5.6 5-D AI PROCESS

The AI process focusses on creating information, rather than discovering information, as is the case in traditional research. The process should encourage participants to create new ideas and thoughts (Reed, 2007:112). To enable the co-creation of the best way to transform MEC, we followed a 5D approach (Figure 5.7).

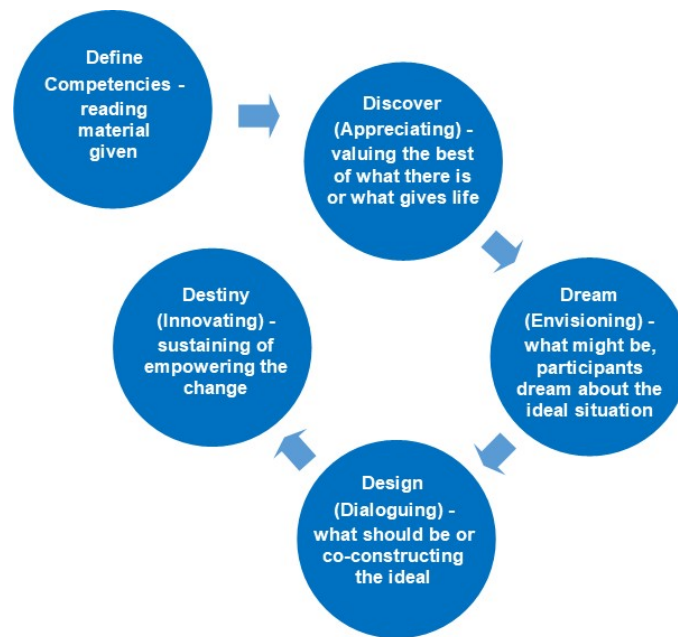


Figure 5.7 5D approach of AI

The first step was presented as information (refer to Section 5.6.1) to ensure optimal use of the limited time available for co-creation. Refer to Section 1.10.1 for more detail on the AI steps.

The following discussion of the steps will be presented as a holistic entity, in which the process followed and data will be presented and substantiated by direct quotes from the participants and literature. The participant codes follow the simple numeric order in which the AI process booklets were numbered.

5.6.1 Defining

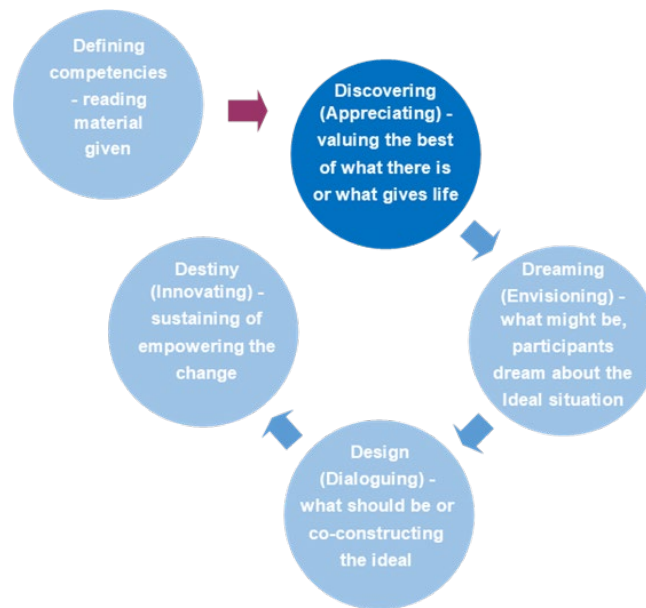
In the first step of AI, an opportunity to engage participants in the focus of the process is created. Handouts were provided for each participant at the tables. The first

document had resources and participants could take it with them after the session. Annexure F contains the documents provided.. Resources included the WHO document on MEC (WHO, 2013) as the core document on the topic. Other topics included in the ring-bound document were information on AI, background on the theoretical perspectives, the ICM Philosophy and model of care and Benner's stages of clinical competence. The second document is the AI proposal document (Included as Annexure A); with guided questions for every step of the AI. Participants wrote in the booklets and these documents were used for the data analysis and is called the AI process booklet. As time was limited, making the resources available was an attempt to optimise time.

The presentation (refer to Annexure G) that started the session briefly alluded to the resources, so that everyone had the same understanding moving forward. Providing the documents and an introduction to them in a short presentation captured the first step, of defining. Although the step was not part of the participant activity, the information that was provided bridged the time gap and did reach the objective of developing the topic (MEC) and ensuring that everyone could be involved (Cockell & McArthur-Blair, 2012:24).

5.6.2 Discovering

The second step of the 5D process is discovery, which is designed to use interviews, in pairs, to ask positive questions to uncover what gives life, in this case, to discover the life-giving elements of MEC. Refer to Figure 5.8 for the current step in the AI process.



5.8 Discovery step in AI process

5.6.2.1 AI step of Discovery

Appreciative interviews unlock the strengths that give life to the chosen topic. The intentional use of stories provides more in-depth and broader meaning and engages participants' imagination. Telling stories has a universal benefit and power across cultures. Stories generate relationships, as the teller and listener create their shared reality. As the stories are personal, a dynamic and memorable, and knowledge transfer takes place, which stimulates creativity (Barrett & Fry, 2008:56,57; Cooperrider & Whitney, 2005:25; Lewis *et al.*, 2011:46; Watkins *et al.*, 2011:146-148,155,156).

Most importantly, discovery creates an opportunity to look back on what gives life, and on successes of past endeavours, which ignite transformation into a new reality. By discovering past strengths, the new reality can capitalise on current strengths. The intentional selection of questions to illuminate the best of the past, urges the listener to actively look for positive elements in the story of the teller. Using stories unites people and provides them with energy (O'Flanagan & Corrigan, 2019:86). Essential elements are covered by general AI questions that revolve around the best experiences, values about yourself or work, core life-giving elements and considering their three wishes (Barrett & Fry, 2008:56,57; Cooperrider & Whitney, 2005:25; Lewis *et al.*, 2011:46; Watkins *et al.*, 2011:146-148,155,156).

5.6.2.2 Data from Discovery

Participants were asked to discuss a set of eight questions with the person next to them. The time limit was an hour, but this eventually took almost 90 minutes. The component was introduced by the facilitator, and was also captured in the AI process booklet, as follows:

*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.

Questions focussed on inquiry into exceptionally positive events in midwifery education. The event could have been experienced either as an educator, or in their own education. What was required was one half of the pair discovering, capturing, and sharing life-giving forces with the interviewer in the pair, other participants around the table and, lastly, the room (Cockell & McArthur-Blair, 2012:25).

The Discovery questions, with emergent categories and subcategories from the analysis of the answers noted in the AI process booklets of participants and the flip charts, are shown in Table 5.4.

Table 5.4 Discovery questions with emerging categories

Discovery questions	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 for 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)
Categories and subcategories	Education based • Innovation in education • Appreciation of use of technology • Introducing new content to curriculum • Teaching and learning strategies	Deductive analysis identified the competencies from WHO Competency list. See figure 5.9 for identified competencies	Personal traits and competencies	Student competence	Student competence	Engagement with students strengthening self-worth	Inclusivity • Advocacy for women seeking care • Advocacy for male students	Human and material resources, including infrastructure and simulation equipment
	Content based • Safe motherhood		Content • Community service learning	Passion	Innovative teaching and learning strategies	Student success	Distancing	Capacity development opportunities

	- Community-based education - Family-centred care		Evidence-based practice					
	Advocacy		Development and implementation of policy	Value of teamwork	Value of teamwork and appreciation	Use and expansion of evidence-based practice		An independent midwifery regulatory body with autonomy and well-developed scope of practice
Categories and sub-categories	Relationships		Research	Reciprocity and reflexivity	Content - Evidence-based practice - Research - Respectful care			Elimination of political interference in education and call for political support
	Student success - Student competence - Academic development - Theory-practice integration		Deep, engaged learning and student competence	Self-directedness, interconnected to continuing professional development	Relationships within teaching teams and institutions			Establishment of direct-entry midwifery pathway
			Advocacy	Evidence-based practice guidelines				Student selection

			Continuing professional education and development (CPD)	Clinical teaching platform				Revitalisation of clinical teaching departments
			Passion					Passionate educators
			Practice of education					Textbooks relevant to the context
			Positive and supportive attitude to students					Standardisation of education for midwives
								Independent midwifery practice to increase
								Accountability of midwives
								Research focus

The categories and sub-categories that emerged in the analysis of data generated by each question will be discussed next.

Discovery question 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.

The categories that emerged from the experiences that participants appreciated, covered a range from education-based to content-based aspects. Sub-categories in the **education-based category** include innovation in midwifery education, an appreciation of not stagnating regarding the use of technology, introducing new content to curriculum and teaching and learning strategies. Implementing innovations in teaching and learning were mentioned, as were new policies for assessment that had been developed and implemented. Other examples were changing a curriculum so that it was based on the ESMOE programme. A participant elaborated on her embrace of innovation by stating:

"Encourage students to use gadgets as part of their learning and obtain information from reliable sources, moving away from being dependent on textbooks" (Participant 26).

Here, the importance of providing alternatives to students who have a greater affinity for technology is acknowledged and actioned. Considering that the majority of educators were from the Generation X or Baby Boomer groups, as described by Stutzer (2019:79), bridging the generation gap is appreciated by the participant. In a survey with senior midwifery and nursing students and early career workers in the United Kingdom, the importance of generational differences is highlighted. Generation Y and Z grew up in a world with technology and gets distracted easily; a way of engaging them is by using technology (Warren *et al.*, 2015:36,37). The fact that the

category of education-based elements giving life to educators was mentioned accentuates that this participant embraced innovative education strategies.

The category on midwifery **content** covered teaching of safe motherhood, community-based education, and family-centred care. Content that was mentioned by the participants reflects how the element that gives life to their midwifery education experience aligns with midwifery and midwifery education in South Africa. In Section 2.3, the impact of safe motherhood on quality maternal health in South Africa is described. In the context of a country that is still to meet the targets described in 2.3, to focus on safe motherhood is reassuring.

"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" (Participant 17).

Examples of how students mastered safe motherhood content and the introduction of programmes like ESMOE were given.

"A comm(unity) serve (service) sister (former undergraduate student) came excited and bright eyed told the story that she was left alone with a woman in labour, while adv(anced) midwives and others went for tea. The woman gave birth and shoulder dystocia occurred; now all the techniques came back as were taught in class, she applied them and the baby was born and got praises from the seniors when they got back" (Participant 8).

The appreciation of community-based education and family-centred care reaffirms the spirit of the ICM philosophy and model of care. The significance of childbearing for the family and the community is the second philosophy statement, which reads, "Pregnancy and childbearing is a profound experience, which carries significant meaning to the woman, her family, and the community" (ICM, 2014c:2).

These topic areas speak to the heart of midwifery education in South Africa. The country's health focus on improving maternal health; within a healthcare system that should provide, at the core, community-based interventions, confirms that education is focussed on national priorities. The triennial report on maternal deaths identifies the community as one of the key focus areas for preventing maternal death. The

community should be engaged and coverage of community-based interventions, such as contraceptive care for women who do not want to be pregnant, is essential in saving mothers (Pattinson & Moodley, 2018:9). One participant, for example, linked the profound experience of childbirth with family-centred care and, in her rendition of the birth, referred to contraceptive use.

"During clinical accompaniment educator demonstrated how to involve the father as a birth companion. During birth the father collapsed to the anguish of the students. Learning: Father said family planning will be encouraged by him in future" (Participant 31).

Three participants (2, 9, and 20) had their peak experience concerning **advocacy**. Participant 2 referred to advocacy skills in general. Participant 20 specified advocacy to protect the mother-baby dyad, while Participant 9 focussed on gender inclusivity with reference to male students. Advocacy as a leadership activity is, indeed, part of the WHO competencies for midwifery educators. Competency #17 (discussed in Section 2.3.4) revolves around advocacy, and the targets include midwifery education and practice, and covers both professionals and the community. Structural advocacy can focus on issues such as attitudes of health workers and respectful care and can extend to eliminating harmful practices and beliefs (WHO, 2013:22).

Another major category that emerged related to **relationships**, between students and clinical staff, educators and the childbearing families (Participants 3, 5, 6, 13, 28, 29, 31, and 32). Participants appreciated the students' engagement and passion, for instance:

"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 a trust relationship with them" (Participant 28).

The ICM Philosophy and Model of Care reaffirms the importance of the relationship between the midwife and the childbearing families. By extension, if the midwife educator values this relationship, it confirms that there is a deep-rooted focus on this philosophy (ICM, 2014c:2). The ICM Code of Ethics' first section of four is devoted to midwifery relationships. The relationships with childbearing families, other midwives,

interprofessional teams and the policy arena form part of the exposition (ICM, 2014b:1, 2).

The category that featured most often in the documents of participants is **student success in education**. Responses ranged from student competence to academic development and theory-practice integration. Some educators also appreciated their own developing competence. Participant 23 said: "*Transfer of knowledge and ability to build the character of midwives*". This participant captures a number of issues in this statement. In addition to the importance of transferring learning, she also values the development of the professional behaviour component of competency and expresses that as character. She also calls her students midwives, whereas the autonomy of the profession is often not respected in the current conflation of nursing and midwifery in South Africa, and midwifery students are called nursing students. Participant 23 is able to use the unique identity of the midwifery consistently, which, to me, indicates that she is cognisant of the autonomy of the midwifery profession. She herself identifies as a midwife, and not a nurse educator.

Discovery question 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?

Question 2 intended to ignite what would be needed to have peak experiences. The analysis reveals how the different WHO competencies were applied and identified by the participants. Deductive analysis was done to identify the WHO competencies (discussed in Section 2.3.4) from the responses of the participants. The 12 competencies identified in the analysis, together with the number of participants who referred to each are presented in Figure 5.9.

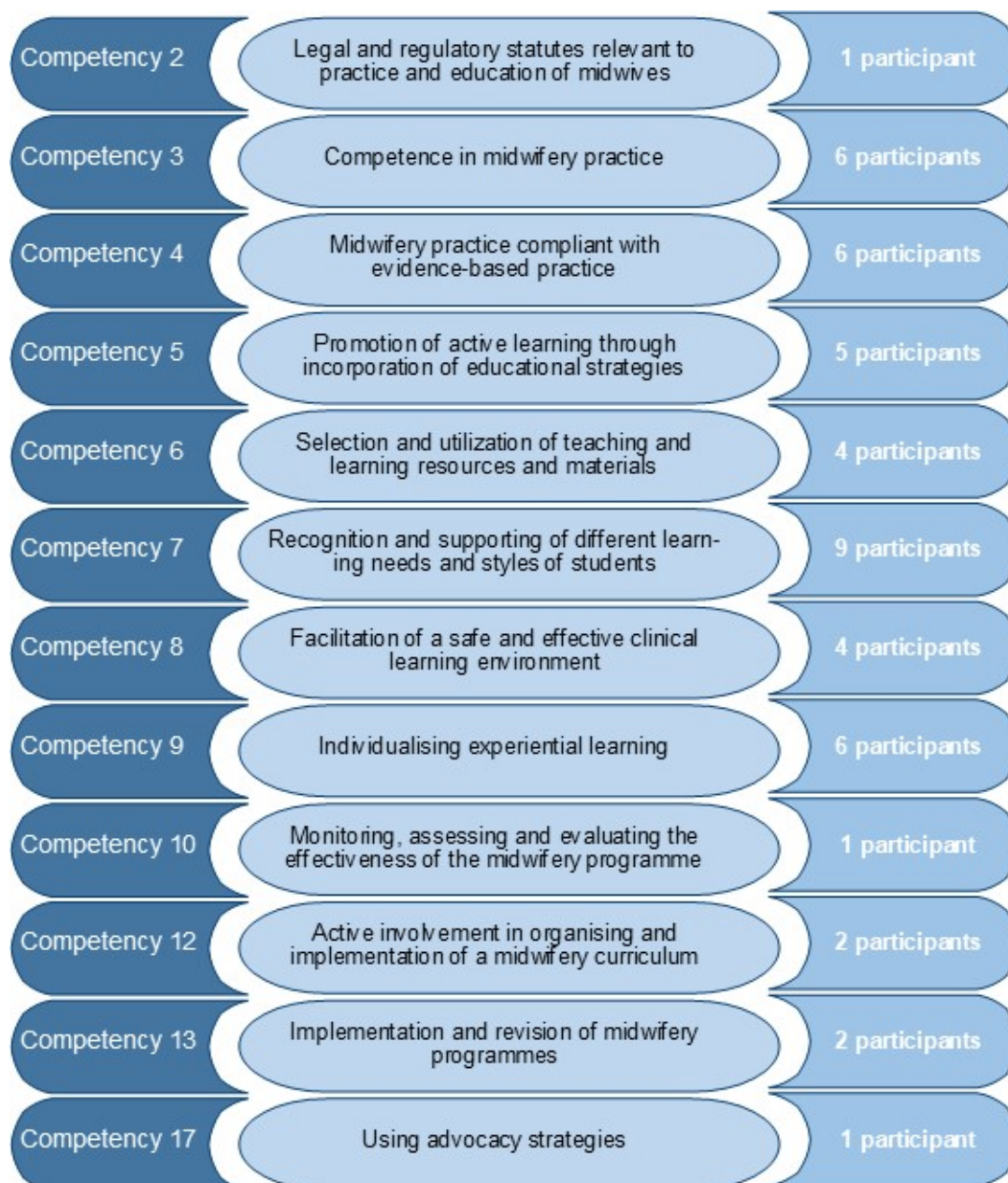


Figure 5.9 WHO Competencies identified in the analysis

Peak experiences of educators are connected to competencies that correspond with the WHO competencies. Participant 7, who listed Competencies #2 and #3, which cover clinical midwifery, expressed it by saying, "*Expert knowledge in theory and practice of midwifery*". The importance of clinical competence as a life-giving source is made clear, and with six participants (2, 4, 7, 18, 28 and 31) referring to this as a motivation for the peak experience, shows how much these participants value clinical expertise.

A powerful statement confirms the commitment and value of relationships, also mentioned in the first question. *"Commitment and the ability to run extra mile for the students"* (Participant 24). If there were no relationships, she would not have considered running anywhere for the students. The deductive analysis found 12 of the 19 competencies. Competencies that were not mentioned were # 1, #11, #14, #15, #16, #18 AND #19. Competency #7, which focusses on unique learning needs and styles, was mentioned by nine participants, and Competency #3 (clinical expertise), #4 (evidence-based practice) and #9 (individualising experiential learning) were each found in six contributions.

Discovery question 3

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

Question 3 guided the participants on what they value regarding MEC. Participant reflections varied between content that is taught, personal traits and competencies, and elements of the practice of education.

Content-focussed contributions included incorporating community service learning and evidence-based practice in education. The significance of doing so was discussed in the first question, where it also emerged. **Development and use of policy** was also mentioned by Participant 17: *"Ability to participate in policy formulation which will affect the training and education of students"*. Domain 6 of the WHO competencies pertains to organisation, management and leadership, and states that midwifery educators should participate in formulating outcomes for programmes, designing and implementing a new curriculum and developing policies (WHO, 2013:8). **Research skills** were highlighted by Participant 19, who included that as an enabling factor that she used to develop a new module. Other elements she valued as part of the process were technical skills and teamwork. As discussed in Section 2.3.4, the last

competency domain of the WHO competencies is research, with Competencies #18 and 19 addressing the importance of research competence for midwifery educators.

Many participants reflected on **deep, engaged learning** by students and related that to **student competence**. For the educators, the value of student competence was a major category that emerged in the first question. The domain of theoretical learning, as discussed in Section 2.3.4 and comprising Competencies #5, 6, and 7, was also identified by many participants in Question 2, which links with appreciation of deep learning by students.

Participants continuously reflected on the importance of the students being competent midwives and considered students who evolve into competent midwives as a reward for their (educators') work. Making meaning of this affirms several elements, such as the need for competent midwives, as elaborated on in Section 2.3.1, which relates to quality care based on community needs. The importance of competent midwives is, furthermore, described in the ICM's *International Definition of the Midwife* (2011b), and in the ICM's *Philosophy and Model of Midwifery Care* (2014).

Advocacy was mentioned again (by six participants), after it also appeared in Question 1.

"I value to promote and instil ethical and legal aspects of midwifery care by considering patients' rights, confidentiality and privacy" (Participant 5).

In addition to reaffirming the importance of advocacy, this statement by Participant 5 expresses an understanding for the importance of the human rights foundation of midwifery, as discussed in Section 1.1.3.

The importance of keeping themselves updated with developments in midwifery was identified and analysed as valuing **CPD**. Participant 6 expressed her appreciation for CPD by saying:

"Adherence to the hallmarks of midwifery practice. Maintaining and upgrading the standard of midwifery practice".

The "hallmarks" of the profession are surely those articulated in the ICM core documents. Keeping midwifery education and practice updated is captured in the ICM

Philosophy and Model of Care. The responsibility of lifelong learning, together with shaping a new generation of midwives (ICM, 2014c:3) are mentioned explicitly. Furthermore, the value of midwifery was confirmed, with better resource efficiency associated with improved outcomes when the practice of midwives is educated, licensed, and regulated (Renfrew, *et al.*, 2014:13). The licensing and regulation of midwives should be done in compliance with global standards, of which one of the six core components is based on CPD (ICM, 2011d:4). Equally, midwifery education, where the educators is underprepared or the curriculum is outdated, is associated with poor quality midwifery education. Implementation of CPD programmes improves theory-practice integration and the quality of midwifery education (West *et al.*, 2016:21). In the WHO's *Strengthening Quality Midwifery Education for Universal Health Coverage 2030* (2019), the importance of strengthening midwifery educators to international standards is a key action. One of the components refers to the pre-service and in-service education of midwifery educators. The connection of access to CPD is a key element. In the report, the negative influence of gender inequality, as a professional barrier in the midwifery profession as a feminised profession, is stated. Midwives are undervalued, which means too little is invested in their education, which includes CPD (WHO, 2019:21, 32).

The **practice of education** was mentioned by 13 participants. Participant 7 summarised it well by declaring: "*Practice what you teach*". Her statement links to both the role modelling for and mentoring of students and supports evidence-based practice. In addition, they referred to the importance of up-to-date content taught with clinical competence. In the WHO action plan described in the previous paragraph, in addition to CPD, the importance of clinical competence is captured in two elements that refer to enabling and strengthening midwifery educators to international standards. The first is that teaching and practice cycles should be created, to allow educators to remain practicing midwives. In addition, a combination of theory, practice and simulation should be included as part of the educators' roles to improve theory-practice integration (WHO, 2019:32). Simulation, as part of competency-based education, is a teaching and learning method used in SBA preservice and ongoing education. The modalities of simulation might vary based on resources available, but is valuable as fire-drills on preventable causes of maternal mortality. Fire-drills are also an integral component of the ESMOE ongoing education of SBAs in South Africa

(Atukunda & Conecker, 2017:12; Pattinson & Moodley, 2018:iv; Shaw *et al.*, 2016:2283).

Passion also emerged in Question 4 and will be discussed in detail. The traits that were included emphasise that competence is a multifaceted component, as explained in Section 2.3.4.1. A **positive and supportive attitude to students** reiterates the importance of relationships, as captured in the first question in this section.

Discovery question 4

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

Question 4 brought the focus closer to the core life-giving element that participants identified. Participant 13 associated the two most frequently mentioned categories, **student competence** and **passion**, and phrased it as follows:

"When students develop(s) passion and succeed in mastering midwifery as evidenced during assessment".

Participant 19 related the value of passion by calling it,

"the internal drive to develop a model that will produce the product you are expecting".

At a personal level, the fact that so many of the participants referred to student competence (10) and passion (9) touched and excited me deeply. As indicated in my explanations about the factors that influence my own reflexivity and personal stance (Section 4.2), my passion for midwifery and midwifery education has been a driving force throughout my journey as a midwife and midwife educator. To experience that participants shared this passion confirmed a personal belief that educators with passion provide the best education they can.

The renowned French obstetrician and author, Michel Odent (2013:124), writes about what he refers to as enthusiasm, a synonym for passion. He states that the future of *Homo sapiens* and the future of enthusiasm cannot be separated. Enthusiasm is said to be inspired by divinities and is often related to religion and excluded from discussions on emotional traits. Odent, however, associates creativity with enthusiasm, and confirms that Socrates saw the inspiration of poets as a form of enthusiasm. In addition to inspiration, enthusiasm provides a way of transcending the daily reality. He furthermore connects the birth process and how that is conducted with a discussion on enthusiasm. The transition between intra-uterine and the extra-uterine life is routinely disrupted in modern obstetric care. Birth, as the transition, is a crucial period of emotional development. Considering the interruption of the normal process, the concern is that, in the future, the cultural level of transcendental emotional states might be altered (Odent, 2013:124). In addition to passion, other values were also highlighted.

A **value of teamwork, reciprocity, reflexivity and self-directedness** were also treasured. Self-directedness related to continuing professional development and evidence-based practice guidelines, were discussed in previous questions. Domain 8, revolving around educators' ability to utilise research in education and practice has components that rely on creating a climate that supports inquiry and evidence-based practice, which means relying on self-directedness (WHO, 2013:23). Teamwork, reciprocity and reflexivity are captured in the behaviour component of Competency #16: the ability of an educator to integrate values, including respect, collegiality and caring, to create a platform for the development of students and other educators. The ability and practice of self-reflection is also a component of the behaviour component of this competency (WHO, 2013:22) . Some participants reported that the **clinical teaching platform** was the most valuable element in their practice. The categories emanating from the data link very well with the WHO competencies a discussed in the explanation of Question 3.

Discovery question 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?

Question 5 asked participants to reflect on the appreciation on the best example of MEC and why this was so memorable. In the analysis, we coded the responses using the WHO MEC.

The majority of participants reflected on **student competence**, which was also mentioned in Question 1. Although the category is recurring, the repeated examples given by the participants confirm the life-giving force of competent midwifery students in more ways than only from the perspective of AI.

"Students that delivered breech successfully when the intern could not"
(Participant 26).

This story literally and figuratively confirms how the students' competence gave life. The newborn was born in a breech birth, of which the level of complication left the intern doctor unable to manage the obstetric emergency, yet, the students were able to save the life of the baby. The AI concept of what gives life is confirmed by saving the life of this newborn.

Another frequently re-emerging category was the **use of innovative teaching and learning strategies**. The **value of teamwork** and **appreciation** shows how important the relationships within teaching teams and institutions are. **Content**, such as the use of evidence-based practice, research and respectful care, are all captured in the WHO MEC.

Again, the good **relationships** with students emerged from how Participant 16 expressed her contribution:

"Student sending a message at night reporting on a gained skill due to ME [midwifery educator]".

The open relationship between the midwifery educator and the student lead to the student immediately sharing of progress with the educator. The usual communication in many institutions would be governed by office hours, yet this student crossed the conventions, possibly driven by the nature of the relationship. The educator was accessible to the student at all hours. Sharing and celebrating outcomes implies a personally close relationship. The inspiration ignited in the student gave her the impetus to celebrate with the educator, even if it was at night.

Discovery question 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?

Question 6 asked participants what they do when feeling "highly relaxed, most secure, or most cherished as midwife educator – when it is simply great to be a midwife educator". The intention was to elicit the elements that elevated the daily work to an energising activity. In the process of analysing the data from this question, however, it transpired that many participants did not understand the question as it was intended. The replies varied from reference to personal activities, such as sleeping and reading, to grounding, including spiritual and religious statements. Categories that emerged from participants who had an understanding similar to the intent of the question, include **engagement with students strengthening self-worth** (5 participants), **student success** (2 participants), and use and expansion of **evidence-based practice** (1 participant). These categories all re-emerged and the affirmation of student success and how that strengthened the effort of the participants confirms the reward that the educators received from engaging with students and being part of their progress to becoming competent midwives.

Participant 12 said:

"When I get appreciation and positive feedback, I feel I want to do more".

Participant 12 captures the essence of AI, as appreciation of what works is, indeed, the driving force that improves any organisation or system. The principles of AI, as discussed in detail in 3.3 and Table 3.2 centre on the power of appreciation as an element that can ignite change.

Discovery question 7

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

Question 7 focussed on the best aspect of MEC for igniting change in an environment of gender inequality. Gender inequality in midwifery has sociocultural, professional and economic ramifications. Sociocultural influences include midwifery being perceived as low-skilled "women's work". The role of male students and how they are perceived as either advantaged or disadvantaged in the profession informed this question (WHO, 2019:21).

One participant raised the question as follows:

"Is gender equality for midwifery educators or whom? Empowering women on SRH [Sexual Reproductive Health] through advocacy" (Participant 15).

This question illuminated hesitance or a timid response in relation to even considering themselves as being treated differently as women or care-providers in a women-focussed profession. The feminisation and perceived status of the profession impacts on both the professional status and the sociocultural perspectives held regarding midwifery. The postulation is also that the remuneration of midwives is lower than other healthcare workers and skilled birth attendants due to gender inequality. The salaries of midwives are indeed lower than those of medical doctors. Yet, if we consider the

response to Question 5, where Participant 26 referred to *"students that delivered breech successfully when the intern could not"*, we might ask whether this is fair.

The responses participants provided fell into two main categories. One category focussed on **inclusivity**, including advocacy for women seeking care, and which extended to male students in the profession. Responses about male students ranged from perceiving them as advantaged, to considering them to be disadvantaged. In this category, the importance of communication and care for male students was highlighted. Participant 22 captured inclusivity in saying:

"To be accommodative of your students regardless of their gender and sexual orientation. Respect of human rights and encourage the expression of and discussion of multicultural views".

The majority of responses were in the inclusivity category (14) but, sadly, there were two that displayed **distancing**. Participant 31 said: *"Males do not fit"* and Participant 29 indicated,

"I feel that someone who cannot experience pregnancy, birth and baby cannot be able to have empathy with a mother in such situation".

The participants did not have the opportunity to elaborate on their sentiments, so the context from which these comments were expressed is not known. Considering that the explicit purpose of AI is embedded in positivity, seeing the two distancing statements created a personal internal conflict. In an attempt to avoid manipulating the data, and without the opportunity to engage with the participants, to understand the motivation for their statements, I perceived that the discovery process stimulated the participants' energy and self-efficacy and led them to voice their true opinions (Donovan & Roff, 2018:4; O'Flanagan & Corrigan, 2019:91).

Discovery question 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)

Question 8 in the discovery phase asked participants to imagine three wishes to create the ideal midwifery education, if they had the opportunity. The purpose of asking participants to share three wishes was to support their energy and self-worth through an exploration of previous successes (Moore *et al.*, 2016:69,70). Having been encouraged to "think big", the participants shared what would strengthen their practice. From the categories that emerged, Figure 5.10 was compiled:

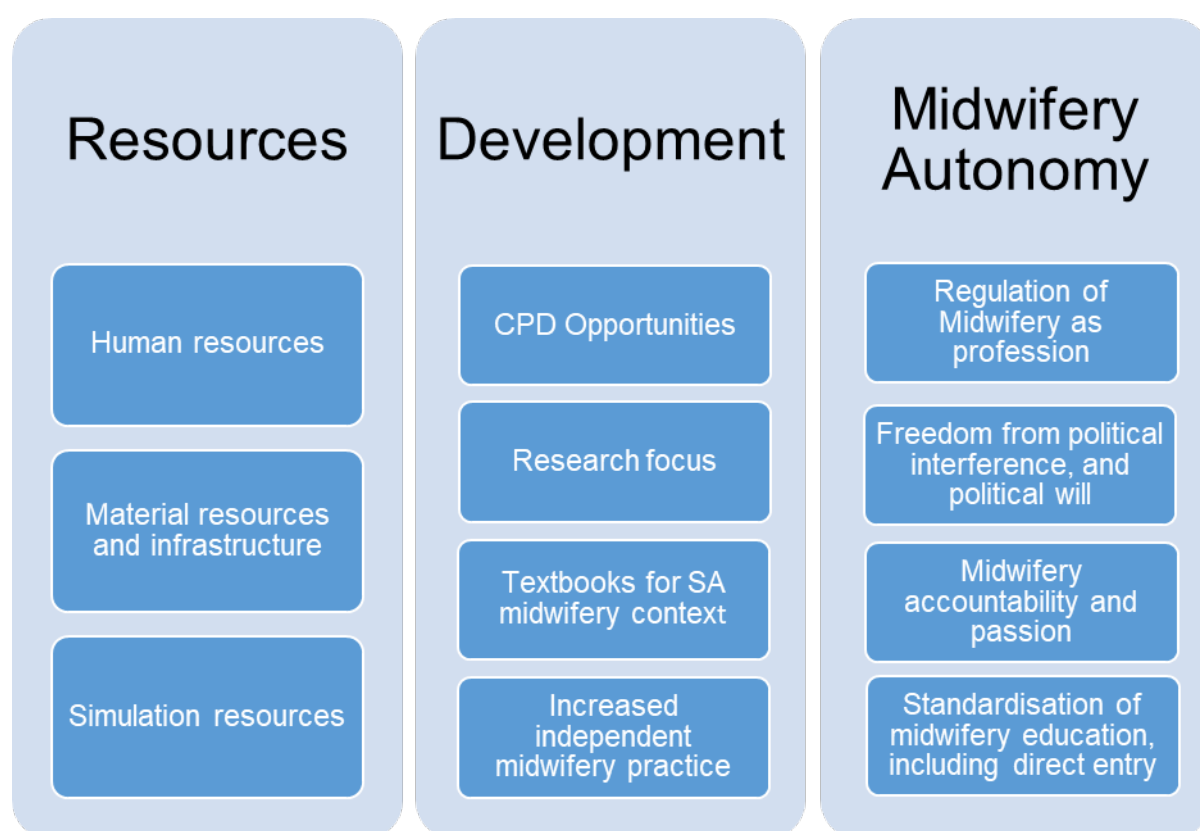


Figure 5.10 Summary of elements to transform MEC, Question 8 of AI

Three main categories relating to resources, developmental concerns and the autonomy of the midwifery profession were identified. From this wish list, an enabling environment emerged as an essential factor – this was captured under resources. The revival of clinical departments was also an expressed wish. These departments were designated staff working in hospitals that were part of the NEIs; however, the system has been abolished. Clinical departments was not added as a separate element, as human resource constraints led to the abolishment. Development captured statements revolving around CPD, a research focus, development of textbooks that are appropriate for the South African context and increasingly independent midwifery practice in South Africa. This could also be seen as part of the category of midwifery autonomy, but it was predominantly considered as a developmental wish. The majority of independent midwives do function autonomously within an appropriate context of referral of emergencies or complications. Issues of professional autonomy and compliance with standards as presented in the ICM global standards for regulation and education, discussed in Section 2.3.3, were expressed without specific reference to the documents. Standardisation of the curriculum and opening direct entry pathways to midwifery education were also mentioned, and these are elements captured in the global standards for education and regulation. Midwifery autonomy was also the section in which the importance of passion and accountability were grouped. Political influence was one of the elements mentioned and this was placed under the autonomy sub-section. Selection of students and policies influencing maternal healthcare is often influenced by political structures. Political will captured the wish that politicians and administrators should support the profession, as captured by the words of Participant 11:

"Governments say that midwifery is important for humanity".

After the feedback at tables, the participants joined in a general discussion in the room that was conducted in round-robin fashion. If an element had already been shared, the next group only mentioned that it was also part of their discussion. The process took longer than expected, because some participant tables needed more individual facilitation than others. The discovery step is seen as the most crucial step of AI, as it is during this step that the foundation is laid and participants can appreciate their self-

worth. The AI principles (as discussed in Section 3.3) and in particular, the simultaneity principle, applied well with how the participants responded despite the complexities that were incurred. Inquiry and change are simultaneous. Allowing participants to progress thoroughly through the discovery provided time for the development of the poetic principle or narrative principle and shape their ability to author their change. Inquiry into our strengths in themselves is transformational (Moore *et al.*, 2016:70).

5.6.2.3 *Emerging theme 1*

Following the coding, categories emerged, as presented in Figure 5.10. Through a process of analytic synthesis, the different codes and categories shaped a new heuristic (Saldaña, 2013:10). The research question that guided this phase of the research is,

What are the appreciated competency strengths of South African midwifery educators?

Reflecting on the research question, as well as the overarching process of the Discovery step of identifying what gives life to midwifery educators' work, the codes and categories emerged from the analysis. Considering the eight questions and the responses to them, the synthesis process consolidated new meaning (Saldaña, 2013:10). Categories that emerged and re-emerged, coupled with the wishes expressed in the Discovery and finding the strengths of MEC shaped the following theme:

Passionate midwifery educators in a well-resourced environment draw energy from their students and for their own growing competence within an autonomous midwifery profession.

The theme, and others that emerged from the AI, will be integrated in the inference with the gap analysis, to allow the participants' discovered strengths to ignite the transformative framework for MEC.

Stories build a bridge between the past and the future. The next steps of the AI continued after the round-robin discussion of the discovery. At that stage, participants' work started slowing down and they seemed fatigued. However, all the participants stayed present throughout, showing that, despite their exhaustion, they were engaged in the AI process.

5.6.3 Dreaming

The next step of the AI, Dreaming, followed. As the Discovery had taken longer than anticipated, participants took the refreshments served during the afternoon tea break of the congress and immediately continued with the AI process.

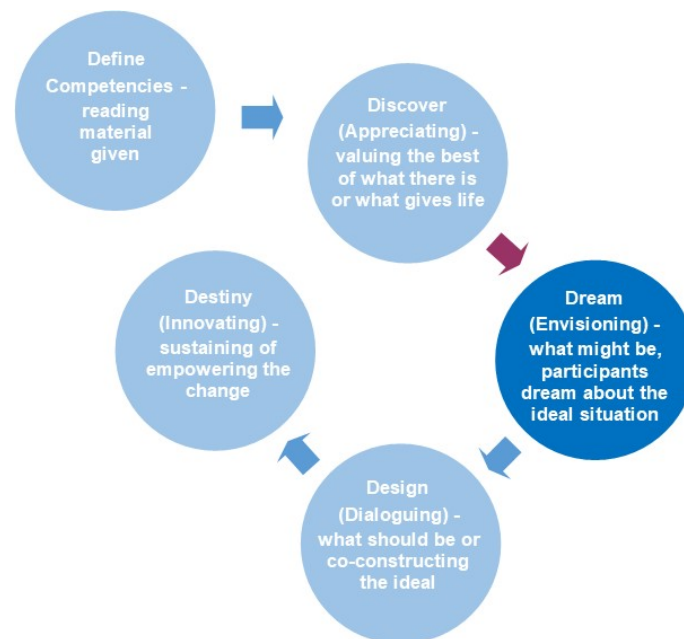


Figure 5.11 Dreaming step in AI process

5.6.3.1 AI step of Dreaming

This step of AI builds on the excitement created by appreciating the positive core of the MEC. Dreaming is a step during which participants can imagine possibilities. The narrative style is intended to help stories and images spark ideas that other

participants can supplement or complement. AI practice encourages many forms of expression of the imagined future. Participants can be creative and express themselves through poems, songs or artwork. Creating visual material is considered to be an emancipatory, and playful and creative strategy of involving participants (Cooperrider *et al.*, 2008:132; Emmison *et al.*, 2012:20) The purpose of the phase is to move beyond the current situation and to use the positive inspiration to articulate a new future (Barrett & Fry, 2008:59–61; Cooperrider & Whitney, 2005:26, 27).

5.6.3.1 *Data from Dreaming*

The facilitator moved to the dream phase after a refreshment break. Participants were encouraged to dream by use of the following prompt that appeared in the booklet:

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?

Six of the participants did not complete this component in their AI process booklets and the assumption is that this failure can be attributed to fatigue. Everyone, however, did still contribute to the group discussions.

The same categories that emerged from the responses to the three wishes in the discovery phase were identified in the written feedback.

- Human and physical resources, including career development opportunities (Participants 2, 9, 13 and 27).
- Content to be taught included evidence-based practice, safe motherhood and gender-based violence (Participants 5, 6, 11, 14, 16, 28, and 30).
- An autonomous profession and pathways such as direct-entry midwifery programmes were mentioned, as were passion for and the status of the profession (Participants 8, 10, 15, 19, 20, and 32).
- Standardisation of the curriculum (Participants 7, 21, 22, 23, 24, 25 and 26).

The latter category, standardisation of the curriculum, was expressed as a wish.

"Produce competent, competitive cadres that are marketable in the world. With a research culture and primary health orientated". (Participant 5)

The statement confirms that competence should encompass the primary health re-engineering focus, to ensure health promotion, protection, and the prevention and treatment of conditions identified in the burden of disease in the South Africa (Moeti & Padarath, 2019:70). Additionally, the need to comply with global standards and integrating ICM competencies for basic midwifery education (as discussed in Section 2.3.3) was mentioned explicitly.

Unique aspects mentioned as dreams included independent practice as a personal dream of one participant, together with restoring the image of the profession.

"Midwives to attach value to their profession so we can regain the good image we used to have" (Participant 19).

Participant 11 phrased her statement, which evoked the same need as Participant 19, to position the profession, as by saying: *"Happy midwives, happy women and children"*. This sentiment echoes the passion that emerged during Discovery.

An interesting observation was that participants aligned their dreams with the wishes in the Discovery phase, which confirms the power of AI. The discovered strengths are seeds for the dreams now created (Moore *et al.*, 2016:70). Indeed, they imagine their dreams to be attainable, rather than impossible.

In addition to providing text to describe the dreams, the participants were given the freedom to make a collage or write a poem to express their dreams. To provide options for the creation of collages, each table received several magazines, scissors and glue sticks. Past editions of a campus publication, pregnancy parent-focussed magazines, as well as general publications were provided, to provide a variety of visual materials.

No poems were received, possibly due to the level of fatigue of the participants. Some collages were created, and one participant drew a picture on a flip chart. Visual analysis of the collages was performed with the assistance of the research supervisor. Textual descriptions were considered in accordance with Liebenberg *et al.* (2012, cited in Roos, 2016:120), who recommends that images are analysed in context with the

accompanying narrative or text descriptions. As similar magazines were placed on tables, some images appeared in more than one of the collages. The collective analysis, as described in Section 5.5, where the process of the data analysis was described, led to the following interpretations. It is acknowledged that the original intent of the participants could not be confirmed when textual descriptions were vague or very brief.

Participant 21 presented a collage containing a single magazine picture of a woman in process of birth (Dream collage 1).

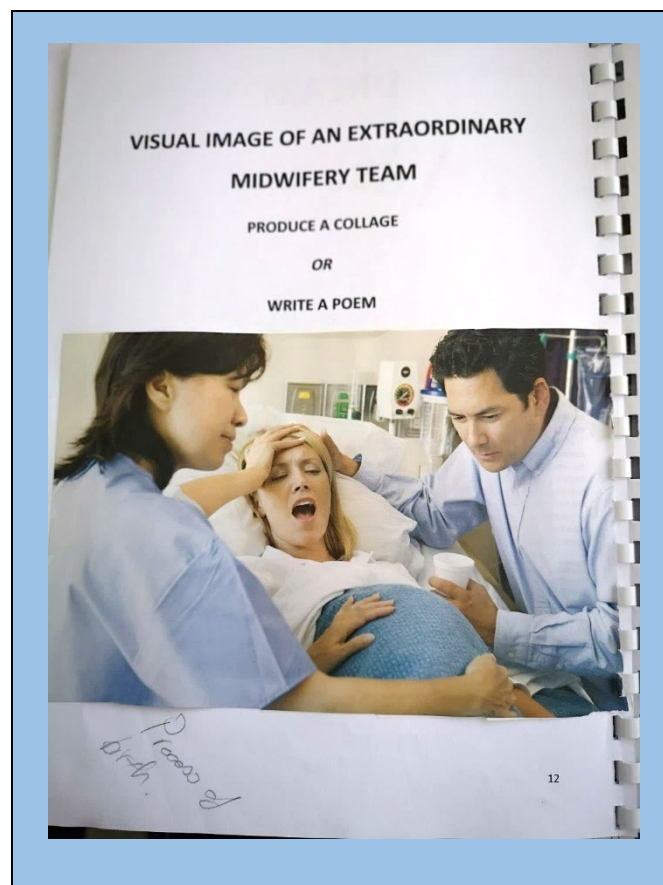


Image 5.4 Dream collage 1: Process of birth

Dream Collage 1 Process of birth

A pregnant woman is in a hospital bed, positioned on her back and propped up with pillows. Oxygen and suctioning equipment is mounted on the wall behind her and a

drip stand is visible in the background. The woman appears to be in process of birth. Her eyes are closed, her mouth is open and she is holding her forehead. On her left, a man dressed in office clothing is laying his right hand on her head while holding a disposable cup in his left hand. His gaze is directed toward her abdomen. The impression is created that he is possibly the father of the baby. On the right of this woman is a woman dressed in scrubs, with her hands positioned on the woman's abdomen. Her focus seems to be on what she is doing.

As the participants were interested in or practicing midwifery educators, this visual image could represent the clinical environment and subject content, as covered in the domain (Domain 2) of midwifery practice (WHO, 2013:8).

Participant 22 created the collage presented in Dream collage 2:

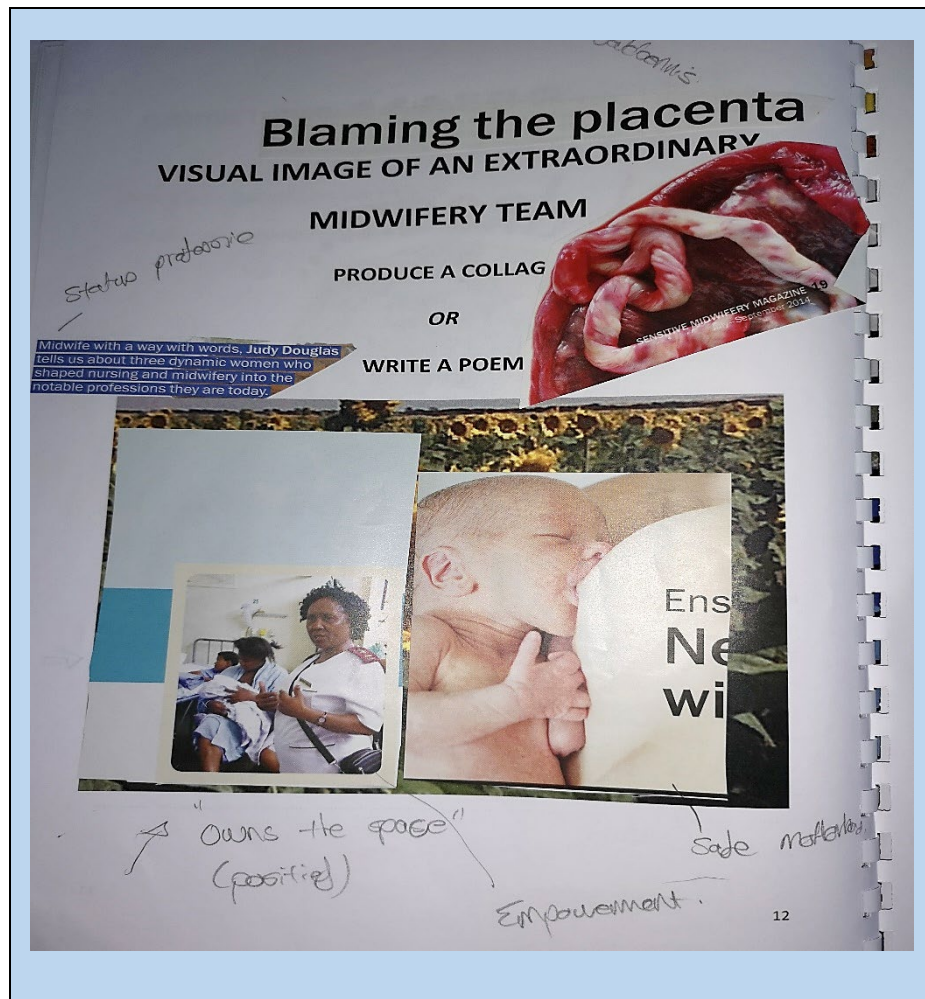


Image 5.5 Dream collage 2: Blaming the placenta

Dream Collage 2 Blaming the placenta

At the top of the collage is pasted a cut-out heading with the words, "Blaming the placenta". Below the heading on the right is a picture of a placenta with a swirl of umbilical cord draped over it.

To the left of the collage a text snippet from a magazine article with the words, "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".

At the bottom of the collage are two pictures. The one on the left is a picture of a hospital room. In the background, a mother in a dressing gown is seated next to the bed holding a baby wrapped in blankets. A young boy is seated behind the mother. In the foreground is a registered midwife in uniform with a handbag slung across her chest who appears to be in conversation with someone next to the photographer. The picture on the right portrays a small baby, skin-to-skin with the breast, being breastfed.

Prominent placement of the phrase "*Blaming the placenta*" appears to be a heading for the collage. The reason for including this phrase is uncertain, but possibly refers to the midwifery content as captured in the domain on midwifery practice (WHO, 2013:8). Another magazine clipping stated:

*"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".*

My interpretation of this is that this quote refers to the dynamic nature and ideal status of midwifery. An image of midwife and mother feeding an infant in the background represents the scope of midwifery practice. Another image of infant latched to the breast can also refer to the scope of practice, extended to safe motherhood.

Participant 23 pasted only one picture, of a mother with a newborn and a midwife touching both the mother and baby. This image could also refer to the scope of practice of the midwife. As confirmed, the impact of midwifery across the continuum of reproductive healthcare is significant, and it is the focus of quality midwifery education (Renfrew *et al.*, 2019:397; WHO, 2019:5,6).

Participant 24 pasted more pictures in the collage (Dream collage 3).

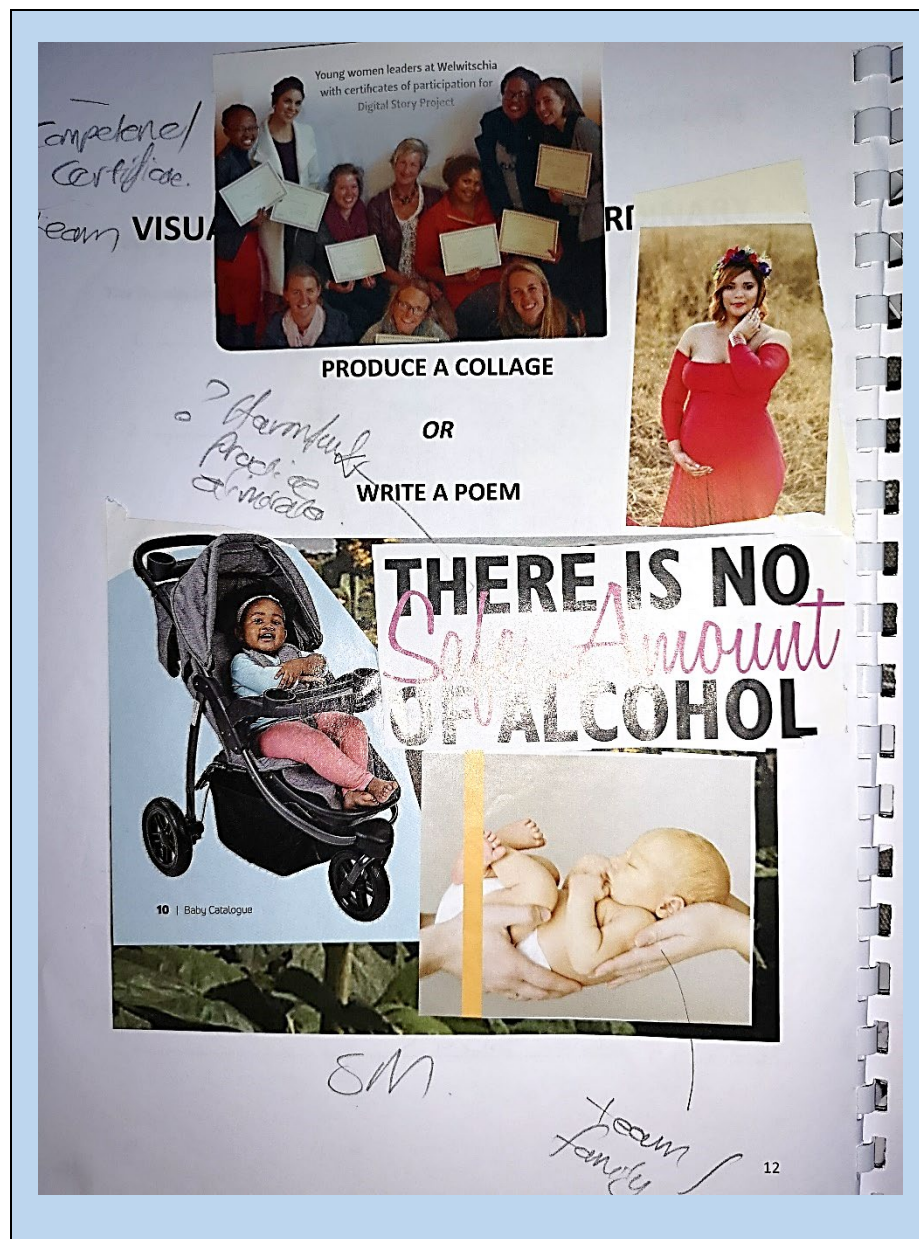


Image 5.6 Dream collage 3: There is no safe amount of alcohol

Dream Collage 3 There's no safe amount of alcohol

In the middle, on the right of the collage, a text snippet with the words, "There is no safe amount of alcohol", in large letters draws the attention.

At the top of the page is a group photo of women in smart casual dress holding certificates. The caption reads: "Young women leaders at Welwitschia with certificates of participation for Digital Story Project".

In the lower right is a picture of a pregnant woman in a red, long-sleeved dress with open shoulders, posing in a field of dry grass. The woman is wearing a floral crown. Her left hand is positioned on her neck and her right hand is tucked under her abdomen, as if supporting it.

On the left of the page is a picture of a smiling toddler in a stroller. The picture on the bottom right is of a small, sleeping baby, lying on its back with limbs curled up. The baby is in a nappy and is held by two sets of adult hands. A woman's hands are cradling the baby's head and upper body, while a man's hands are holding the lower part of the body.

The caption, "*There is no safe amount of alcohol*", at first, left me without clarity on the intent. The clipping, taken from a pregnancy magazine, probably related to the elimination of harmful practice, which is part of normal midwifery care, as captured in the ICM Philosophy and Model of Care. Midwives need to provide information that empowers a family and enables decision-making (ICM, 2014c:2). Four images from magazines were part of the collage. The first picture, of young women leaders with certificates, could represent general student competence. The pictures of the pregnant woman, two parents holding an infant and the last one of a smiling baby in a stroller, were categorised as partnerships with families and safe motherhood. The drive of safe motherhood is captured in the impact of quality midwifery education, as discussed in Section 2.3.

Participant 25 also chose the caption stating, *"There is no safe amount of alcohol"*. The other pictures of pregnant mothers and families reaffirm the previous collages. (The image is in the data summary included as Annexure I) This participant pasted individually cut letters to construct *"TEAM"*. Teamwork was mentioned in Discovery, and reaffirmed in the dream phase.

Participant 26 chose a variety of pictures, including a mother and baby in kangaroo mother care.



Image 5.7 Dream collage 4: Small legs, great heights

Dream Collage 4 Small legs, great heights

The collage contains four smaller photo images and three snippets of text. At the top of the page, in large letters, are the words, "Small legs, great heights". A second clipping of text in small font is pasted above this heading and reads: "and it all was for a good cause". Under the heading are two pictures of hikers. In the middle of the page is a small image of a child walking along an earthen path with an adult on either side. Both adults are holding a hand of the child while holding water bottles in the other hand. On the left is a group photo of nine hikers. The caption of the photo is pasted at the bottom of the picture, and reads, "At the peak with the entire nine-member team who took care of him during the climb". Pictures on the right portray motherhood. Above the pictures is the hand written inscription: "Good Cause + Final outcome Outcome". A hand-drawn arrow points down towards the top picture of a mother-baby dyad, with a baby in a kangaroo mother care wrap and position. Below is a picture of a mother holding a smiling baby above her head, making eye contact with the baby. The picture of sunflowers was printed on the page of the booklet.

Pictures of the team of hikers with the captions, "*Small legs and great heights... and it all was for a good cause*" signifies a victory over a difficult task and links to safe motherhood, as described in Section 2.3.

Participant 26 also wrote on the collage, "*Good cause final outcome Outcome*" The repeated "Outcome" with the arrow represents that a healthy mother and baby dyad, as depicted in the picture, represents the goal of the good cause, that is, safe motherhood (WHO, 2019:5, 6).

The last image created is of a participant known to the researcher. She drew a picture on a flipchart (A1size) with the markers provided. Due to the slower than anticipated progress of the session, there was not enough time during the feedback to present the picture and what it represented to her. Since we have a close working relationship, she came to the facilitator and me afterwards and said she wanted to share what she

had created. Having a close working relationship might carry the risk of bias, but in the essence of respecting every contribution, her explanation is included. The analysis with the supervisor added balance to ensure rigour. The contribution was characterised by coherence and insight, in addition to paradigmatic and philosophical congruence (Creswell & Creswell, 2018:226). The explanation was videotaped and transcribed.

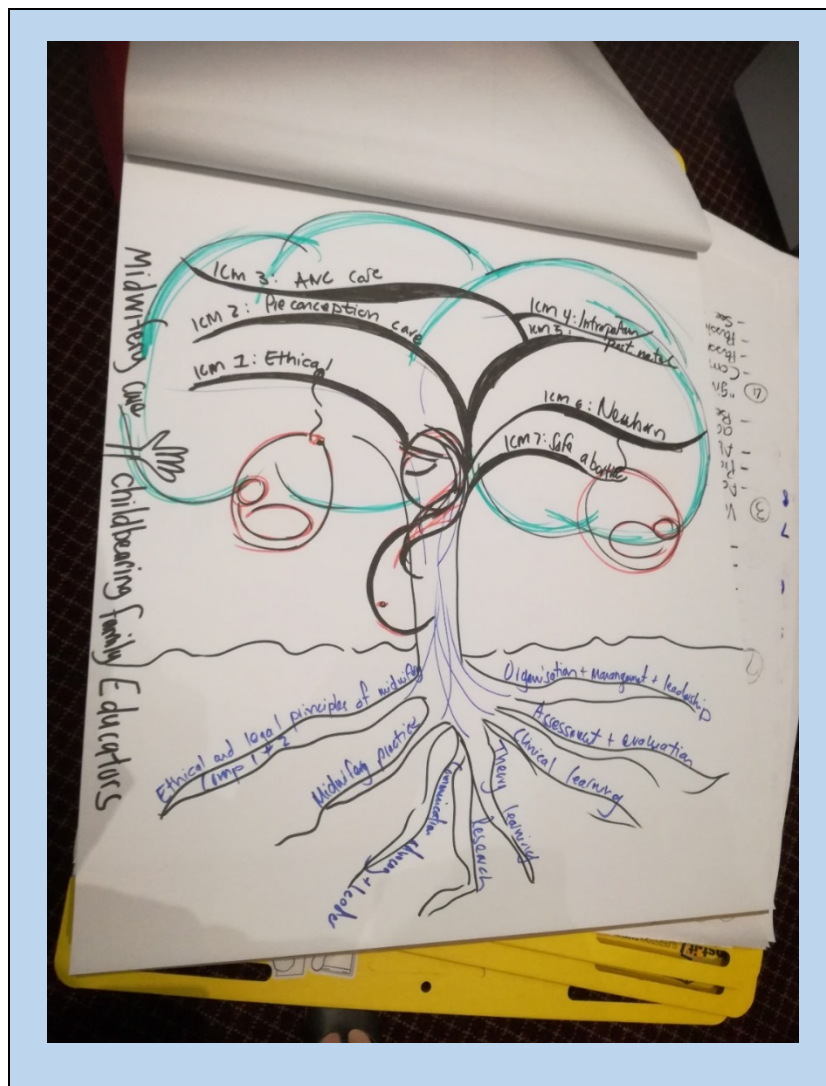


Figure 5.12 Graphic design: The tree of life

The hand-drawn picture is of a tree. At the centre, the tree trunk contains the superimposed figure of a pregnant woman. With her eyes closed, head slightly bowed and strands of hair gracefully dangling down over one shoulder, her expression seems serene. The rest of her hair appears to spread upwards to form the branches and green foliage of the tree. Seven branches each contain the inscription of an ICM MEC, as follows: ICM 1: Ethical; ICM 2: Preconception care; ICM 3: ANC [Antenatal care] Care; ICM 4: Intrapartum; ICM 5: Post Natal; ICM 6: Newborn and ICM 7: Safe abortion. Two of the branches (ICM 1: Ethical and ICM 4: Newborn), positioned on either side of the tree, each bear a balloon-shaped fruit, in the shape of the enveloped rudimentary image of a baby.

At the bottom of the image, spread out in width and breadth similar to that of the branches, is a root system of eight strong-looking roots. Each holds a domain of the WHO Competencies for Midwifery Educators: Ethical and legal principles of midwifery (Comp.1 + 2); Midwifery practice; Communication, advocacy + leader; Research; Theory learning; Clinical learning; Assessment + evaluation; Organisation + management + leadership.

From the middle of the image on the left, a hand reaches towards the tree. Above the hand, the words "Midwifery care" are written downward along the outer edge of the page. Below the hand are the words "childbearing family" and lower down, seemingly beneath the soil, "educators".

The explanation was done in a mixture of English and Afrikaans and the verbatim transcript is presented.

Participant: The picture starts with the educator's competencies wat die wortels is [*which are the roots*].

En uit hulle uit gee dit die lewe aan die boom en die boom is die vroedvroue of midwifery care [*And from that, life is given to the tree and the tree is the midwives or midwifery care*].

en die sterk stam is die ICM se [*and the strong trunk is the ICM's*] basic midwifery competencies and the fruit it bears is die gesonde stam en die gesonde boom en gesonde ma en [*are the healthy trunk and the healthy tree and healthy mother and*] the fruit is the newborn baby.

Die boom en stam kan nie gebeur sonder die [*The tree and trunk cannot happen without the*] partnership between mother and child, ag [oh] midwifery and the childbearing family

so dit gaan oor die hande vat tussen die twee. [*so it is about taking hands between the two.*]

Me: Hmmm!

Facilitator: Elgonda se gedagtes as sy dit sien, ek sal haar gesig afneem as sy dit sien [*Elgonda's thoughts as she sees this, I would take a picture of her face when she sees this*].

The facilitator noticed how the explanation of this picture touched me. This participant, a former student and colleague, incorporated many elements that are core to how our team of midwifery educators sees and teaches midwifery. By conceptualising MEC as the roots of the strong and healthy tree, which will bear fruit in the form of healthy mothers and babies, touched my heart. Education and midwifery educators represent the soil in which the tree is planted. Educators nurture and ground midwives via roots, which are the WHO MEC. The tree of midwifery is producing fruit, that is, healthy mothers and babies.

The analogy of a tree that feeds humanity through healthy mothers and babies confirms the existence and life-giving capacity of midwifery and midwifery education, while capturing essential elements, like partnerships between midwives and

childbearing families. A pregnant mother with a serene expression represents a calm mother, prepared for birth and confident with her situation.

In the department where this participant and I both work as a midwifery educators, the ICM Core documents are central to our education and practice. We place emphasis on keeping birth normal by respecting the birth process, as a process created by the Almighty God. In addition to the focus on the normality of birth, we also aim to teach students how to meet the basic needs of childbearing women. Michel Odent (2011) wrote extensively about the need of labouring women and how the need is governed by both physiological concepts and psychological concepts. A major concern is the adrenalin-oxytocin antagonism concept, in which adrenalin, which is secreted in a fight-or-flight response, suppresses the action of oxytocin, which Odent describes as the "hormone of love". As the hormone involved in orgasm during sexual intercourse, with the ejection of milk from the milk ducts during breastfeeding and with the contractions facilitating birth, oxytocin can only be secreted in a safe, loving environment. Odent considers the need to respect the needs of the labouring woman as a crucial determinant involved in the selection and education of midwives and obstetricians (Odent, 2011:97).

Portraying midwifery education and educators as the soil, with roots of the tree of midwifery branching into student competencies, affirms data from the Discovery phase about student competence (Section.5.6.2). Another affirmation is the fruit of healthy mothers and babies, which we categorise as safe motherhood. As I grew up, my family preserved seasonal fruit, so, the fruit and tree are preserved in my heart. Expressions captured in the picture and the conceptualisation of the tree will resemble well-preserved fruit that can feed my appreciation for and give life to midwifery for years to come.

5.6.3.3 Emerging Theme 2

The ability to draw from the discovery of what gives life to create a picture of the ideal future (Watkins *et al.*, 2011:214) emerged in this phase. Similar to the process followed to create consolidated meaning from the codes and categories in these AI steps, a theme emerged. As the focus of the session was on MEC, the time and energy limitations that led to fewer processes being completed in the bigger group did not limit

the process for each individual. A personal treasure was the picture of the tree that took what gives life to the level of midwifery educators and connecting our work to midwifery as giving life to humanity. The drawing and its description inspired the second theme:

Rooted in MEC, midwifery care, branching out in essential competencies for midwifery care, can produce quality maternal healthcare.

This second theme will be incorporated in the inference to allow the co-created dreams to shape the transformative framework.

5.6.4 Designing and Destiny

As the session progressed and fatigue, coupled with tasks perceived as complex by some participants, less data were captured in the AI process booklet.

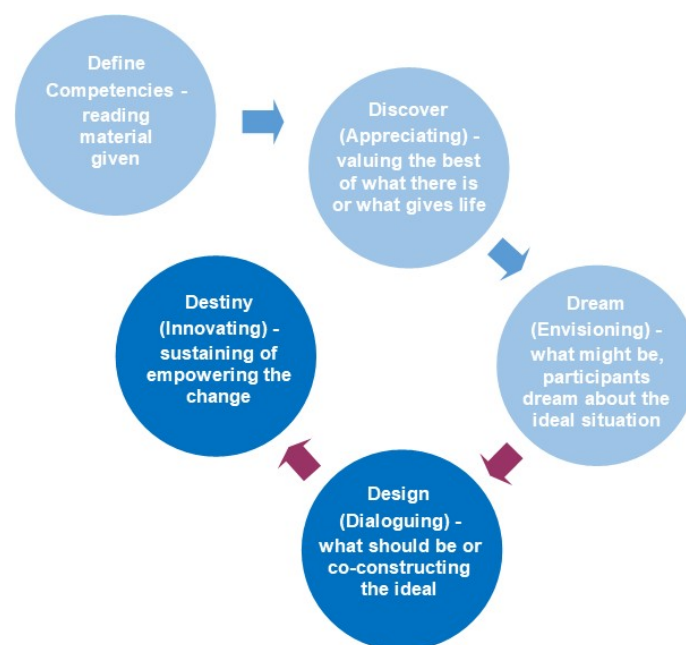


Figure 5.13 Design and Destiny steps in AI process

5.6.4.1 *AI step: Design and Destiny*

In the Design phase, the emphasis is on co-creating a new destiny by reflecting on the discovered strengths and dreams. The discovered strengths and dreams inform the new reality. The AI principles (as discussed in Section 3.3) that are relevant in these two steps include the constructivist principle. In this principle, the process of construction shapes thoughts, actions, and change. Although not all the AI steps could be completed as thoroughly as the Discovery, the awareness principle, which implies the ability to keep reflecting on our actions, words and relationships, reduces assumptions and increases general awareness. The participants were all part of the final steps and the energy and increased self-awareness of the AI process can effect personal change (Moore *et al.*, 2016:70, 71).

Designing allows participants to articulate personal values that have now emerged to change the future. The drawing of the Tree of Life (Figure 5.12) is an excellent example of personal values brought into the final product that is presented. Similar to constructing a new building, the foundations that are created during this phase are often referred to as social architecture to reflect the opportunity that exists to create a new reality (Barrett & Fry, 2008:61, 62; Cooperrider & Whitney, 2005:29, 30; Watkins *et al.*, 2011:238, 239). In planning the session, the intended Design step was to request participants to describe their intended future by writing a provocative proposition. A provocative AI proposition is a statement of intent, which is regarded as a compelling and powerful catalyst for change. The power of the statements is drawn from the own work of the participants, which had been constructed from their own experiences and strengths (O'Flanagan & Corrigan, 2019:94).

Because few contributions were received in the two last phases, the analysis of those phases will be presented together. The instruction in the AI process booklet was as follows:

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?

At this stage, a provocative proposition could be incorporated into the Dream or Design phase. The application of elements in an AI session is not predetermined, and creative solutions evolve from what flows naturally in a given context. Originally, the Design and Destiny phase was referred to as the Delivery phase of AI but, in some instances, the expansion of the Destiny captured more of the essence of the phase (Cooperrider & Whitney, 2005:34; Watkins *et al.*, 2011:238).

In the Destiny phase, the purpose is to liberate the structures that limit change. Action planning and working through scenarios and blueprints for change is often done in AI processes (Barrett & Fry, 2008:68; Cooperrider & Whitney, 2005:34). During the conceptualising of the AI, the participants had the opportunity to contribute to the transformative framework. The instructions were as follows:

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.

Only three **provocative propositions** were received.

Participant 15 stated,

Competent educators – competent midwives – confident practitioners.

Participant 16 brought,

"SA [South African] midwives of the future: strong and competent".

Participant 32 wrote,

"SA [South African] midwives must be a midwife".

In considering the three statements, all were compliant with the expectation that the aspiration statements are positive statements, built on what gives life. Also, the statement should challenge and provoke positive change. Another sentiment carried by all three statements is that it bridged the past strengths with future realities (Barrett & Fry, 2008:64; Cooperrider *et al.*, 2008:168). One central category was competence.

The statement from Participant 32 referred to part of the welcoming address that I had given at the opening of the congress the previous day, where I asked the question: **"Is a midwife A MIDWIFE in South Africa?"** In reflecting on the choice of the words, I am cognisant that, due to my profile within the association and during the congress, this participant could have been giving this particular statement because the session was part of my research, or because the statement was fresh in her memory.

Elements valued by two participants who completed the **destiny** phase that are crucial to strengthening MEC were as follows. Participant 16 wrote: *"Opportunities, Competence, Assertive"*. This participant also provided the provocative statement: *"SA [South African] midwives of the future: strong and competent"*. The ideal framework elements address her provocative statement, as the strong and competent midwives she wishes for the future, can be produced if there are opportunities, and a focus on competence and assertiveness.

Participant 19 indicated, *"Education by compassionate and competent lecturers, SA [South African] Midwifery Council not appointed by a political person"*. She did not write a provocative statement, but the elements provided captures an emphasis on passion, competence and autonomy.

Despite the lack of time and fatigue setting in, incredible contributions were received that mapped out what gives life to MEC of the group of participants who attended the

session. The data of the Design and Destiny phases confirmed categories and themes that had emerged from other steps of the AI process.

5.7 AT THE END OF THE AI

After the AI process concluded at the congress, participants lingered and expressed their gratitude, despite the intense input they were required to provide during the session. The appreciation confirms that, as envisaged, participants were possibly encouraged by the AI process. I, in turn, appreciated that they were part of mapping the social change needed to transform MEC. The AI session left everyone tired, but excited to be part of transforming our future. The analysis process left me in awe about how passionate educators can contribute to humanity every day, and to changing our profession.

5.8 CONCLUSION OF THE AI

AI, as the qualitative method chosen to appreciate the strengths in MEC, provided an enriching session to everyone involved in the research. The collaborative process culminated in two themes.

The theme that emerged from the discovery phase was,

Passionate midwifery educators in a well-resourced environment are drawing energy from their students and their own growing competence within an autonomous midwifery profession.

From the dreaming phase emerged,

Rooted in midwifery educators' competencies, midwifery care branching out in essential competencies for midwifery care can produce quality maternal healthcare.

From the data collected from the enthusiastic group of participants at the session, the appreciated strengths provided the impetus to construct a transformative framework

of the strengths. The heliotrophic principle of David Cooperrider found new meaning in the appreciation of how the drawing of the tree connects the two themes. The importance of resources, developmental needs, and an autonomous profession, as captured in Figure 5.10 can represent the soil in which quality midwifery education is embedded. Basic care of any living organism relies on providing water and nutrition – which was voiced by educators when they expressed their wishes. Investing in midwifery education and providing the environment needed can provide a return on investment, and secure quality midwifery education and, subsequently, quality midwifery care.

Chapter 6

Gap analysis



CHAPTER 6 GAP ANALYSIS

"We have a unique opportunity to empower and dignify midwives and ensure women and newborns receive the quality care they deserve. Investing in quality midwifery education to improve quality of care and ensure better outcomes for all women, newborns and families, everywhere" (WHO, 2019:v).

6.1 INTRODUCTION TO GAP ANALYSIS, PHASE 2

After the first part of the story of data collection and data analysis covering the AI in the previous chapter, in this chapter, the quantitative component, the gap analysis (GA) of MEC will be discussed. Within the transformative paradigm and the philosophical foundation of feminism, choosing a gap analysis could be perceived as lacking congruence with the appreciative and inclusive intention of the research. However, the 72nd World Health Assembly in May 2019 saw the launch of a framework to strengthen midwifery education to achieve universal health coverage by 2030. Strengthening all midwifery educators to meet international standards is captured by several actions. One of the steps of this framework is to assess educators according to the WHO core competencies (WHO, 2019:32). The relevance of the gap analysis was confirmed by the WHO framework, which requires an assessment of the skills of midwifery educators in every country. Although there could be reservations about the positivist methodology, the importance of this step, as a contributory factor to producing competent midwives validates the gap analysis. Dignified midwives who ensure quality care and improve outcomes are one of the most significant contributions to humanity.

6.2 DATA COLLECTION OF GAP ANALYSIS – PERMISSION

In this quantitative component of the study, the WHO Midwifery Educator Core Competency Gap Analysis Tool was selected for application. Team members working on the WHO educators' competencies developed the questionnaire. After seeking and

receiving ethical clearance for the study, as described in Section 4.4.2, the gatekeeper permission process started.

6.2.1 Permission for university-based educators

The university-based midwifery educators in South Africa are all affiliated with a national body, FUNDISA (discussed in Section 1.11.2.2.) and permission (Annexure J) was obtained from FUNDISA to access the educators. An annually updated list of educators and their contact details was obtained from FUNDISA and all lecturers at South African universities were contacted via email and informed about the gap analysis. From the initial list, 58 educators were identified. Topic areas of interest, reflecting midwifery and maternal or reproductive health, were selected. All the identified educators were invited by email to take part in the research. In addition, the heads of each department were emailed to ask for the email addresses of their midwifery educators. The email addresses were added into the Evasys® email system. Four persons indicated that they would not participate, because they were not involved in clinical programmes; these educators were either based at distance learning universities, involved in research or were management-focussed staff. Ultimately, 54 educators' email addresses, from the initial list of 58, were entered to send the Evasys® questionnaire.

6.2.2 Permission for Department of Health institutions

Public health NEIs where midwifery programmes are offered were initially targeted by requesting permission from the chief nursing officer, as her office, amongst other matters, deals with education at the colleges of the national Department of Health and the military services. The permission process was, however, extremely complicated. As directed by the chief nursing officer, permission was requested from the heads of each of the nine respective provincial Departments of Health. Within the national Department of Health, a Health Research Database exists that allows for an online system where a researcher can upload the research proposal, and proof of ethical approval. The researcher then selects research sites per province and submits the request for permission. This application process was completed in April 2018. Some provinces granted permission within two weeks and others only in June 2019, 14 months later. The information is captured in Annexure J. Access to public health NEIs

in Kwa-Zulu Natal was denied, thus, preventing data collection at all the campuses of this college. The college head indicated that staff members at this institution were exposed to other studies. Hence, none of the midwifery educators at public health NEIs in this province were included in the gap analysis.

In addition to the complicated permission process, due to a lack of uniformity, obtaining provincial permission was complex. Furthermore, per college and campuses within colleges, a myriad of uncommunicated and numerous levels of permission had to be followed. There was no standard guideline, and the additional levels of permission were discovered via telephonic and email follow-up. As these processes became known, they were followed, and the email addresses of midwifery educators were requested. After an extended period and several follow-ups with individuals, a decision was made in June 2019 to continue with the available list. In total 107 email addresses had been obtained from the public health NEIs, of which many were private email addresses, because many gatekeepers indicated that provincial email systems were not always reliable.

6.3 PILOT STUDY

While the permission process was in progress, the WHO Midwifery Educator Core Competency Gap Analysis Tool (Annexure B) was transferred to an anonymous electronic format in Evasys®. A link to the questionnaire was sent to five colleagues on the Evasys® system. They were requested to complete the questionnaire, to indicate the time it took them to complete it, and to comment on the clarity of questions (Cohen *et al.*, 2011:402; Creswell & Creswell, 2018:174). Four people completed the pilot study.

In Table 6.1, the suggestions, comments made, and actions instituted are summarised.

Table 6.1 Pilot study actions

Component	Suggestion/comment	Action implemented
Time spent completing the questionnaire	40 minutes 45 minutes 90 minutes 120 minutes	Questions to match AI component were reduced and excluded
User-friendliness	- The questionnaire was regarded as user friendly - One person did not notice that questions required two answers, one on level of competence and a second on confidence	- The instructions were amended to emphasise the two components - The two different sections were coloured, one blue and one green, and more vivid differences in the two were selected to enhance the visual difference
Similarity of questions	- Q 8.11 & 8.14 - Q 10.6 & 12.6	- Question 8.11 was removed - Both were kept. One refers to the processes of student assessment and the other to assessment of a woman
Q 3.5 –start with "Compliance"	Q 3.5	Rephrased to start with compliance
Suggested clarity on questions provided	- Q 4.7 - Q 4.10 - Q 10.10	- To identify the need was added - Addition of "to maintain own competence" was added - I added, "with individual students"
"Incomplete" questions	- Q 7.5 - Q 12.7 ends with or...?	- Merged Q 7.5, 7.6 and 7.7 - Corrected
Concern about the ability of Evasys to allow more than one answer per question	It is not possible with the version used to limit responses to one option, as there had to be an option for the competence component and the confidence component.	
Incorrect colour	Q 6.13 "did at least once" was green instead of blue	Colour corrected

Unclear questions	• Q 15.6 unsure whether the word "women's" is applicable in question • Q 20 statement not understood well: "Midwifery educators cultivate a culture supporting critical inquiry and evidence-based practice."? Suggested amendment to: "Midwifery educators cultivate a culture that supports critical inquiry and evidence-based practice" • Q 9 in Competency #8- "not sure how much we can influence structures of clinical settings."	• Kept original • Changed • Contribute or facilitate was added

Changes were effected and questions on gender inequality were added in alignment with the theory as discussed in Section 3.2. The proposed additions were circulated to the pilot study group and added to the questionnaire on their recommendation.

6.4 PROCESS OF DATA COLLECTION FOR THE GAP ANALYSIS

Evasys® contains multiple options for sending and tracing completion of questionnaires. Group questionnaires sent via electronic media have the benefit that participants can complete the questionnaire in their own time and it is less cumbersome to complete and mail back. In addition, electronic distribution is economical, offers complete anonymity and, important in this study, reduces bias and provides data ready for analysis (Polit & Beck, 2017:275). A weakness of questionnaires is, however, that the response rate can be low (Brink *et al.*, 2018:153; Cohen *et al.*, 2011:405; Maree *et al.*, 2019:198). One of the strategies to improve the response rate was to use electronic systems, rather than mailing questionnaires. Evasys®, as electronic survey platform that is licenced for use at the UFS, follows steps for survey distribution that enhances the response rate. The email contains the information and link to the questionnaire and the reminder system can be set to prompt participants that have not yet completed the questionnaire (Creswell & Creswell, 2018:174).

Emails with a link to the questionnaire were sent to each of the 161 email addresses that I was able to gather. These were the 107 from the public health NEI's and 54 from the FUNDISA list. The Evasys® system was set up to send automatic reminders every two weeks (Creswell & Creswell, 2018:174). The fact that the emails went to the recipients of uncompleted questionnaires enhanced the opportunity for participants to take part. Immediately after sending the emails on 20 June 2019, seven emails bounced back as undeliverable. One was from a university-based educator and the others were email addresses received from gatekeepers. In each subsequent round of reminders the same group of emails was undelivered.

The Evasys® questionnaire was closed on 26 August 2019; by that time, 48 midwifery educators had completed the questionnaire. With 161 original emails and seven non-functional email addresses, a total of 154 questionnaires were sent and the response rate was 31.1%. It was found that the automatic reminders every two weeks assisted in increasing the number of completed questionnaires every time (Cohen *et al.*, 2011:404; Creswell & Creswell, 2018:178). Access to technology, whether due to inadequate resources or low computer literacy of many educators, especially at public health colleges, might have negatively affected the response rate. The data were submitted to an electronic database, to protect participants' anonymity, were then exported to Excel and shared with the biostatistician for analysis.

6.5 DATA ANALYSIS OF THE GAP ANALYSIS

As per procedure of the Faculty of Health Sciences at the UFS, a biostatistician, who was from the Department of Biostatistics at the Faculty of Health Sciences at the UFS, assisted with the analysis of the closed-ended data. A non-parametric analysis was done. The researcher and supervisor coded responses to the open-ended questions. The coded items were assigned numerical values, and the responses were counted and analysed with the rest of the data (Cohen *et al.*, 2011:407). Descriptive statistics were generated in the analysis (Cohen *et al.*, 2011:606; Creswell & Creswell, 2018:200; Grove & Gray, 2019:378). As indicated by the developers of the questionnaire, who used it previously in workshops on competency based midwifery education, the majority of the questionnaire items was analysed by a using a simple

comparison of the self-ratings of the participants. Steps of data analysis starts with cleaning the data (Grove & Gray, 2019:378). In this questionnaire, some of the responses from participants did not export effectively from the Evasys® questionnaire to the Excel spreadsheet if they had used certain characters, as they had typed their answers to open-ended questions. Hence, the original typed answers were typed to exclude characters (Brink *et al.*, 2018:180; Grove & Gray, 2019:378; Maree *et al.*, 2019:226).

Another major step in the data analysis is to consider missing data. One participant, (No. 29) left the majority of the answers open and, hence, a decision had to be made whether to include or exclude this questionnaire's data from the analysis (Grove & Gray, 2019:378; Polit & Beck, 2017:428). In remaining true to the transformative paradigm and feminism, which both rely on respecting the voice of participants (Mertens, 2017:19; 2018:2), this participants' data were retained in the final analysis. Guided by the paradigm and grand theory, the decision was made, in collaboration with the supervisor and biostatistician, to consider answers given by Participant 29, even if only a few. In consideration that transformative mixed-methods research is aimed at societal change, while respecting the people involved, the reciprocal relationship between research processes and questions was retained (Molina-Azorin & Fетters, 2019:279), even if the incomplete questionnaire could be considered as limited in conventional quantitative analysis. To keep the answers, thereby allowing their voice to be heard (Barnhardt *et al.*, 2016:2; Shannon-Baker, 2016:327), valued their contribution, even if doing so complicated the data reporting.

A simple comparison of the self-ratings in the gap analysis was made for the competence and confidence of each item. Descriptive statistics, namely, frequencies and percentages for categorised data and percentages for some numerical data, were calculated (Cohen *et al.*, 2011:606; Grove & Gray, 2019:378). A census (of all South African midwifery educators) was attempted for the very specific population and context (Martínez-Mesa *et al.*, 2016:326). Therefore, statistical inferences were not calculated (Cohen *et al.*, 2011:606; Creswell & Creswell, 2018:200). If the quantitative data were collected with the purpose of drawing conclusions about the population and to generalise the data collected, the probability statements implied by inferences would

have been suitable (Cohen *et al.*, 2011:606; Creswell & Creswell, 2018:176; Maree *et al.*, 2012:198).

Reliability was tested by testing the Cronbach Alpha coefficient. The score of α 0.94 was calculated. This score confirm a very high rate of internal consistency for the questions, as a score above α 0,8 is considered as a high and appropriate score (Grove & Gray, 2019:341).

6.5.1 Data presentation

The descriptions, reporting, and interpretation of that data will be done according to the best way of making meaning of the questions asked (Cohen *et al.*, 2011:606; Creswell & Creswell, 2018:177; Maree *et al.*, 2019:228). Numerical summaries are provided and percentages are used as part of the frequency distributions. Some of the data are presented without including the percentages, as the responses given cannot be quantified as a percentage of the participants or sample size, and it is a report of what participants presented (Cohen *et al.*, 2011:606; Maree *et al.*, 2012:184). In general, three percentages can be calculated in quantitative data, as described by Maree *et al.* (2019): One is the total percentage that reflects the frequency as percentage of the sample size. A second possibility is column frequencies, where the frequencies are expressed as percentages of the column total and, lastly, row percentages, where the cell frequencies are expressed as a row total (Maree *et al.*, 2019:228).

In this research, there were no forced answers. Hence, participants did not answer all questions or respond to all components of questions. The Evasys® questionnaire platform allowed questions with more than one possible response, which respects the paradigm that guided the research. Selecting one option did not exclude another item also to be indicated. A participant could have selected that she did something once as well as rate her competence. The instructions to participants encouraged selecting only one per category. Therefore, the expression of responses as percentages, either row or column, is not appropriate and the data are presented without percentages. The data are self-reported gaps of midwifery educators regarding the items in the MEC, and the interpretation and reporting of the data were done with sensitivity to the

power dynamics often perpetuated by positivist indications of percentages (Shannon-Baker, 2016:328).

6.6 DEMOGRAPHIC AND MIDWIFERY PROGRAMME DETAIL OF GAP ANALYSIS PARTICIPANTS

The demographic information that was gathered is similar to the information obtained from the AI participants. Questions were asked about gender, age, qualifications, professional registration, programme involvement and the roles in the programmes, years of experience (clinical and education), and the amount of time spent in practice. In addition, the gap analysis participants were asked which elements gave energy to midwifery educators. Questions on gender and, lastly, the opportunity to provide elements that they considered necessary for a transformative framework were added as open-ended questions.

All the participants in the gap analysis were female. The age distribution was 31 to 65 years, with a median of 52. In Table 6.2, the age distribution of the two sets of participants, from the AI and the gap analysis, are presented.

Table 6.2 Age distribution of participants in the AI and gap analysis

	20-30 years	31-40 years	41-50 years	51-60 years	61+	n
AI participants	n=1 (8.3%)	n=3 (1.1%)	n=5 (18.5%)	n=14 (51.8 %)	n=4 (14.8%)	27
Gap analysis participants	0	n=7 (14.8%)	n=15 (31.9%)	n=21 (44.6%)	n=4 (8.5%)	47

From both the data sets, it is clear that the majority of educators that formed part of the data collection was within 10-15 years of retirement. The median was 52 years of age. As elaborated in 5.4, in the discussion of AI participants' ages, we see a similar picture in the participants of the gap analysis. Only 14.8% were younger than 41 years, and 53.1% were more senior, and older than 51 years. Refer to Section 5.4 for the

generational differences that could have an influence on participants' use of technology, which could have been a factor in the age distribution of the participants.

The qualifications listed by participants in the gap analysis are shown in Figure 6.1.

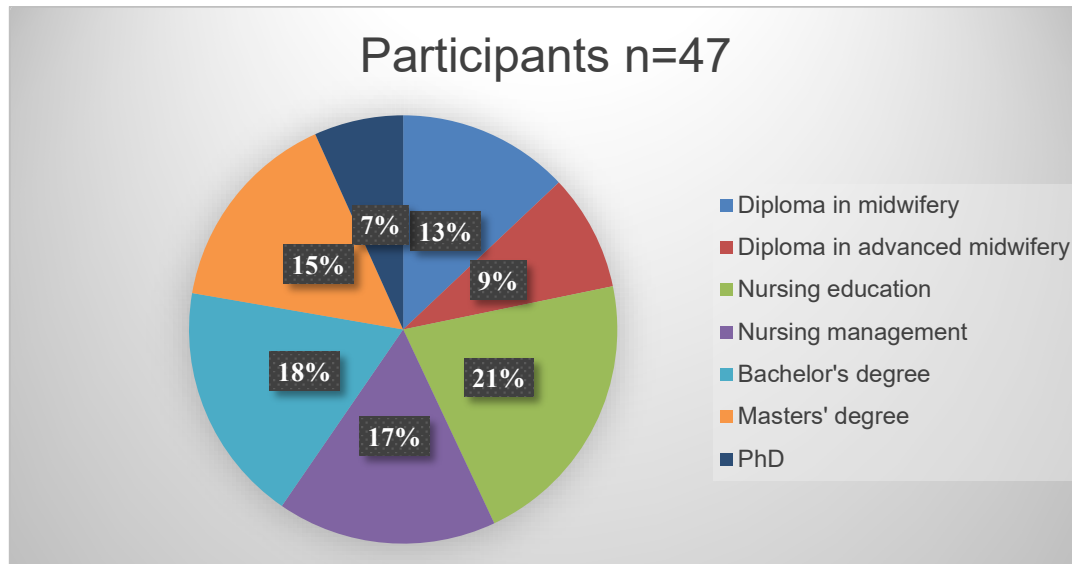


Figure 6.1 Qualifications of gap analysis participants

Participants had the opportunity to list all their qualifications. Therefore, the total number is not considered, as many participants had more than one qualification. The regulatory authority, SANC, registers practitioners professionally once they submit proof of qualifications. Professional registrations indicated by the participants are shown in Figure 6.2. Most educators have more than one professional registration. One participant did not complete the demographic information. Except for this person, all participants had registrations in general nursing and midwifery.

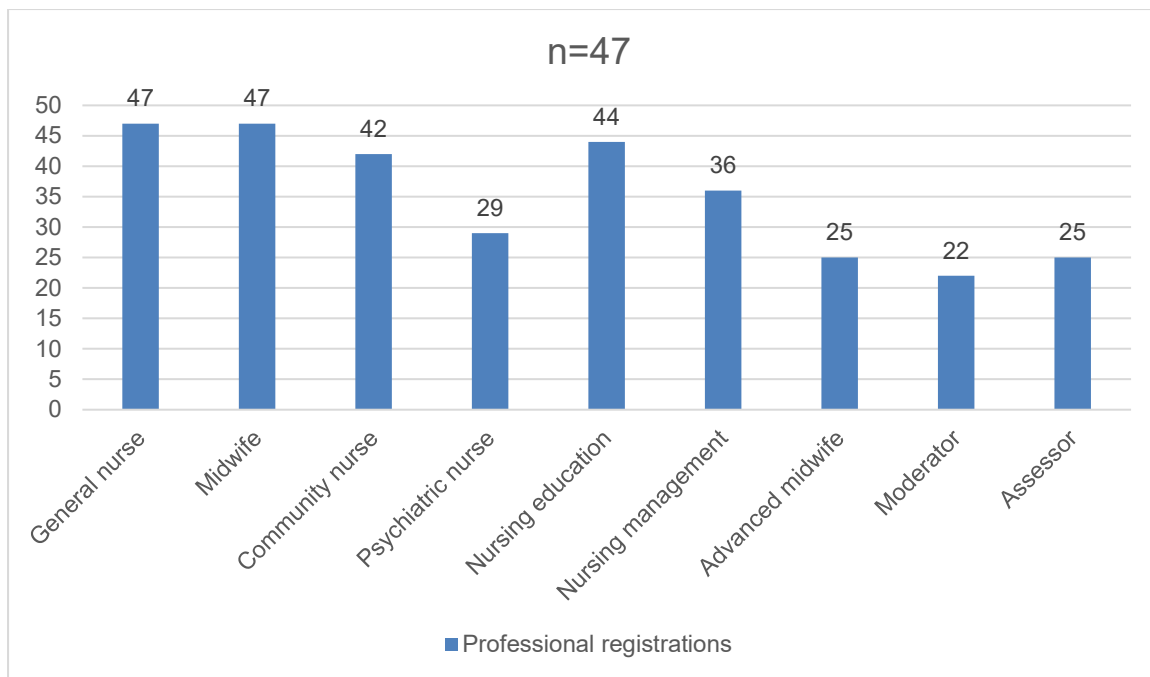


Figure 6.2 Professional registrations of gap analysis participants

A few educators listed other professional registrations, namely, Forensic nursing (1), Occupational health (1) and a Master's degree (1). In addition to general nursing and midwifery, the majority (44) listed a registration in nursing education.

Participants were asked to indicate programmes within midwifery in which they were involved. Their responses are captured in the chart of Figure 6.3.

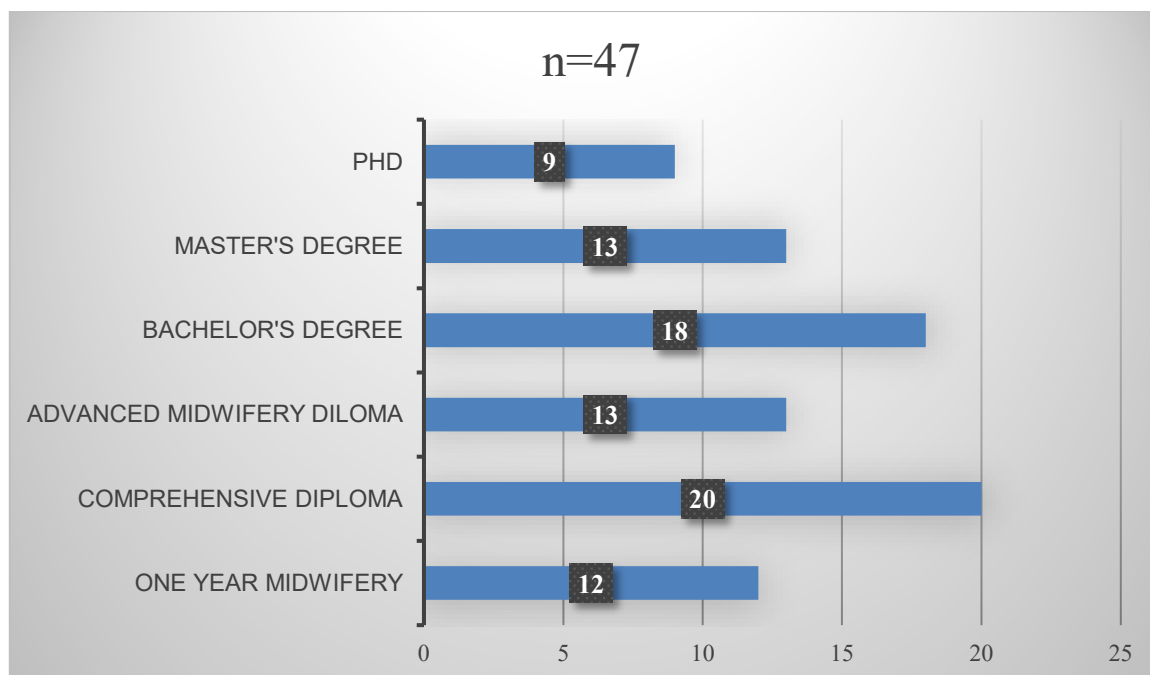


Figure 6.3 Programmes involved gap analysis participants

The participants also marked all the programmes in which they are involved. Only 26 of the participants were involved in a single programme. One participant did not complete the question. Therefore, from 47 responses, 55% had one group of students to deal with, which can be in different year groups. The other 45% were involved in more than one programme, which can imply a higher workload for these midwifery educators.

Participants had to indicate their responsibilities in the programmes they teach. Again, more than one option was given. Figure 6.4 shows the numbers of midwifery educators involved in clinical accompaniment, theory and practical lectures, programme coordination and research supervision. One of the participants was only involved as clinical preceptor. Another participant indicated that she was only the coordinator of the programme. As discussed in Section 5.4, midwifery educators should, ideally, integrate theoretical learning, clinical practice and simulation activities.

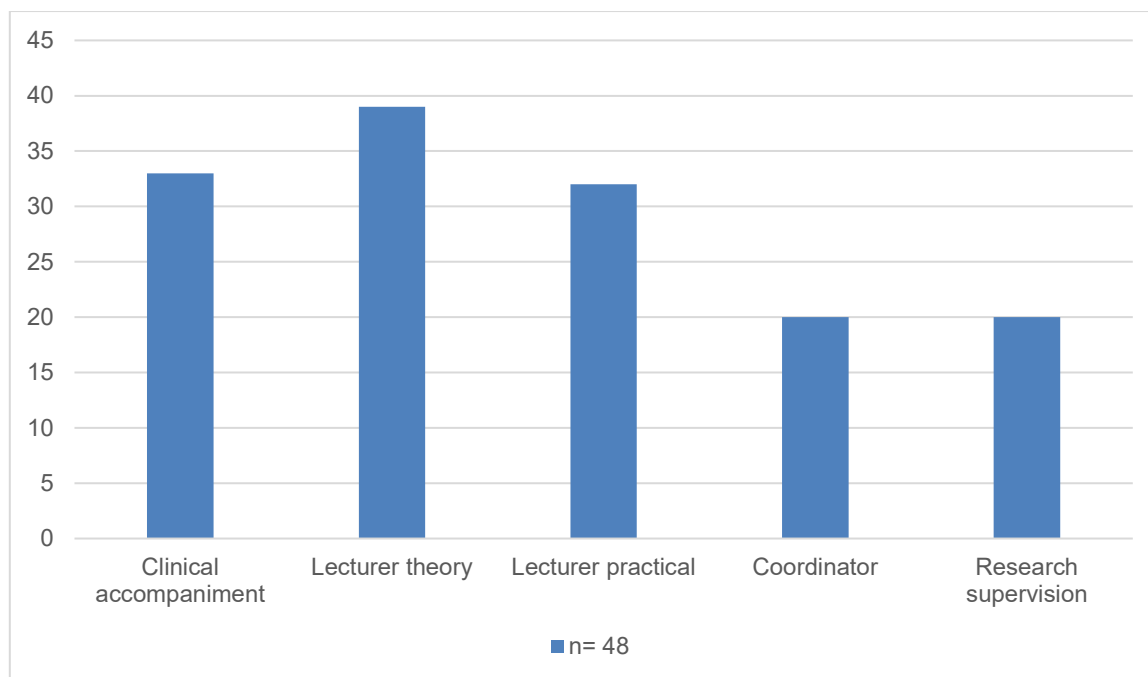


Figure 6.4 Roles in programmes

With 39 midwifery educators being involved in theory lecturing, it is concerning to see that three educators were involved in only the theoretical module, and not in the practical module or the clinical accompaniment of students. One of these participants indicated that she is the coordinator and involved in research supervision. I assume that this participants' involvement in clinical practice is minimal, as she is more involved at an administrative level, as a coordinator, and with research supervision.

The number of years' clinical midwifery experience, as indicated by 47 participants, and the number of years' education experience, as indicated by 45 participants, are both indicated in Figure 6.5.

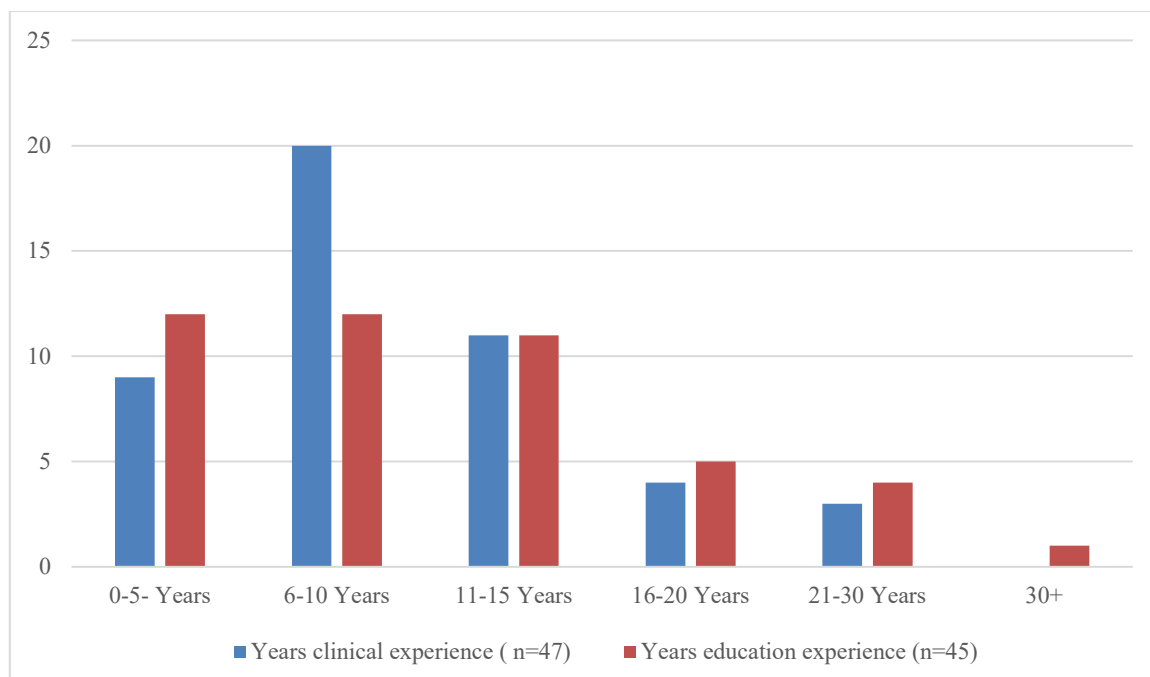


Figure 6.5 Years clinical and education experience

The median for the numbers of years' experience was ten years with the minimum of 0 years and the maximum of 30 years. The years of experience as an educator had a mean of 9.5 years. The median age for starting as a midwifery educator was calculated as compared 39 years, compared to the median starting age as an educator of 38 years. The minimum was recorded as 23 and the maximum at 55 years of age. It is concerning that three of the nine educators who indicated that they had at most five years clinical midwifery experience (reflected by the first bar of Figure 6.5), had less than a year of experience. As discussed in Section 2.3.4, clinical expertise of educators is important, as it will ensure a sound basis for educating the next generation of midwives.

The number of hours per week that educators spend in clinical practice was provided by 45 participants. As seen in Figure 6.4, some midwifery educators were not involved in any clinical accompaniment. Six participants did not report spending any time in clinical practice. The maximum indicated was 80 hours per week; though the question was open-ended, this number of hours does not seem realistic, as a general formal work week does not exceed 45-54 hours. The median was 8 hours per week.

In summary of the demographic descriptors collected, all the participants were female, and most were approaching retirement within the next 10 to 15 years. Many were involved in more than one programme, which could indicate a high workload. Some educators did not have clinical experience or exposure, and the majority were responsible for both theory and practical components.

6.7 OPEN ENDED QUESTIONS

In order to give an appreciative voice to the participants of the gap analysis, as was done in the AI process, additional open-ended questions were included in the questionnaire. Although the questionnaire primarily required self-rating of competence, the opportunity provided by transformative mixed-method research, to design, interpret and present the research with sensitivity to the theoretical perspectives, was provided (Fetters *et al.*, 2013:2135; Mertens, 2018a:3). The answers were coded and checked with the research supervisor before the data were analysed for purposes of verification.

6.7.1 Elements that give energy

Educators were asked (similar to the discovery step of AI) what gives them energy in their task as a midwifery educator. It was an open-ended question. The codes identified were the following:

- Passion for midwifery;
- Student growth/competence or transfer of learning;
- Evidence-based practice/research;
- Contributing to safe motherhood and continuum of care; and
- Positive feedback from or about students.

Figure 6.6 shows the numbers of responses under different codes. Individual participants could give more than one response.

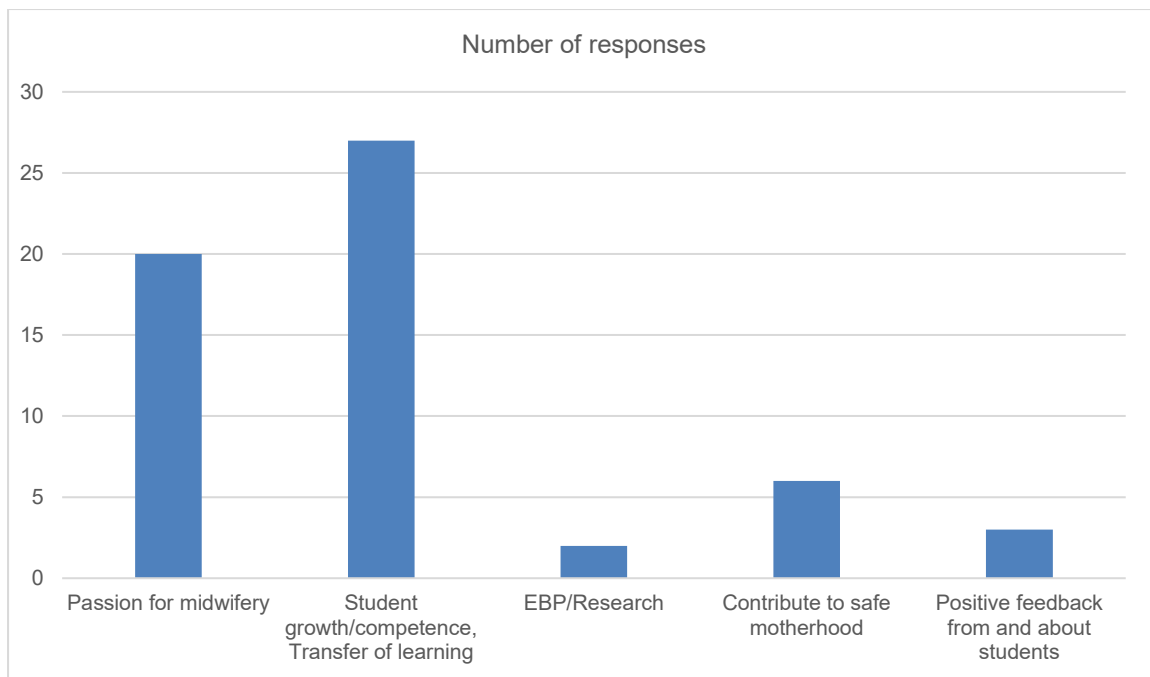


Figure 6.6 Number of responses of elements giving energy to midwifery educators

Although the question could not be as comprehensive as in the AI step, very similar answers emerged (see Section 5.6). Appreciation of student competence, and passion for midwifery were the two elements that were most frequently presented. As mentioned in the AI analysis, having competent midwives who have a passion for midwifery is of personal significance for me. To see these two elements identified by a second group of participants was a personal highlight that I treasure in this research process. This element of the data excites me and energised me in the journey of the research.

In another open-ended question, educators could indicate the component that they teach that excites them. Many had more than one component, and the responses are summarised in Figure 6.7.

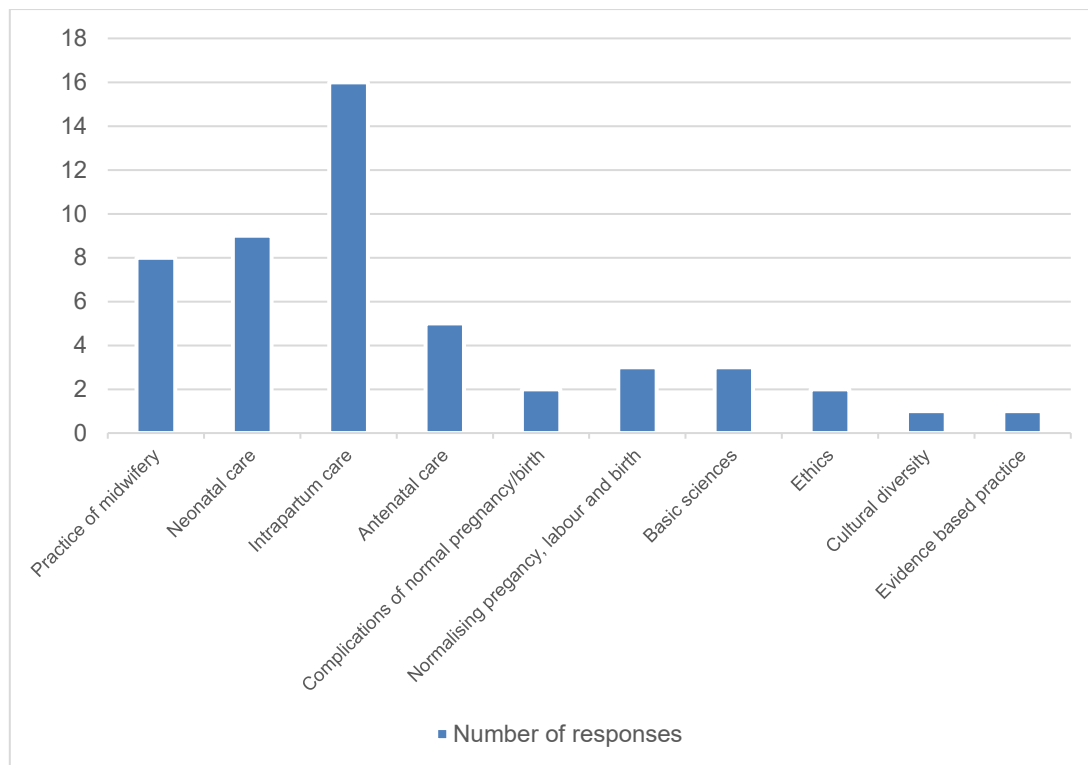


Figure 6.7 Component that excites midwifery educators

The participants were energised by student growth and competence, their passion and love for midwifery, the indirect contribution they make to saving mothers and babies, positive feedback from and about students, and the implementation of evidence-based practice. All areas of midwifery were named when participants chose their favourite components – intrapartum care, in particular, was chosen by a large number of participants.

6.7.2 Questions on gender

The aim of achieving universal health coverage and reproductive health targets are embedded in human rights issues, of which one is gender. Concerns on the international level link gender inequality with unsatisfactory progress on maternal health (Renfrew *et al.*, 2019:397; WHO, 2019:21). The intersectionality of gender, social determinants, professional status, and economic disempowerment within a patriarchal system hamper the ability to reach the global maternal health targets. Midwives, who are predominantly women, serve a population that is not regarded as a high priority and midwives faces disempowerment and discrimination on

professional, socio-cultural and economic levels (Renfrew *et al.*, 2019:397; WHO, 2019:21). Questions focussed on the possible gender inequality encountered by midwifery and midwives, and aimed to investigate the perceptions of South African midwifery educators on gender inequality.

There were five questions about gender that had the same motive: whether gender contributed to disempowerment. In Table 6.3, the questions and responses are summarised.

Table 6.3 Questions on gender and disempowerment

Question	Yes	No	Total
Does the unequal social position of women negatively affect their maternal health needs?	n=35 (72.9%)	n=13 (27.1%)	48
Do you, as midwifery educator, consider yourself to have the ability to make choices and act on those choices concerning midwifery educators' competencies?	n=37 (77.1%)	n=11 (22.9%)	48
Do you consider the profession of midwifery as an autonomous profession in your context in South Africa?	n=28 (60.9%)	n=18 (39.1%)	46
Is the autonomy of the midwifery profession linked to the fact that midwives work with women?	n=25 (52.1%)	n=23 (47.9%)	48
Do midwifery educators experience disadvantage or discrimination in any way?	n=26 (54.2%)	n=22 (45.8%)	48

The participants mostly (72.9%) recognised the impact of intersectionality and how gender can negatively influence maternal health. Most participants (77.1%) expressed that they had the ability to act and make choices with regards to their MEC. The autonomy of the midwifery profession was confirmed by 28 of 46 participants, and almost half (52.1%) of the midwifery educators linked issues of autonomy to the fact that midwives work with women. Considering that a more significant percentage (60.9%) was not concerned about the autonomy of the profession, quite a large number (54.2%) did report disadvantage and discrimination.

Feminism acknowledges that concerns about women's subordination, which are often legitimate, are unnoticed and, therefore, not always acknowledged (Mertens, 2007:214; Shannon-Baker, 2016:327). In addition, the patriarchal systems are seen as the norm. Moreover, feminism carries emotionally charged connotations that are often seen as either militant or man-hating. Due to this fear or hate, many researchers avoid assigning gender labels (Jaggar, 2018:1, 3).

Participants were requested to motivate why they indicated either disadvantage or discrimination, or not (as summarised in Table 2.3). Categories that emerged and the frequency of each are captured in Table 6.4. The pink-shaded items represent responses that were congruent with elements of feminism, whereas the green-shaded items indicated no link to gendered disempowerment.

Table 6.4 Motivations, discrimination, disempowerment, or not

Category assigned	Number of responses per item
Judgement from clinical staff towards students or faculty	5
Reduced ability to implement evidence-based practice/opportunities for CPD	4
A higher workload in midwifery education in comparison to other areas in nursing education	8
Female-led profession for the care of women	5
Midwives and midwifery educators' competence not acknowledged	7
Separation of midwifery from nursing – different role/direct entry programme for midwifery	3
Midwifery educators not given a clinical platform to remain competent	2
Some older midwives resistant to change	1
Lack of appropriate regulations	1
Professional jealousy	1
Epistemicide/colonialism threat to midwifery	1
Treated similar	6

Do not know	2
Admired	2

The green-shaded items, which indicate that participants saw no link to disempowerment, refer to comments by two participants, who commented that they were not sure of content; another participant did not understand the question. Six responses reported that the participants did not see midwifery educators receiving different treatment. Two participants mentioned that they believed they were admired for their competence.

The pink-shaded responses are those that acknowledged an element of inequality or disempowerment. The motivation that was mentioned most (eight times) is related to the workload. The participants indicated that they carried a higher workload than staff working in other areas of nursing education. An explanation for this belief was that their involvement with more than one group of students or programmes increased their workload. Often, midwifery students have more SANC-regulated clinical outcomes and are placed in rural areas, and midwifery educators mentioned that their work continues after regular working hours.

"There is discrimination especially between midwives who are in the wards and educators they don't believe we are doing a lot of work but in reality we work even after hours. In our case we have 184 in one level and 150 learners in the other level. This is a lot of work which requires extra hours after normal working hours" (Contribution 13).

Seven participants mentioned that the unique competencies of midwifery were disregarded. A reason offered was the assumption that anyone could teach midwifery, or that midwifery educators should teach in other disciplines.

"Where there is a lack of understanding and appreciation of midwifery as a profession, I find some midwife educators are undervalued and are expected to 'mix and match' anywhere in a nursing curriculum" (Contribution 30).

An issue indicated by five participants was judgement. The explanation was that credit was seldom granted for the production of competent midwives. Instead, any negative occurrence in a novice midwife's practice would be blamed on the midwifery educators.

In addition, the perception that midwifery, as a subject, was "less scientific" was conveyed.

"In my context, we are not viewed as midwife educators, we are nurse educators that teach midwifery. There is a perception that pregnancy and labour is a natural process and therefore midwife educators don't work as hard as other specialties in nursing. The work that we do is seen as 'not as scientific' as other specialties" (Contribution 25).

Five participants referred to the fact that the majority of midwifery educators are female. The notion that men feel uncomfortable in the profession was also mentioned. However, the participants who indicated that men and women were treated similarly also alluded to the fact that there are male midwifery educators.

Four participants claimed there were fewer opportunities for CPD or evidence-based practice, which was attributed to their high workload. Midwifery educators do not have the same opportunities for further education or for attending CPD sessions. It was also mentioned that midwifery educators are not included when new initiatives are shared by the Department of Health.

Three participants mentioned the need for a separate identity for the profession. International examples of how a separate identity strengthened midwifery in those areas were offered. It was observed that midwifery is often not recognised (autonomy of profession).

"This group need to be certified as clinical specialist from the beginning. They need to be allowed to have their own board not mixed with other categories like what is done in Sweden where midwifery is trained for four years" (Contribution 10).

Two participants mentioned that midwifery educators do not get opportunities to practice their skills. Individual responses included the opinion that there was professional jealousy, alluded to a perception that older midwives were resistant to change, and reported that there was a lack of regulation to support the profession.

One participant also provided a significant motivation:

"As a historically female- dominated profession in a Eurocentric-male dominated world, midwives and midwifery educators suffer the burden of epistemicide, the removal of birth from communities, decreased social status due to the profession. This is the legacy of colonisation. Birthing bodies are seen to be primitive and 'othered' by society as a result, and when led by midwives = DANGEROUS" (Contribution 26).

This participant highlighted a number of issues:

- Midwifery as female-dominated profession negatively impacted by the Eurocentric domination
- Midwives and midwifery educators exposed to a lower social status as birth was removed from communities (epistemicide)
- Legacy of colonisation and the resultant epistemicide where the birth process is degraded as dangerous if it is midwife-led.

Colonisation, as primary cause, extends to a deeper conviction of cultural supremacy of the colonisers (Sommer, 2011:183, 189, 190) that includes "the expansion of Eurocentric forms of knowledge" (Zembylas, 2018:2). Within the context of South African higher education, the concept carries the implication of Eurocentrism with the ethical obligation to correct the wrongs of epistemicide ("the murder of knowledge") and restore social justice (Santos, 2014:92). Restoration encompasses what is termed cognitive justice or knowledge democracy (Zembylas, 2018:2). The participant links the negative impact of Eurocentric domination with colonisation and the resultant epistemicide.

Concepts presented in the arguments about the medicalisation of childbirth, as discussed in Section 2.3 are reiterated in the participant's comment. In addition, members of a historically female-dominated profession, midwives and midwifery

educators suffer the burden of epistemicide, the removal of birth from communities, and decreased social status of the profession. The view conveys "midwifery epistemicide" meaning that midwifery was harmed by colonisation. Moreover, gender inequality, its impact on the profession, and socio-economic realities in midwifery are regarded as a barrier to quality midwifery education (WHO, 2019:21).

The threat of gender inequality is also captured in the statements on epistemicide, a term that can be defined as the systematic destruction of rival forms of knowledge, which can be rated as symbolic genocide (Bennett, 2007:3). Hall and Rajesh (2017:8) report that Sousa Santos, a Portuguese sociologist, coined the term epistemicide in 2007, which refers to the killing of knowledge systems (Hall & Rajesh, 2017:8). The epistemicide of normal vaginal birth is a central preoccupation of the work of the French obstetrician, Michel Odent. He indicates that humanity is facing a challenge, as a large proportion of the population is not born vaginally. He predicts that the medicalisation of birth could have effects on the characteristics of our civilisations (Odent, 2004:131). Furthermore, he associates the increased specialisation of science with transformations in *Homo Sapiens* and a deeply modified human lifestyle (Odent, 2011:13). From a Primal Health Research Database, which specialises in studies that explore correlations between foetal life, the perinatal period and the first year after birth, and the long-term health and personality traits, the long-term consequences of what happened at birth is important. He states that the ideal birth can take place when the normal physiological process and the needs of the labouring woman is respected, ideally by a midwife or obstetrician conversant with the art of midwifery (Odent, 2011:9, 97). In the exploration of concerns about the epistemicide of midwifery and the medicalisation of birth, the connection between the epistemicide of midwifery, colonisation and the medicalisation of birth is clear.

The number of midwifery educators who acknowledged the threat of intersectionality and epistemicide is in the minority – 8 of 38 motivations received. However, the motivations given confirm that midwifery educators in South Africa, indeed, experience systematic disempowerment.

Another confirmation of the socio-economic barriers midwives and midwifery education faces is captured in this quote:

"Unequal social position negatively impact their [women] maternal health needs as they are mostly earning less or unemployed. Previously their partners were employed but now majority is unemployed which makes their life even more difficult to meet their needs.

Midwife educators' competencies have a wide gap to those [midwives] who are working in urban and rural areas as they sometimes have an advantage of working in well-established institutions e.g. tertiary hospitals where learners have a chance to witness/observe and handle most of the conditions that our institutions transfer" (Contribution 13).

The two contributions touch on two elements: the impact of gender inequality on the women seeking care, and working conditions (socio-economic impact) experienced by midwifery educators. This contribution confirms that gender inequality is a reality for mothers and midwifery educators, as contributed to by colonisation.

6.7.3 Elements needed for transformation

The last question before the self-rating of competence and confidence of the WHO MEC asked participants to indicate what, in their opinions, could transform MEC to ensure that maternal and child health goals and universal health coverage are achieved. This open-ended question was coded and categorised, as indicated previously. A summary of the categories and frequency of the responses are presented in Table 6.5.

Table 6.5 Categories that would transform MEC to achieve universal health coverage

Categories identified by participants that would transform MEC	Frequency
CPD at national and international levels	22
Midwifery education to comply with global standards	1
Midwifery educators to be involved in the professional association	3
Practice involvement of midwifery educators	6
Research	5

Appreciation of work of midwifery educators	1
Increased human resources for midwifery educators, including preceptors	6
Standardisation of micro curriculum	2
Autonomous regulation of midwifery	3
Simulation resources	1
Only competent midwives to be allowed to teach the subject	1
Increase focus on neonatal content	1
Interprofessional teamwork, also in midwifery education	3
Focus midwifery education on what mothers need	1

In the simple comparison of the responses received simplistic numeric values guided the interpretation. The majority of motivations (n=22) in one category referred to insufficient opportunities for updates; midwifery educators indicated the importance of national and international exposure. The second most identified (n=6) need is a need for human resources, including preceptors, to assist with clinical accompaniment and to ensure that midwifery educators remain involved in practice. To do research (n=5) and incorporate the latest research in education was the third most mentioned response. Involvement of educators in the professional association for midwives, autonomous regulation of midwifery, as well as interprofessional teamwork in education were each noted by three participants. The need to standardise the micro curriculum was identified by two responses.

Single responses could be integrated with other categories, and they reflect similar categories as those that emerged from the AI session. Compliance with global standards, for instance, fits in with autonomous regulation, as both these needs are in the ICM core documents, such as the *Bill of Rights of Women and Midwives* and *Global Standards for Regulation and Education*. Similarly, the ICM advocates for partnerships between women and midwives, with the mothers' needs as the guiding principle. The ICM *Philosophy and Model of Midwifery Care* confirms the need for interprofessional teamwork. Furthermore, compliance with global standards was captured in the latest statement of the *Skilled Birth Attendant* of the WHO, to which the ICM also contributed (ICM, 2011c; 2013; 2014b; WHO, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the ICM, the ICN (2018).

Content-based categories, such as inclusion of neonatal content, could be addressed by standardisation of the curriculum, which was mentioned in the AI too. Simulation overlaps with resources, learning, and teaching concepts, as in a standardised curriculum. The value of appreciation and the unique competencies required to be a midwife educator were also mentioned.

The open-ended questions provided the opportunity for participants to voice their opinions on sensitive issues such as gender inequality (Cohen *et al.*, 2011:395; Shannon-Baker, 2016:328). The inequities facing mothers who seek care, and midwifery educators were shared. Participants indicated that their energising elements were student competence and their passion for midwifery – elements that had also been identified by the participants in the AI. A significant contribution was the linkage between epistemicide that threatens normal pregnancy and birth, and how colonisation with the implied Colonisation contributes to epistemicide. Lastly, the elements that participants deemed necessary for transformation highlighted the need and opportunity for CPD. The item that was mentioned the second most often relates to resources. Again, the elements identified had also been valued by the AI participants.

6.8 WORLD HEALTH ORGANIZATION COMPETENCIES

The next section of the questionnaire dealt with the WHO MEC, as discussed in Section 2.3.4. The 19 competencies cover eight domains. As indicated, participants were not obligated to complete any component of the survey; therefore, in the 48 completed questionnaires we consequently often see the cumulative frequency for competencies being less than 48. Table 6.6 to 6.24, which cover the extensive questions on each competency, reflect the actual number of responses per item given in the 48 completed questionnaires.

The option was given to participants to reflect on their own perceived competence (blue columns) and confidence (green columns).

Competency #					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident

The questionnaire also gave participants the option to indicate if someone had performed a task at least once as part of the competence rating. Therefore, a participant could mark their level of competence as either feeling competent, or not. Therefore, a participant could choose two options of the three to indicate competence. The request in the information leaflet discouraged this, however the Evasys® question types could not exclude the possibility of a participant choosing more than one option in the same category.

Confidence was another one of two options they could indicate. Participants did not all answer all the questions. The questionnaire was very long and, therefore, completion of items was at times scanty.

As participants could choose more than one option and as there were no obligation to answer, the percentages are not included. Instead, the number of responses in each option are presented, as the responses that could vary do not express the answer in relation to the entire participant group. Cumulative frequencies and percentages per rows and columns were not included (as explained in Section 6.5.1). Responses that were received were judged in the simple comparisons in each question applying a simplistic sliding scale and a comparison with the specific elements in the competency was done with other items in the same competency.

1-3 Responses	4-6 Responses	7-9 Responses	10+ Responses
Minor	Moderate	Major	Significant

If fewer than three of the participants rated an item, it was considered as a minor number. Four to six responses were regarded as a moderate response, while seven to nine represented a major number. Ten and more were regarded as a significant number of responses.

Table 6.6 contains the summary of responses for each component of Competency #1.

Table 6.6 Questions on WHO Competency #1

Competency #1 Midwifery educators behave in ways that reflect the ethical standards of teaching and the midwifery profession					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident
1. International ethical responsibilities and obligations related to teaching and {midwifery} practice	15	3	26	14	27
2. Local ethical responsibilities and obligations related to teaching and {midwifery} practice	5	4	32	5	39
3. Use knowledge of ethical issues as the basis for influencing, designing, implementing, and evaluating policies and procedures related to:					
▪ Students	7	5	29	10	34
▪ Clinical environment	7	3	34	5	36
4 Display ethical intent incorporating the fundamental ethical principle of respect and responsibility	1	2	38	-	42
5 Protect the rights of women when teaching or delivering midwifery care	1	-	40	1	41
6 Recognise potential ethical issues and dilemmas in the workplace	3	3	33	2	40
7 Discuss ethical issues and dilemmas with students and other appropriate persons	2	2	36	4	40

From the responses given by midwifery educators, it is clear that the majority considered themselves confident and competent, according to their self-assessment of the items. Question items that showed the least confidence (n=14) or competence (n=15) was international ethical responsibilities and obligations related to teaching and midwifery practice, which drew a significant number of responses (>10). The knowledge component of the competency carried the least confidence. The conflation of the midwifery profession with the nursing profession, which involves midwifery being seen as a component of nursing (Cadee & Wiklund, 2020:1877), lead to midwifery educators completing nursing education in preparation for the education role. In South Africa there is no midwifery education programme or short learning programme that covers specific content, such as international ethical responsibilities related to teaching and midwifery practice.

The second question item on which educators indicated possessing less competence and confidence was regarding the use of knowledge of ethical issues as the basis for influencing, designing, implementing, and evaluating policies and procedures related to students and the clinical environment. Competence for both the student and clinical environment had (n=7) educators not feeling competent, but the confidence was higher (n=10) in relation to students, compared to (n=5) the clinical environment on confidence with moderate number (n=5) of responses. The ICM Global Standards on Midwifery Education, in the component relating to the administration and organisation of midwifery education, reaffirms the role of the midwifery educator as being self-governing, and places the responsibility for development and leading policies and midwifery education programme curricula on midwives (ICM, 2013a:4). The conflation of the profession with nursing can contribute to midwifery educators sometimes being excluded from the policy domain. As midwifery is a smaller profession than the nursing profession, the unique midwifery elements are often overlooked (Cadee & Wiklund, 2020:1877). Therefore, exposure of midwifery educators in education institutions where nursing is also present might has limited opportunities to develop this competencies.

The following competency, #2, which deals with legal and regulatory issues, is summarised in Table 6.7.

Table 6.7 Questions on WHO Competency #2

Competency #2 Midwifery educators demonstrate an understanding of legal and regulatory statutes relevant to midwifery teaching and practice					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident
1 Law and regulation related to midwifery practice	3	2	35	3	42
2 Law and regulation relating to teaching and in health professions	3	3	35	4	40
3 Incorporate legal and regulatory requirements into midwifery education during:					
▪ Implementation of teaching and learning	2	2	36	3	41
▪ Assessment of teaching and learning	1	1	38	1	44
4 Comply with legal and regulatory statutes	-	2	39	-	43
5 Ensure students comply with legal and regulatory statutes	2	2	37	2	42

The majority of midwifery educators, again, indicated in the self-assessment that they felt confident and competent about elements of the legal and regulatory decrees that affect midwifery practice and education. The first domain of the competencies, which deals with ethical and legal principles of midwifery education, is, according to the responses of the participants, one where they see themselves as competent and confident. The education and training quality authority for the midwifery and nursing profession is the SANC, and the education process has a long history of state registration for the profession. South Africa was the first country in the world to legislate the registration of nurses and midwives (Loots & Vermaak, 1975:110). The education component is regulated by the Nursing Act 33 of 2005, Scope of Practice and Regulations for education, published in the Government Gazette (*Nursing Act 33 of 2005*). Therefore, all educators are exposed to the regulations, which explains their

positive self-evaluations on these items. A minority of responses were lack of competence and confidence.

In Table 6.8, the collection of answers for competency #3 is shown.

Table 6.8 Questions for WHO Competency #3

Competency #3 Maintain competence in midwifery practice					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident
1 All areas of the theoretical component of the midwifery curriculum	3	3	35	4	40
2 All areas of best practice in the clinical practice of midwifery	5	8	27	12	32
3 Evidence-based and up-to-date midwifery content and related subjects	5	7	29	10	32
4 Provide safe, competent and effective midwifery care to women and their newborns	4	2	34	6	37
5 Apply research findings in practice	8	4	27	12	30
6 Fulfil the requirements of the midwifery regulating body	1	2	36	1	42
7 Participate in professional development activities to increase the effectiveness	3	5	32	4	40
8 Participate in accord with a code of ethics	2	4	34	6	38
9 Provide high quality midwifery care	2	2	35	5	38
10 Demonstrate and value lifelong learning to maintain their own competence	-	-	39	1	43

The responses in this set of questions indicate that midwifery educators considered this topic differently than the questions in the domain of ethical and legal principles. As midwifery practice and competence in practice is such an essential component of midwifery education, as reflected by their statements that practice involvement was a crucial factor for transform competence, it can explain their reflexivity in reporting on this issue. Midwifery educators (n=8) did not feel competent about the use of research.

In the areas that they indicated as the areas of midwifery that excite them (Figure 6.7), there were clear areas that were more popular than others. Their passion could, possibly, be linked to their clinical experience, although no question linked these two elements. The honesty expressed in this self-evaluation confirms that the participants did not always indicate competence in all fields.

The second set of questions for Competency #4 in the domain for midwifery practice is captured in Table 6.9.

Table 6.9 Questions on WHO Competency #4

Competency #4 Midwifery educators practice midwifery in ways that reflect evidence-based and up-to-date knowledge					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident
1 Research processes	2	4	36	6	36
2 Locally relevant epidemiology	11	3	29	16	27
3 Locally relevant community health issues	4	6	31	9	35
4 Locally relevant health issues	3	6	32	8	36
5 Locally relevant provision of SRH [sexual and reproductive health] services	4	4	33	5	39
6 Access research findings	3	5	33	6	38
7 Review literature for evidence related to practice	3	3	36	5	38
8 Implement research findings	5	4	31	8	34
9 Willingness to adjust practice in the light of evidence	-	1	40	1	42

The focus on evidence-based practice and the way midwifery educators valued their abilities regarding teaching and practicing contained, according to research findings, elements that were rated positively and others that raised concern. With the exception

of one response, the group members all indicated confidence in altering practice according to evidence. The knowledge components that showed the most significant lack of confidence were epidemiology (n=16), followed by community health issues (n=9) and sexual and reproductive health issues (n=8). Similar to responses for Competency #3, research was an area of lower perceived competence and confidence. As shown in Figure 6.2, 42 of the participants indicated that they had professional registration in community nursing, so the high number of responses that indicated lower confidence and competence regarding community midwifery care issues are concerning. In summary, by expressing less confidence and competence regarding certain elements, a number of midwifery educators did not regard their midwifery practice as reflecting the desired level of evidence-based and up-to-date knowledge.

The questions of the next competency, which is in the domain of theoretical learning, are summarised in Table 6.10.

Table 6.10 Questions on WHO Competency #5

Competency #5 Midwifery educators incorporate education strategies to promote active learning					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident
1 Theories of learning that result in the development of clinical competence	2	5	36	5	37
2 Competency-based education	6	4	34	7	34
3 Acknowledge students as adult learners	2	1	40	1	40
4 Ground teaching strategies in educational theory and evidence-based teaching	5	3	35	7	34
5 Use educational approaches reflecting contemporary educational theory and practice of midwifery, including:					

▪ Problem-based learning	1	3	39	3	38
▪ Case-study or narrative based learning	1	9	33	6	33
▪ Discussion and group work	4	1	35	-	43
▪ Seminar presentations	10	10	24	15	26
▪ Experimental learning(e.g., role play, simulation, simulated patient/woman)	1	5	34	3	41
▪ Workshops	6	7	31	8	33
▪ Projects	12	3	26	15	29
▪ Active/participatory lectures	2	1	38	2	42
▪ Effective use of audio-visual materials	2	4	35	3	39
▪ e-learning	22	7	12	26	17
6 Model critical and reflective thinking	3	6	33	8	35
7 Show enthusiasm for teaching, learning and midwifery that inspires and motivates students	1	1	41	1	40
8 Foster a relationship of mutual trust and respect	-	2	39	1	43

Education strategies that promote active learning are at the core of the activities of any educator. The number of participants that indicated that they have a professional registration in nursing education (Figure 6.2) was 44. Therefore, with the exception of four participants, all participants had qualifications and registration in education. The responses for educational approaches, where many educators indicated a lack of confidence and competence, should make us question whether nursing education courses adequately prepare midwifery educators for what is needed. The component for which the least confidence and competence was expressed, by far, is e-learning, followed by seminars, projects and workshops. When the global pandemic of SARS-CoV-2 started impacting on global education systems, including that of midwifery

education, many institutions of higher learning immediately adopted a system of online learning and teaching. Even though the data collection was concluded before the global pandemic, considering that the highest levels of lack of confidence and competence were reported for online education, these sudden demands to present online teaching could cause a great amount of anxiety and stress among midwifery educators.

Questions on the incorporation of educational strategies were followed by a set dealing with the selection and effective use of resources. Responses are captured in Table 6.11.

Table 6.11 Questions on WHO Competency #6

Competency #6 Midwifery educators select and use effective teaching and learning materials/resources					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident
1 Educational and learning resources and materials based on best available evidence	5	2	31	9	36
2 Evaluate and choose appropriate teaching and learning materials and resources	2	-	40	2	38
3 Develop appropriate educational materials that are matched to the learning domain [psychomotor, cognitive, affective]	4	3	34	7	35
4 Use information technologies skilfully to support the teaching-learning process	4	3	35	9	31
5 Ensure safe and appropriate physical learning environments including classroom conditions such as light, temperature, desk arrangement	4	1	38	2	38

6	Ensure safe and appropriate physical learning environments including classroom size and number of students	6	1	34	8	34
7	Advocate for change when the learning environment not provided	4	2	38	3	36

From the responses of educators, it seems as if the most significant challenges relate to the selection of material to suit the domains of education and, again, the use of information technology. Given that this questionnaire was distributed and completed electronically, the participants are all able to use technology. Therefore, the concern is that those who were not able to complete the questionnaire could possibly have more severe shortcomings regarding competence and confidence in the use of technology for and in education.

The last component of theoretical learning focusses on learning styles and learning needs of students. The summary of questions is given in Table 6.12.

Table 6.12 Questions on WHO Competency #7

Competency #7 Midwifery educators recognise and support different learning styles and unique needs					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident
1 Theory and methodology of educational needs assessment [of individual learners]	5	3	33	5	37
2 Social and human relationships and the conditions for learning	4	2	34	4	38
3 Interaction between educator and learner	-	-	1	1	42
4 Principles of counselling	3	4	34	4	37

5	Provide resources to diverse learners that help meet their individual learning needs	8	-	33	7	35
6	Engage in effective advice and counselling strategies that help learners meet their learning goals	3	4	34	4	38
7	Create effective learning environments that are focussed on socialisation of the role of the midwife	2	2	36	4	37
8	Create effective learning environments that facilitate learners' self-reflection and personal goal setting	2	-	38	4	39
9	Recognise the influence of teaching styles and interpersonal interactions on learner outcomes	-	-	40	1	41
10	Foster the cognitive, psychomotor and affective development of learners	1	-	40	1	41
11	Demonstrate interest in and respect for learners	-	-	41	-	41
12	Support learner's continuous lifelong learning as a professional midwife	-	1	39	1	38
13	Use personal attributes (e.g., caring, confidence, patience, integrity and flexibility) that facilitate learning	-	-	40	-	43

In this last component of the domain on theoretical learning, the responses of the participants showed that they mostly feel confident and competent in support of learning styles and the needs of students. Compared to the other question items, there was, however, a slight lack regarding providing resources to diverse learners that could help meet their individual learning needs.

In the public health college system, electronic connectivity is not very good. As reported in the permission process discussed in Section 6.2.2, the majority of lecturers based at public NEIs do not even have access to operational email. Compared to

universities, which mostly use learning management systems, the lack of electronic resources in the public health system is severe. The situation during the SARS-CoV-2 pandemic meant that, during the lockdown period, students and lecturers had no learning or teaching modalities, as reported in communication with lecturers working at public health NEIs. During this time, universities were able to convert to online teaching. From personal experience in this time, the reality of diverse learning needs and abilities of students were highlighted. In a well-resourced system with electronic capabilities, it is a challenge to ensure that no student is left behind. In the context of poorly-resourced public health NEIs, compounded by the self-evaluated gaps in the ability to provide in students' needs, the reality, especially in the current pandemic, is concerning.

Learning in clinical areas is the focus of the fourth domain. Competency # 8 relates to the facilitation of a safe and effective learning environment in clinical practice. The questions participants responded to are captured in Table 6.13.

Table 6.13 Questions on WHO Competency #8

Competency #8 Midwifery educators contribute to or facilitate a safe and effective learning environment in the clinical setting					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident
1 The clinical environment and governing structures	5	4	32	11	32
2 Competency-based clinical learning	5	2	35	7	34
3 How students integrate into a new practice setting	5	1	36	4	36
4 Evidence informed practice	4	3	33	6	36
5 Ethical expectations of midwifery practice including supporting informed choice	2	-	39	3	38
6 Facilitate effective learning and the development of competence within an area of					

practice by correctly teaching students the process of:					
• assessment	1	-	40	1	42
• planning	2	-	39	1	41
• implementation	1	-	41	-	41
• evaluation	1	-	39	1	40
• documentation of midwifery care	3	-	36	3	39
7 Create an environment in which practice development is fostered, evaluated and disseminated	4	2	33	5	34
8 Demonstrate effective midwifery relationships with patients/women	-	1	41	-	41
9 Obtain free and informed consent for student involvement in care	5	-	38	3	36
10 Protect the woman and her baby from harm	1	1	38	-	41
11 Enable students to relate theory to practice encouraging reflective learning	-	-	39	1	41
12 Build and maintain collegial relationships with staff in the clinical environment	3	-	37	4	38
13 Demonstrate to students principles of effective delegation and supervision	2	1	37	2	41
14 Demonstrate effective interpersonal skills	-	-	40	-	42
15 Seek clarification or assistance from the staff as needed	1	-	41	2	39
16 Set effective professional boundaries while creating a dynamic, constructive teacher-student professional relationship	1	1	37	1	39
17 Foster professional growth and personal development by	1	-	40	1	41

use of effective communication					
18 Facilitate and develop the ethos of interprofessional learning and working	1	1	37	1	42
19 Identify teaching opportunities in the clinical setting	-	-	39	1	42
20 Set boundaries of safe practice	1	-	38	2	41

The participants responded more frequently in the options for confidence, with the exception of the first two question items. Eleven participants did not feel confident regarding the clinical environment and governing structures. Competency-based clinical learning had (n=7) participants indicating lack of confidence, followed by evidence-informed practice (n=6) and the creation of an environment where practice development is enhanced (n=5). The ability to influence the environment and governance structures, the creation of a conducive environment and relationships with clinical midwives were areas where participants expressed less self-rated competence (5 each). In considering the responses for this competency, many of the question items are tasks that form part of some of the managerial tasks in institutions. As mentioned, the ICM Global Standards of Education place the administrative tasks for midwifery education in the hands of midwives (ICM, 2013a:4) and within the conflation of nursing (Cadee & Wiklund, 2020:1877), which might leave the administration of midwifery education in the hands of nurses who might not be competent midwives.

The next competency in this domain, Competency #9, and the related questions are summarised in Table 6.14.

Table 6.14 Questions on WHO Competency #9

Competency #9 Midwifery educators foster individualised, experiential learning					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident

1	Experiential learning	5	1	38	5	35
2	Diversity of learning processes	6	-	36	7	34
3	Design and deliver programmes of learning in practice settings supporting a range of students in their area of practice	4	3	32	5	38
4	Assess programmes of learning in practice settings	6	1	32	5	39
5	Assess, create and develop opportunities for students to identify and undertake experiences to meet their learning needs	1	2	36	3	38
6	Provide advice and support to identify changes required [to demonstrate competency]	2	-	39	3	39
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 is intermeshed.	1	2	37	3	39
8	Act with respect for and interest in the students	1	1	36	4	40
9	Demonstrate patience with individual students to foster experiential learning	1	1	38	2	41

Educators mostly responded with confidence and competence ratings to the questions dealing with individualised, experiential learning. The items in the domain on clinical learning for which less confidence and competence were expressed, were the relationships and structures of the clinical facilities in which students are placed, dealing with diversity in the learning processes (n=6), and assessment of practical programmes (n=6).

The fifth domain deals with the assessment and evaluation of students and programmes. The first competency in this domain refers to the evaluation of programmes. The responses are captured in Table 6.15.

Table 6.15 Questions on WHO Competency #10

Competency #10 Midwifery educators continuously monitor, assess and evaluate the effectiveness of the education programme					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident
1 Theory and methodology of learning outcomes assessment and evaluation including:					
• Examination [paper/pencil test]	-	-	40	-	43
• Essay	9	4	29	8	33
• Seminar presentation	10	7	24	12	31
• Midwifery case study	1	1	39	2	38
• Project	8	7	27	10	32
• Objective structured clinical examination (OSCE)	-	-	41	1	41
2 Use methods of assessment and evaluation of learning that are linked to learning goals	-	-	39	1	42
3 Use a variety of strategies and tools to assess and evaluate learning in the cognitive, psychomotor and affective domains for:					
• Formative evaluation	-	-	40	1	42
• Summative evaluation	-	1	38	2	41
4 Participate in the selection of the critical elements of assessment tools (e.g., examination blueprinting, examination item writing, validity, reliability)	4	1	35	4	36
5 Construct tests and appropriate evaluation tools	1	-	39	1	41

6	Participate in setting pass or fail standards and assessment criteria	4	1	34	5	37
7	Provide timely, constructive and thoughtful feedback to learners	1	-	39	1	40
8	Use assessment and evaluation data to enhance the teaching-learning process	-	1	39	1	42
9	Maintain accurate records of student progress and achievement	-	-	39	-	44
10	Participate in programme evaluation	2	2	36	4	39
11	Display ethical intent and objectivity in all evaluation processes	-	1	39	-	42

The responses of participants indicate that they were less comfortable using assessments such as essays, seminars and projects. The competence and confidence ratings were high for OSCE, written tests and examinations and the professional and ethical conduct and recording of assessment. Assessment strategies for which educators indicated a lack of competence were seminars (n=10), essays (n=9), and projects (n=8). The second component of the domain on assessment refers to student competence, and is reflected in Table 6.16.

Table 6.16 Questions on WHO Competency #11

Competency#11 Midwifery educators assess student competence					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident
1 Assessment procedures	-	-	40	-	42
2 Adapt, design and use of tools for assessing and documenting the clinical practice	1	-	38	1	43

3	In partnership with other members of the teaching team, use knowledge and experience to design and implement assessment frameworks	4	1	37	3	36
4	Assess progress to plan for the students' increasing level of skills	1	3	38	2	39
5	Make accurate judgments about the competency/proficiency of students including cultural and respectful care competency	3	-	39	2	37
6	Provide constructive feedback to students and assist in identifying future learning needs and actions	1	1	38	-	42
7	Manage unsuccessful students so that they may enhance their performance and capabilities for safe and effective practice	1	2	38	4	37
8	Manage unsuccessful students so that they can understand their failure and the implications of this for their future	1	1	35	4	36
9	Be accountable for confirming that students have met, or have not met, agreed on standards of competency and are capable of safe and effective practice	-	2	39	-	41
10	Act as a role model	-	-	38	-	43
11	Display ethical intent and objectivity in all competence assessments	1	-	39	2	41

The domain of assessment and evaluation elicited very confident and competent self-ratings from the participants. Every response to the ability to act as a role model was that of competence and confidence.

The sixth of the eight domains focuses on organisation, management and leadership. Competency #12 considers midwifery educators and how they actively can participate in curriculum organisation and implementation. The questions for Competency #12 are addressed in Table 6.17.

Table 6.17 Questions on WHO Competency #12

Competency#12 Midwifery educators actively participate in organising and implementing a midwifery curriculum					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident
1 Educational management theories	5	6	31	8	34
2 Participate in developing midwifery curriculum including:					
• Identifying programmatic and student outcomes	6	3	31	11	33
• Developing competency statements	6	2	31	7	34
• Writing learning objectives	2	2	35	3	40
• Selecting appropriate learning activities	1	1	38	3	40
• Selecting appropriate evaluation methods	1	1	40	2	40
3 Participate in the design of midwifery curriculum based on educational decision, principles, theory and research	8	1	32	7	35
4 Participate in the development of syllabi, and class/course outlines including learning objectives, target audience, contents of the subject, teaching materials and evaluation methods	8	1	32	7	35
5 Ensure the curriculum reflects:					

• The institutional philosophy and mission	7	2	32	6	35
• Current midwifery and healthcare trends, and	8	-	34	6	35
• Community and societal needs to prepare graduates for practice in a complex, dynamic, multicultural healthcare environment	8	3	28	9	33
6 Incorporate strategies for efficient management of time and resources	6	3	32	8	34
7 Work in multidisciplinary, interdisciplinary teams	4	1	36	4	38
8 Make inclusive and collaborative decisions	3	1	39	2	37
9 Participate as effective team members	2	-	39	2	40

From the responses of the participants, the most significant reports of lack of confidence (1, 2a and b, 3, 4, 5, and 6) and competence (items 3, 4 and 5) seem to relate to participation in curriculum development. Several questions dealt with the development and inclusion of midwifery content that addresses societal needs. Excluding midwifery education from the curriculum process implies that the midwifery educator might fail to advocate for the needs of women. The second component in this domain is the competency of revising and implementing new programmes. The responses to the questions on Competency #13 are given in Table 6.18.

Table 6.18 Questions on WHO Competency #13

Competency #13 Midwifery educators implement and revise midwifery educational courses/programmes					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident

1	Curriculum monitoring and evaluation	8	4	31	10	29
2	Curriculum revision	6	8	29	8	31
3	Organisational management including organisational monitoring and evaluation	11	6	24	12	29
4	Quality assurance of organisational performance	8	6	27	11	27
5	Revise curriculum based on:					
	A. Systematic monitoring and evaluation of programme outcomes	10	3	29	8	32
	B. Learner needs	4	4	32	6	34
	C. Healthcare trends	10	3	29	9	29
	D. Midwifery trends	7	2	31	7	30
	E. Evolving community and societal needs	8	5	30	9	31
6	Implement curriculum revisions using appropriate change theories and strategies	8	5	29	7	34
7	Collaborate with external constituencies throughout the process of curriculum design, implementation and revision	15	5	21	13	25
8	Design and implement programme assessment models that promote continuous quality improvement of all aspects of the programme, including:					
	A. Student performance	7	-	35	6	35
	B. Student evaluations	2	1	36	3	40
	C. Peer observations	7	4	31	6	33
	D. Graduation rates	7	2	32	8	32
	E. Qualification or registration success	7	-	34	7	34
9	Monitor and review midwifery programmes to ensure congruence with international	11	2	30	6	35

and regional goals and national standards					
10 Contribute to the quality assurance processes of the organisation	4	3	34	5	37
11 Participate in the evaluation of organisational effectiveness in midwifery education	7	1	32	9	34
12 Keep thorough and accurate records	1	-	39	1	41
13 Display integrity in undertaking monitoring processes	-	-	39	1	43

Similar rating was seen as for Competency #12, with low confidence and competence for curriculum revision and updates. In this domain, it appears that these competencies are not optimally developed, and participants indicated items 3, 4 7 and 11 as areas of less confidence and competence. In comparison with responses for most other competencies, the majority of items had more than five scores of lack of self-rated confidence and competence. The summary of questions for the following domain, covering communication, leadership and advocacy, is started in Table 6.19, where the responses of participants on questions relating to competency on communication as are given.

Table 6.19 Questions on WHO Competency #14

Competency# 14 Midwifery educators communicate effectively using a variety of methods in diverse settings					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident
1 Communication techniques	-	-	39	-	44
2 Presentation methodologies	2	2	37	3	40
3 Report writing	-	-	39	-	43

4	Communicating effectively using oral, written and electronic communication to achieve learner outcomes	1	-	38	1	42
5	Write clearly, produce concise reports and present effectively	-	1	39	-	43
6	Demonstrate effective communication skills in working with women, learners and other members of the healthcare team in clinical settings	-	-	41	-	40
7	Teach students how to engage in the education of the childbearing woman and the family	-	-	40	1	41
8	Document effective feedback	-	1	39	-	43
9	Maintain accurate records	1	-	39	-	42
10	Engage in conflict resolution as necessary	-	-	41	1	39
11	Demonstrate public speaking and active listening skills	1	1	40	-	40
12	Demonstrate excellent interpersonal and communication skills	-	-	42	-	41
13	Demonstrate an awareness of self and others	1	-	40	1	39

The responses of the participants clearly show confidence and competence in communication in a variety of contexts. The domain of competency covers written communication, like writing reports, with all responses indicating competence and confidence. The participants mostly regard the administrative component of keeping records and communication with education systems, healthcare systems, students, and the public as areas of competence and confidence.

The next set of questions focussed on cultural competence and is captured in Table 6.20.

Table 6.20 Questions on WHO Competency #15

Competency #15 Midwifery educators demonstrate cultural competence in course design and development, teaching and midwifery practice					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident
1 Cultural diversity and identity	3	-	38	3	39
2 Human rights	2	1	37	4	39
3 Impact of power relations, racism and sexism	4	1	37	5	34
4 Recognise and describe multicultural, gender and experiential influences on teaching and learning	1	2	36	6	35
5 Facilitate the provision of culturally appropriate care	4	1	35	5	36
6 Encourage the expression and exchange of multicultural views	3	2	35	5	37
7 Respect and protect human rights	-	-	40	1	39
8 Foster in students the ability to act and speak up when there are violations of human rights	2	1	36	1	39
9 Demonstrate cultural sensitivity	1	1	39	3	37
10 Model cultural sensitivity when advocating for change	2	2	39	3	37
11 Be accountable for their actions and inactions in safeguarding human rights	1	-	39	1	41

The issues that scored most responses indicting lack of confidence and competence were related to the question on power relations, racism, sexism and multicultural, gender and experiential influences in education. With 6 responses for item 4 on confidence and the rest of the items in the competency all indicated below 5 from the responses provided, there were no major shortcomings. As discussed in Section 6.7,

perceptions of gender and agency issues were under-reported by the participants. The under-reporting can be seen as confirmation that, perhaps, participants lack agency themselves. The standpoint theory in feminism confirms that consciousness of inequalities is often not reflected in the conditions of women's' lives. Inequality is an oppressing and disabling reality that is not consciously admitted (Cadee & Wiklund, 2020:1187; Yuill, 2012:38).

To explore the topic further, the following Competency #16 deals with the advocacy role, leadership and the role of change agent. The responses are reflected in Table 6.21.

Table 6.21 Questions on WHO Competency #16

Competency #16 Midwifery educators function as change agents and leaders to improve both midwifery practice and midwifery education					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident
1 Change management	3	2	39	5	35
2 Leadership theory	4	4	30	5	36
3 Interdisciplinary collaboration	2	4	36	4	36
4 Act as a guardian of safe, competent, respectful midwifery care	1	1	37	1	41
5 Create and maintain community and clinical partnerships that support educational goals	5	2	34	7	34
6 Integrate a long-term, innovative and creative perspective into the midwifery educator role	3	1	36	5	36
7 Participate in interdisciplinary efforts to address healthcare and educational needs	3	4	33	6	36
8 Implement strategies for organisational change	7	3	31	8	33

9	Provide organisational 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	4	6	27	8	33
10	Assume a leadership role in various levels of institutional governance as appropriate	6	3	31	8	33
11	Use feedback gained from self, peer, student and administrative evaluation to improve role effectiveness	2	-	38	3	36
12	Mentor and support colleagues	1	1	38	2	40
13	Integrate interpersonal values of respect, collegiality, professionalism, and caring to build an organisational climate that fosters the development of students and educators	-	1	38	1	42
14	Demonstrate integrity, courage, perseverance, vitality and creativity	-	-	39	-	41
15	Develop collegial working relationships with students, faculty colleagues and clinical agency personnel to promote positive learning environments	2	1	37	2	39
16	Engage in self-reflection and continued learning to improve teaching practices that facilitate learning	-	1	38	-	41

Questions 13-16 relate to the internal aspects of leadership, for instance, self-reflection, integrity and personal values. Almost all participants expressed competence and confidence in this regard. The external activities of leadership captured in items 5-10 scored lower on confidence and competence. Again, the question is why the participants were reluctant or hesitant to take up this leadership role. The conflation argument as unpacked in the discussion of Competency #1,

provides a possible explanation for these responses. The responses to items 11 and 12, which were related to education and focussed on colleagues and students, were positive.

The last component in the domain on communication, leadership and advocacy relates to advocacy questions. The summary of responses is given in Table 6.22.

Table 6.22 Questions for WHO Competency #17

Competency #17 Midwifery educators used a variety of advocacy strategies to promote midwifery education and practice including professional, community, human rights and structural advocacy					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident
1 Advocacy strategies	4	1	36	6	36
2 Organisational functioning	5	2	33	7	35
3 Demonstrate a leadership role outside of the institutions; e.g., with government and professional associations	10	7	23	10	30
4 Display confidence in presentation and argument	5	2	33	8	34
5 Communicate effectively and professionally	-	-	39	-	42

The responses to these questions indicate confidence and competence on an internal level, and less on the external level of leadership outside their institution. Item 3, which refers to leadership and advocacy in government and professional structures, received lower scores in confidence and competence from a significant number of participants. The systemic disempowerment of midwifery educators by the conflation of nursing and midwifery, discussed in Competency #1, and the subsequent lack of autonomy of midwives can contribute to midwifery educators rarely exposed to and taking up the roles – though there are also those who do.

The last domain is on research. Two competencies are identified for research and Table 6.23 provides the summary of responses on Competency #18.

Table 6.23 Questions on WHO Competency #18

Competency #18 Midwifery educators use research to inform teaching and practice					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident
1 Evidence-based practice and levels of evidence	2	1	39	4	36
2 Available research resources	2	2	36	5	35
3 Qualitative and quantitative approaches	2	3	35	6	37
4 Use online resources to locate research and clinical guidelines relevant to an issue	5	-	36	6	35
5 Interpret the quality and applicability of research papers and reports	5	2	34	7	36
6 Use research in teaching and practice	3	3	36	4	37
7 Demonstrate and encourage inquiry	2	2	36	5	37

The majority of midwifery educators reported positively on their confidence and competence in using research to inform their teaching and practice. The interpretation of quality of research (Item 5) had a major number of participants (n=7) who lacked confidence. Research competence is also connected to other competencies, such as #3, 4, 5, 6, and 8. The midwifery educators listed research focus as one way of strengthening MEC. As displayed in Figure 6.1, 13% of the participants had qualifications on diploma level and 18% had completed a Bachelor's degree, within which an element of research methodology is included. A further 15% had achieved Master's and 7% PhD degrees, which implies competence in research. Participants'

qualifications possibly informed their responses to the questions relating to the last competency, as summarised in Table 6.24

Table 6.24 Questions on WHO Competency #19

Competency #19 Midwifery educators cultivate a culture that supports critical inquiry and evidence-based practice					
Question item	Do not feel competent	Did at least once	Do feel competent	Not confident	Confident
1 Evidence-based practice and levels of evidence	2	2	37	5	37
2 Critical inquiry	4	3	32	8	34
3 Create a climate where inquiring minds can be actively involved in incorporating research into practice	4	3	33	5	36
4 Provide positive feedback for research endeavours	1	2	38	5	37
5 Role model critical thinking in all areas of teaching	3	1	38	3	38
6 Prioritise questions and reflection	1	-	40	2	39

The majority of participants affirmed confidence and competence in cultivating a culture that supports critical inquiry and evidence-based practice. Item 2, dealing with critical inquiry, however, showed a major number (8) who lacked confidence. As indicated, their levels of qualification can shape their ability to be confident and competent in the use of research. The first four question items, although participants mostly rated themselves as competent, had less confidence expressed by participants' self-evaluations to the items. This was the final set of questions on the WHO competencies.

The gaps as rated by midwifery educators can be connected to the context of the nursing and midwifery profession in South Africa being conflation, as well as a lack of

resources for developing themselves and students. Electronic platforms with associated teaching and assessment strategies is a significant area of lack of confidence and competence.

6.9 CONCLUDING COMMENTS FROM PARTICIPANTS

After they had answered the WHO competency questions, participants were asked to add a final comment, if they wished to do so, and 29 participants left comments, of whom three said "no comments". Categories for the remaining comments are summarised in Table 6.25.

Table 6.25 General comments at end of questionnaire

Category	Number	Detail
Questionnaire	4	• questions were challenging to answer (1) • long and time-consuming(2) • well formulated (1)
Encouragement	14	• research is needed in the current context of changes in midwifery and nursing education (4) • questionnaire provided a time for introspection and found it informative (2) • good luck wishes (8)
Elements to transform MEC	8	Added to Table 6.5

The number of items covered in the questionnaire, as received from the developers, was quite extensive. The questions, formulated to match the competencies, can be perceived as challenging, especially if participants are not familiar with the content of different items. At the same time, positive comments on the informative questions connect back to the AI principle of simultaneity, where the asking of questions can spark interest and change (Cooperrider *et al.*, 2008:9).

The messages of encouragement were energising and provided confirmation of the importance of the research. Two participants found the completion of the questionnaire to be a reflexive exercise, indicating their sincerity.

Eight comments were made as further elaboration on previous responses in relation to what is needed to transform MEC. Table 6.5 indicates the needs as captured at the start of the questionnaire. Elements that were repeated in the eight additional comments are listed in Table 6.26.

Table 6.26 Repeated elements in comments on MEC

Element identified by participants to transform MEC	Frequency at start	Listed in comments
CPD at national and international level	22	2
Midwifery education to comply with global standards	1	1
Midwifery educator to be involved in the professional association	3	-
Practice involvement of midwifery education	6	-
Research	5	1
Appreciation of midwifery education work	1	-
Increased human resources for midwifery education, including preceptors	6	1
Standardisation of micro curriculum	2	1
Autonomous regulation of midwifery	3	-
Simulation resources	1	-
Only competent midwives to be allowed to teach the subject	1	1
Increase neonatal focus on content	1	-
Interprofessional teamwork, also in midwifery education	3	-
Focus midwifery education on what mothers need	1	1

With eight of the comments once more revolving round elements to improve MEC, the importance of the need to transform is well articulated. The general comments created

an open opportunity to voice any remaining issues. The categories brought forward at the end of the questionnaire, matched categories found in the direct question earlier on in the questionnaire (as initially presented in Table 6.5). The importance of CPD at national and international levels was mentioned by two commenters.

6.10 CONCLUSION OF THE GAP ANALYSIS

Midwifery educators were asked to self-report on their confidence and competence in a long and detailed questionnaire. Their valuable consideration of the gap analysis and the data analysed after completion of quantitative data collection from 48 participants was presented in this chapter. The questionnaire was offered on an anonymous electronic platform, and captured the participants' self-rated responses on demographic information, their involvement in programmes and questions on gender. The larger part of the questionnaire focussed on the WHO MEC, distributed in eight domains. In the next chapter, the inference of the two data sets, as the crucial components of merging the voices of the stories of the qualitative and quantitative components, will be elaborated on. The different voices as found in the two first data sets are essential for narrating the inference needed to enable the transformation of MEC. The inference of how the two data sets tell the story that is needed to transform MEC in South Africa will be told in Chapter 7.

Chapter 7

Inference



CHAPTER 7 INFERENCE

"Mixed methods research practice is particularly complex, dynamic, and unsettled – that is, messy – because it purposefully brings together multiple perspectives and approaches" (Plano Clark & Ivankova, 2016:294).

7.1 INTRODUCTION

In allowing the story flowing from the need to transform MEC in South Africa to unfold, the backdrop of gender inequality and disempowerment is non-negotiable. It is imperative to consider all the complex and "messy" components and determine the interactions amongst them – as Plano Clark and Ivankova (2016:294) affirm. Synthesising the exploratory data from the AI and the confirmatory data from the gap analysis contributes to the meta-inference, that is, the summative conclusion on what is needed to transform MEC (Bergman, 2008:101; Creswell & Creswell, 2018:246).

The meta-inference is validated against elements of rigour discussed in Section 4.5.2. Furthermore, the metacognition of the paradigm grounds and shapes not only the data collection, but also the analysis and inferences drawn from the data. Elements in the personal, interpersonal and social contexts that impacted on this research are presented in Figure 4.2. The unique data sets were analysed, the perspectives contained in the data, and the findings were triangulated with literature. The significant inferences will be discussed per phase, followed by a discussion of how these inferences culminate in one meta-inference. The transformative paradigm channelled a conscious triangulation of the data within the theoretical grounding of feminism, which necessitated consideration of the power imbalances and gender relations from the data (Mertens, 2018a:3).

In positioning this mixed-methods research so that it has a positive impact on the emergent issues in midwifery and midwifery education, stakeholders were engaged in the process. Furthermore, an attempt was made to strengthen midwifery education through the integration of methodologies and the co-creation of knowledge. The conclusions of the research should, therefore, resonate with the midwifery profession at large. While findings from a qualitative perspective could resonate with certain

people, and some people could be more inclined toward quantitative findings. However, others would be convinced by integrated findings (Molina-Azorin & Fetters, 2019:279); hence, the dialectic nature of the research.

7.2 PROCESS FOLLOWED

In integrating the data and coming to a conclusion on what will make a difference, three steps were followed. The concurrent mixed-method design implied that data of the individual phases were analysed separately, as discussed in Chapter 5 for the AI and Chapter 6 for the gap analysis. Therefore, the first step centred on the analysis of qualitative data and identifying emerging themes, while the second step, of quantitative analysis, produced descriptive statistics. The last step was to integrate the two data sets by merging the qualitative and quantitative data sets, which presented both opportunities and challenges (Creswell & Creswell, 2018:246; Molina-Azorin & Fetters, 2019:280; Plano Clark, 2019b:3). In this research, the two sets of data were presented separately, or "side-by-side", as Creswell and Creswell (2018:246) describe it, after which the final mixing will be presented in this chapter. Joint displays of converging data will be presented (Bergman, 2011:275; Creswell & Creswell, 2018:246; Polit & Beck, 2017:596).

7.3 EMERGING THEMES

The AI session enabled a rich contribution by the participants, of whom the majority were midwife educators (more detail was discussed in Section 5.4). The 5D process was followed.

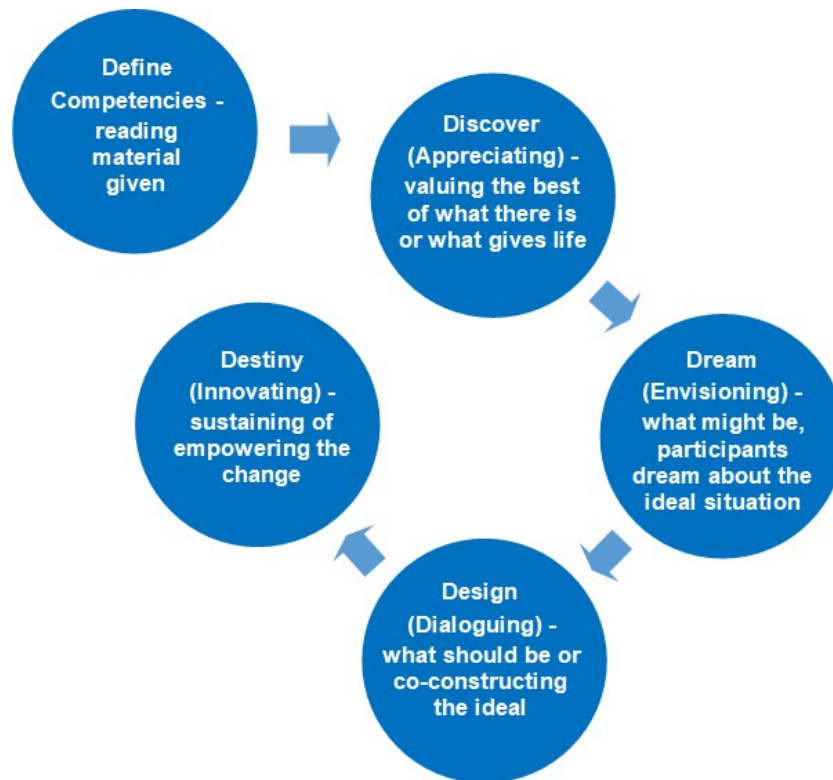


Figure 7.1 5D Process followed during the AI session

The purpose of the qualitative component was to appreciate the strengths of MEC. The expressed and co-created ideas of the AI process could contribute to the transformation needed. A population inference was not intended or possible, as explained in the description of the population and eligibility criteria in Section 4.5 (Bergman, 2011:274; Reed, 2007:139). Analysis of the contributions culminated in two emergent themes (as discussed in Section 5.8):

- **Passionate midwifery educators in a well-resourced environment are drawing energy from their students and their own growing competence within an autonomous midwifery profession.**
- **Rooted in midwifery educators' competencies, midwifery care branching out in essential competencies for midwifery care can produce quality maternal healthcare.**

The power of appreciation enabled participants to uncover the best of the current situation and celebrate it. That sparked the emphasis on the best possible solution (Moore *et al.*, 2016:65). Through AI, which focusses on the positive concept of social constructionism, every social system can create its reality (Cooperrider *et al.*, 2008:14). The AI process empowered participants to envision and create their destiny.

During the session, the step that took the most time, and subsequently contributed the majority of the data, was Discovery, which comprises four major elements; firstly, the best experience of the core topic. In this research, the first two questions (refer to Annexure A for AI process booklet) primarily encouraged participants to reflect and share their best experiences. The second Discovery element draws on the core values – conditions that generate positive experiences. Core values are fuel for the Destiny step and solution – Questions 3 and 4 focussed on illuminating the core values. Thirdly, Discovery elements seek to find the conditions that allow growth. Questions 5 and 6 enhanced the Discovery of the generative conditions for MEC. Lastly, the final Discovery element (Question 8) stimulated the Discovery of the three wishes. By asking the participants what they wanted if they had a magic wand boosted their energy and enhanced their ability to master new goals, based on an increased awareness of their self-efficacy (Moore *et al.*, 2016:68–70).

The first theme emphasised passion, as a value and competence, as a driving force. An enabling environment and autonomy of the profession were conditions in which MEC can flourish. The Destiny emerged from the second theme, where a healthy tree, rooted in MEC, branches out into the ICM essential competencies for basic midwives that could bear the fruit of quality maternal healthcare. The Destiny phase in AI could move participants to embrace the Destiny and an intrinsic drive (Moore *et al.*, 2016:71). From the rich data that participants provided, the intrinsic value of the competence of students, as passionate midwives contributing to quality midwifery care, was a golden thread in every step.

Drawing on the strengths, and considering the Destiny, it was remarkable to see the confirmation of the categories emerging from the gap analysis.

7.4 SIGNIFICANT ISSUES FROM GAP ANALYSIS

Questions similar to what was asked in the AI were included in the open-ended questions to create synergy in the theoretical perspectives shaping the research. From the AI process, which is a detailed qualitative process, emerged several categories and two themes. The data collection and analysis were concurrent and will be presented side by side (Creswell & Creswell, 2018:245). However, from the open-ended questions added to the gap analysis, similar categories emerged.

7.4.1 Energising elements in the work of midwifery educators

Responses to the question of what gives life or energy to their work as midwifery educators matched the categories found in the discovery step of the AI. The significant elements are summarised in Table 7.1.

Table 7.1 Meta-matrix of categories from gap analysis and AI: Giving life

Categories from gap analysis - Life-giving elements	Categories from AI life-giving elements
Student growth/competence or transfer of learning	• Student competence • Academic development • Theory-practice integration
Contribute to safe motherhood and continuum of care	• Safe motherhood • Community-based education • Family-centred care
Passion for midwifery	
Positive feedback from or about students	Relationships
Evidence-based practice/research	
	• Education-based • Innovation in education • Appreciation of use of technology • Introducing new content to the curriculum • Learning and teaching strategies
	Advocacy

Answers provided in the gap analysis and the AI Discovery process show astonishing similarities. For both groups, shaping competent midwives emerged as the most essential element of midwifery education. Furthermore, the importance of safe motherhood content and contributing to quality, relevant midwifery care emerged from both data sets. Producing competent midwives who could contribute to quality midwifery care was discussed in Section 2.3. The WHO *Framework for Action Strengthening Quality Midwifery Education for Universal Health Coverage 2030* (2019) confirms the importance of quality midwifery education to ensure that universal health coverage is attainable by 2030.

7.4.2 Gender in midwifery education

In response to the theoretical framework and current concerns in the profession, questions about the impact of gender inequality were included. Participants were asked whether the unequal status of women affected their maternal health needs, and 72.9% of the participants agreed that it did. The majority (77.1%) reported that they were able to make choices and act on choices concerning their competencies. This declared ability indicates that they do acknowledge their responsibility as self-directed practitioners. To participate in adequate pre-serve and ongoing development as a midwife and educator is an essential component in the development of the workforce needed to provide quality care (Hoope-Bender *et al.*, 2016:5). The responses of participants regarding the autonomy of midwifery in South Africa had 60.9% confirming autonomy. Moreover, 52.1% linked to issues of autonomy of a woman-centred profession. Despite the perceived autonomy, 54.2% of the participants still acknowledged discrimination at different levels.

The motivations for the perceived discrimination mostly concerned the higher workload (n=8), followed by lack of appreciation for the competencies of midwifery (n=7), undue judgement by clinical staff (n=5) and being in a female-led profession working with women (n=5). Other unique contributions emerged, such as resistance to change by older colleagues, the absence of appropriate regulations, and the threat of colonialism and the epistemicide of midwifery. The links between gender inequality, lack of opportunities for education, leadership and career development, coupled with lack of

autonomy are recognised as issues that affect the quality of midwifery education (WHO, 2019:21). Other participants did not report any gender differences in midwifery education.

A significant motivation was made for epistemicide, which is related to the autonomy of the profession. The claim of epistemicide relates to quality concerns about the medicalisation of midwifery, as discussed in Section 6.8, namely, that the killing of the knowledge system of normal birth with a midwife is a global concern. In the context of South Africa, the participant stated the interrelation of epistemicide and colonisation. Decolonising education in South Africa is a priority in higher education institutions.

7.4.3 Elements needed to transform midwifery educators' competencies

The participants in the gap analysis contributed to elements that they deemed necessary for strengthening MEC (refer to Section 6.9). When comparing the listed elements with the categories of the three wishes expressed by the AI participants (captured in Section 5.6.2), the similarities confirm the data of each phase. The three main categories (as shown in Figure 5.10 in Section 5.6.2) were,

- Development, CPD, research development, contextually appropriate textbooks and increased focus on independent midwifery practice;
- Resources, including human resources, material and infrastructure and simulation resources; and
- Autonomy, including regulation of midwifery as a profession, freedom from political interference with political will, midwifery accountability and passion, and standardisation of the curriculum.

In Table 7.2, the two data set elements are combined in a joint display, which shows the similarities of elements to transform midwifery educators' competencies.

Table 7.2 Meta-matrix of elements needed to transform MEC

Element identified by gap analysis participants	Categories identified by AI participants
CPD at national and international levels	Development
Midwifery education to comply with global standards	Autonomy
Midwifery educator to be involved in the professional association	Autonomy
Practice involvement of midwifery educators	Development
Research	Development
Appreciation of midwifery educators' work	Autonomy
Increased human resources for midwifery educators, including preceptors	Resources
Standardisation of micro curriculum	Autonomy
Autonomous regulation of midwifery	Autonomy
Simulation resources	Resources
Only competent midwives to be allowed to teach the subject	Autonomy
Increase neonatal focus on content	
Interprofessional teamwork, also in midwifery education	
Focus midwifery education on what mothers' need	

Two data sets each brought elements that had significant overlap between them. The AI and gap analysis participants deemed similar elements necessary for the transformation. Participants voiced the need for CPD and autonomy, which are mentioned in many different ways, but which emerged in many responses. The participants' expressed needs should, therefore, be included in the transformative framework.

7.4.4 WHO midwifery educators competencies

The majority of the question items in the questionnaire relied on midwifery educators who participated to provide a self-rating on question items. Within the transformative

paradigm and the theoretical perspectives of feminism and social constructionism, the inclusion of a gap analysis could create a challenge. It was possible that injustice to the midwifery educators would be replicated if the evaluation of midwifery educators' competencies was done without sensitivity to the social justice that the paradigm highlights. Hence, a self-rating of confidence and competence regarding each item reduced the possible power imbalance that a quantitative evaluation could create (Barnes, 2019:303).

The items reflected components of the 19 competencies in the WHO midwifery educators' competency document (2013). Each of the competencies is built on items made up of knowledge, skills or behaviour elements. A full exposition of the competencies and items captured within each were discussed in Section 2.3.4. Participants rated their competence and confidence on each item. As the electronic platform created anonymity, the participants gave honest self-ratings. A summary of the domains and simplistic numeric analysis of the self-rated gaps that were found are presented in Table 7.3.

Table 7.3 Domains, competencies and self-rated gaps

Domain	Competency	Identified gaps
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	- International ethical responsibilities and obligations related to teaching and midwifery practice - Use of knowledge of ethical issues as the basis for influencing, designing, implementing, and evaluating policies and procedures related to students and the clinical environment
	Competency 2: Demonstrate an understanding of the legal and regulatory statutes relevant to midwifery teaching and practice	The majority identified no gaps
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	Midwifery practice and the use of research
	Competency 4: Practise midwifery in ways that reflect evidence-based and up-to-date knowledge	- Epidemiology - Community health issues - Sexual and reproductive health issues - Research

Domain	Competency	Identified gaps
3. Theoretical learning	Midwifery educators create an environment that facilitates learning.	
	Competency 5: Incorporate education strategies to promote active learning	▪ e-learning ▪ Seminars ▪ Projects ▪ Workshops
	Competency 6: Select and use effective teaching and learning materials/resources	▪ Use of information technology
	Competency 7: Recognise and support different learning styles and the unique learning needs of students	▪ Provision of resources to diverse learners that could help meet their individual learning needs
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	▪ Clinical environment and governing structures ▪ Competency-based clinical learning ▪ Evidence-informed practice ▪ Creation of an environment where practice development is enhanced ▪ Ability to influence the environment and governance structures ▪ Creation of a conducive environment and relationships with clinical midwives
	Competency 9: Foster individualised, experiential learning	▪ Clinical learning, relationships and structures of the clinical facilities ▪ Dealing with diversity in the learning processes ▪ Assessment of practical programmes

Domain	Competency	Identified gaps
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 education programme	Assessment types, essays, seminars and projects
	Competency 11: Assess student competence	The majority identified no gaps
6. Organisation, management and leadership	Midwifery educators participate in formulating the policy and programme outcomes and in designing and implementing curricula.	
	Competency 12: Actively participate in organising and implementing a midwifery curriculum	- Participate in developing midwifery curriculum, including: - Identifying programmatic and student outcomes - Developing competency statements - Participate in the design of midwifery curriculum based on educational decision, principles, theory and research - Participate in the development of syllabi and class/course outlines, including learning objectives, target audience, contents of the subject, teaching materials and evaluation methods - Curriculum is based on community and societal needs, to prepare graduates for practice in a complex, dynamic, multicultural healthcare environment
	Competency 13: Implement and revise midwifery education courses/programmes	- Organisational management, including organisational monitoring and evaluation - Quality assurance of organisational performance - Collaborate with external constituencies throughout the process of curriculum design, implementation and revision

Domain	Competency	Identified gaps
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	The majority identified no gaps
	Competency 15: Demonstrate cultural competence in course design and development, teaching and midwifery practice	Recognise and describe multicultural, gender and experiential influences on teaching and learning
	Competency 16: Function as change agents and leaders to improve both midwifery practice and midwifery education	- 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 healthcare and education needs - Implement strategies for organisational change - Provide organisational 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
	Competency 17: Use a variety of advocacy strategies to promote midwifery education and practice including professional, community, human rights and structural advocacy	Demonstrate a leadership role outside of the institutions, e.g., with government and professional associations
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	Interpret the quality and applicability of research papers and reports

Domain	Competency	Identified gaps
	Competency 19: Cultivate a culture supporting critical inquiry and evidence-based practice	▪ Critical inquiry

Source: WHO (2013:8,9)

Competencies #2 (legal and regulatory statutes), #11 (assessment of student competence), and #14 (effective communication) were generally rated with confidence and competence by the participants. Gaps, as identified by the participants, were discussed in detail in Section 6.8. The discussion often reverted to the preparation and development of midwifery educators who are part of a nursing education programme. Also, the conflation of the nursing profession – a larger group – and the midwifery profession can contribute to fewer midwifery educators in an NEI being exposed to activities such as curriculum development, leadership roles and other career development opportunities (Cadee & Wiklund, 2020:1877; WHO, 2019:21). Resource availability, such as electronic teaching and learning material and platforms, was also a concern, especially in the context of the global pandemic of SARS-CoV-2.

7.5 META-INFERENCE, THE TRANSFORMATIVE FRAMEWORK ELEMENTS

Two data sets, one from the AI and one from the gap analysis of midwifery educators' self-evaluations on the WHO competencies, were integrated and this information, together with relevant literature, led to the identification of the elements needed to develop the transformative framework.

The individual framework elements should evolve continuously, as none of the elements is stagnant. Continuous transformation of the framework will ensure that MEC will keep developing. Quality midwifery care relies on quality midwifery education, which is confirmed in a position statement of the ICM on the *Qualifications and Competencies of Midwifery Educators*. According to the position statement, midwifery educators need sound preparation for education, as well as for maintaining competence (ICM, 2014a:1), which include CPD.

MEC will strengthen midwifery and benefit childbearing families, as captured in the theme repeated in Section 7.3.

If it is rooted in MEC, midwifery care, branching out into essential competencies for midwifery care, can produce quality maternal healthcare. The themes that emerged from the AI and the data from the gap analysis were similar, as depicted in Table 7.1.

By identifying the consolidated meaning, or inference, further refinement into transformative elements was done. The elements were consolidated in a graphic framework that captures the significant elements of the data and literature, in an attempt to transform the inequities that affect MEC (Mertens, 2007:213, 2018b:6; Saldaña, 2013:14). The transformative framework also serves as a meta-matrix of the joint presentation of the research (Creswell & Creswell, 2018:246; Polit & Beck, 2017:596).

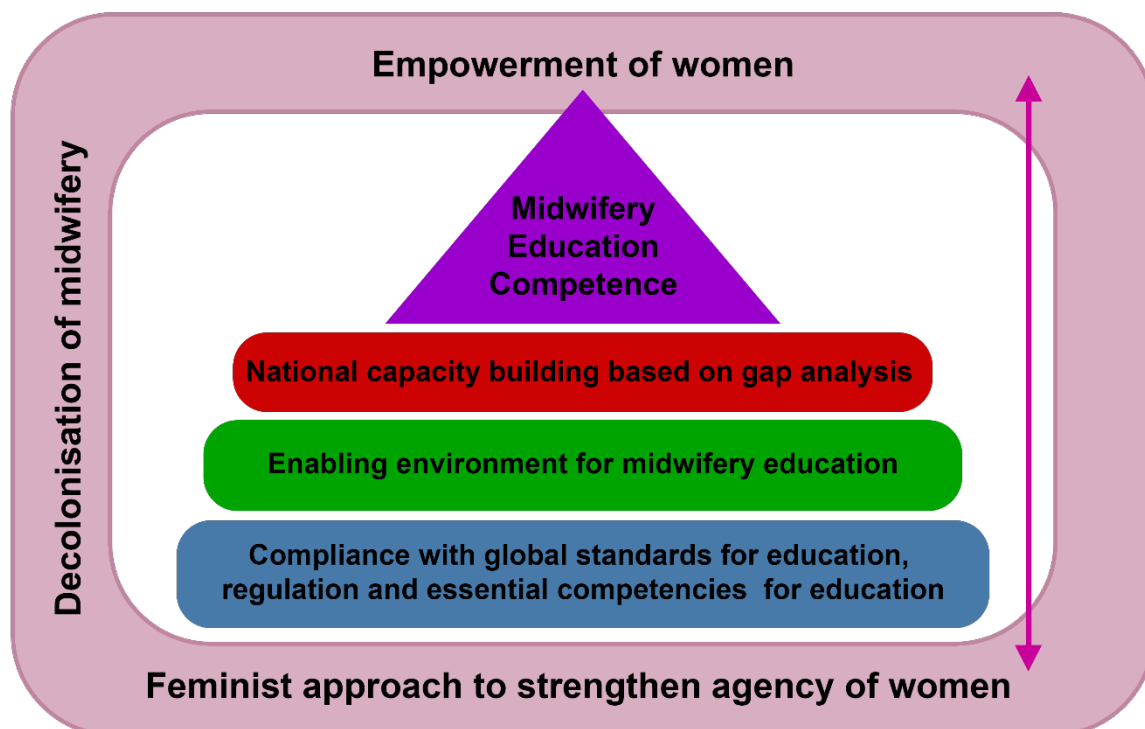


Figure 7.2 Transformative framework as meta-matrix

The elements portrayed in the transformative framework shown in Figure 7.2 will be 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 South Africa, will be presented. The discussion will commence with the frame, moving inwards to the four building blocks and, finally, the arrow, which depicts the process involved.

Colour choices were intuitive and started with the frame, gender issues led me to primarily use pink, which is a classic colour for baby girls; however, on a personal level, I associate it with women. As a girl with fair skin, raised in the 1970s and 1980s, I had had many pink items, which I treasured. One of the stories often told about my younger years is how I cried under the washing line if my pink teddy bear had been washed and was hanging there to dry.

The three ICM colours, of which blue is one, lead to the use of blue for the next block, compliance with global standards. Arising from the tree of life drawn in the AI, as discussed in Section 5.6.3, the enabling environment, for me, was green, a colour of life and growth. The national plan and gap analysis are red, as they represent urgent matters that needs intervention. The original WHO competency document had a purple cover, which represents the MEC.

7.5.1 Frame

The frame represents the contextual backdrop against which midwifery education takes place. As informed by the philosophical perspectives of the research, feminism considers it important to allow women and midwives to claim agency; this is the foundation of the frame. Elements that influence agency for midwifery and women, such as decolonisation and empowerment of women, are part of midwifery education and practice context. The first format of the frame is captured in Figure 7.3.

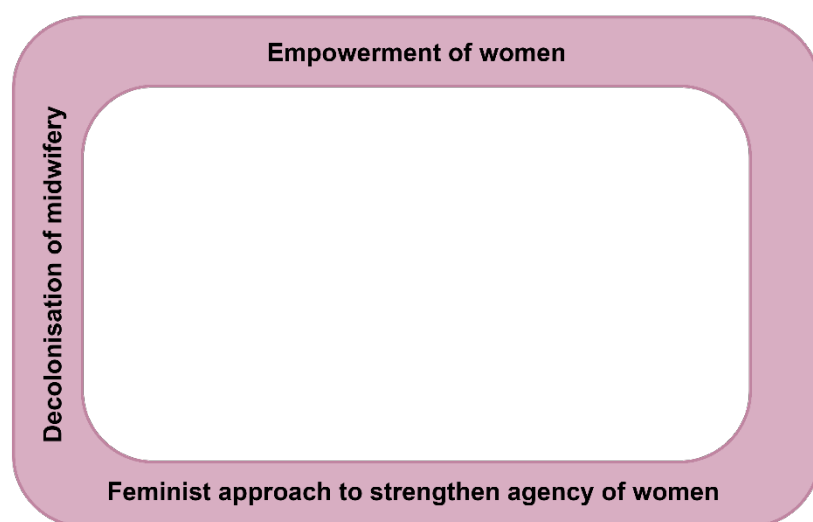


Figure 7.3 Outer frame of the transformative framework

The outer edge of the transformative framework frames the entire midwifery profession, including midwifery education, regulation, and practice. It includes midwifery educators, students, practising midwives and structures, such as the regulatory body and midwifery associations. The frame for the profession is embedded in a feminist approach that provides women (as recipients of care, and the educators and regulators who are part of the midwifery profession) with agency to make decisions and influence their own agenda.

The feminist approach seeks more agency (defined as capacity, condition, or state of acting and exerting power) for women, as care recipients, and male or female midwifery practitioners. Agency for the midwifery educators, midwifery profession and the women in need of midwifery care are all considered by the proposed framing. Individuals in midwifery, including men working as midwives, are disempowered by patriarchal systems. A feminist foundation will enhance the empowerment of women and midwifery. Male midwives within this predominantly female environment are treated differently, whether positively or negatively, than others in the profession. Feminism seeks to reduce systemic, patriarchal oppression. Refer to Section 3.2 for a detailed discussion of feminism in midwifery.

A second contextual element is the decolonisation of midwifery, focussed on normalising pregnancy, labour and birth. The aim is to restore midwifery after epistemicide. Knowledge democracy or decolonisation acknowledges the importance of multiple knowledge systems, and it flows from the ability of women and midwives to own their agency – this is the decolonisation of midwifery. The international concern and debate relating to the normalisation of pregnancy, labour and birth is linked to the epistemicide identified, which regards midwifery care of pregnancy, labour and birth as abnormal, dangerous or primitive (Bennett, 2007:4). Caring for women during pregnancy, labour and birth can be normalised, if it is provided by competent midwives, who have been educated by competent educators (ICM, 2011d:1; 2014a:1). Concepts relating to normalising childbirth were found in the content of midwifery education in both the AI and gap analysis.

Knowledge democracy acknowledges the importance of multiple knowledge systems (Hall & Rajesh, 2017:6). In this context, physiological birth is threatened by epistemicide, which disregards physiological birth and the abilities of women (WHO,

2018:1). The use of the term decolonisation in the transformative framework should not be regarded as de-professionalisation of the profession; instead it refers to restoring the value of physiological birth and midwives as primary caregivers for healthy pregnancy and birth (ICM, 2008:1). Facilitating agency and subsequent decolonisation of midwifery will increase empowerment from within midwifery and midwifery education, and lead to transformation of society.

The transformation should increase social justice for all the groups involved (Barnes, 2019:307). Women and midwives should be able to claim joint rights, as stated in the ICM's Bill of Rights:

- "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. 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" (ICM, 2014b:1).*

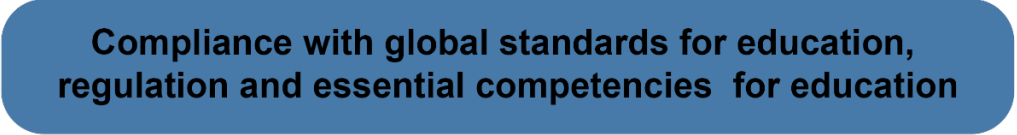
The ICM Bill of Rights distinguishes between rights of women, rights of midwives and the joined rights, as presented. The emphasis on midwives as advocates for women's rights received attention during 2020, which was declared as the year of the nurse and midwife by the WHO. At the time of the International Day of the Midwife, which is celebrated on May 5 annually, the global pandemic had disrupted many activities. However, the focus on advocating for women was continued on many platforms (Cadee & Wiklund, 2020:1877). Social justice for all who are disempowered, as

evident from the data, should be the goal of transformative research (Barnes, 2019:307).

Within the frame, some elements follow as consecutive building blocks that are essential in the quest to strengthen MEC. The building blocks used in the transformative framework will be introduced below. The outer frame encloses the building blocks, which represent steps and processes for transforming MEC.

7.5.2 Building block 1: Compliance with global standards

Protected by the frame, the first building block (shown in Figure 7.4), which carries all the subsequent, smaller blocks, captured the need for compliance with global standards for education and regulation. The incorporation of the essential competencies for basic midwifery education is also included in the foundational block.



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

Figure 7.4 First step of the transformative framework

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

Compliance with ICM global standards for education and regulation was discussed in Section 2.3.3.2, where the importance of global guidelines was explained. Elements that participants in both the AI and gap analysis listed as essential for transformation were coded as autonomy in the AI, and confirmed in the open-ended questions of the gap analysis. Table 7.2 of the meta-matrix of the elements needed, as identified by participants in the two data sets, shows the explicit utterance relating to compliance with global standards. Standardisation of the curriculum could be achieved if the Essential Competencies for Basic Midwifery guides midwifery education. Both groups

of participants expressed the wish to standardise the curriculum, alongside autonomous regulation of the profession – also a need expressed in both data sets.

The ICM global standards for education and regulations provide the norms to which our profession should comply if it is to remain relevant (Vermeulen *et al.*, 2018:129; 2019:6). The global standards ensure that South African midwifery education and regulations will address concerns highlighted by the participants, to ensure autonomy in both midwifery education and the profession at large. Compliance with global standards can open up multiple education opportunities for midwifery. The time and workload of educators and deciding who should educate midwives are all stipulated in global standards, which also emerged from both data sets. Refer once more to Table 7.2.

Compliance, by a national curriculum, to ICM Essential Competencies of Basic Midwifery will ensure that South African midwifery education can comply with the definition of the midwife, as stated by ICM.

*"A midwife is a person who has successfully completed a midwifery education programme that is duly recognised in the country where it is located, and that is based on **the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education**; who has acquired the requisite qualifications to **be registered and/or legally licensed to practice** midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery"* (ICM, 2011b:1)

Elements, such as the ICM Essential competencies for basic midwifery education, define the competence that every midwife should display before licensing to practice, as stated in the definition of the midwife. Participants indicated that to have a standardised curriculum would strengthen the education of midwives to make a difference in safe motherhood and holistic care of childbearing families. Content descriptions that were mentioned in both data sets, for example, safe motherhood and neonatal care confirm the need for a standardised curriculum for midwifery education. A standardised curriculum also aligns with the suggested action proposed in the WHO framework to strengthen quality midwifery education (2019), which considers radical thinking and innovation as ways of strengthening midwifery education.

One avenue that is can be considered is reorganising the way we think about midwifery education, so that it is be based on what women need. The needs of childbearing women are linked to agency and empowerment, as discussed in the frame in Section 7.5.1, with the foundation in feminism and agency for women. Midwives can advocate for women to receive what they need, based on their rights and within the healthcare system, which can either provide *too much too soon* or *too little too late* (as described in Section 2.3.1). In South Africa, characterised by both the overmedicalisation of care and lack of care, a midwifery-led model of care can ensure better care for all, based on the rights of women (Cadee & Wiklund, 2020:1877; Miller *et al.*, 2016:2185).

The participants' views and the elements they identified that should, in their opinion, be captured in this transformative framework echo a multitude of recent publications that confirm that a midwife educated to international standards is in the best position to impact positively on maternal health, as discussed extensively in Section 2.3. (Renfrew *et al.*, 2014:1129; WHO, 2019:vi).

Global standards ensure that education and regulation addresses concerns highlighted by the participants to ensure autonomy in the profession, and open multiple education opportunities for midwifery. The time and workload of educators and decisions on who should educate midwives are all stipulated in global standards.

7.5.3 Building block 2: Enabling environment

The second building block, following on the compliance with global standards, is to ensure that the environment in which the education is to take place is well resourced.

Enabling environment for midwifery education

Figure 7.5 Second step of the transformative framework

Global consensus confirms that an SBA or midwife needs an enabling environment to provide optimal midwifery care. To the contrary, we often see that, due to systemic disempowerment, this environment is not the reality.

"Many midwives are inadequately remunerated or supported, overwhelmed by the workload, and working in situations that expose them to sexual and other forms of violence. Midwives may work in less accessible, low-income areas where there are few other health professionals. Hence, they experience the exclusion associated with vulnerable communities while providing an essential service for the women and children who are likely to experience the worst outcomes" (Renfrew et al., 2019:397).

A review of human resource needs for midwifery education is needed. Participants in both phases voiced concern about resources. The meta-matrix in Table 7.2 indicates that resources, which include human resources, with special mention of preceptors for clinical accompaniment, and simulation resources, were considered as necessary elements in the gap analysis. Figure 5.10 which provides a summary of elements presented in the AI, refers to human resources, material resources and infrastructure and simulation resources.

The importance of the enabling environment is emphasised in a WHO survey of midwifery educators in regions, which states:

"Early results from a WHO survey of midwifery educators in five WHO regions provide a stark picture of the realities of constrained teaching and learning environments... Many are unable to access clinical settings, or simulation tools, to support competency-based education with women and babies".

Few educators reported having the education materials needed" (WHO, 2019:18).

The importance of political will to ensure that the enabling environment is created, was mentioned and categorised as a factor that influences autonomy (refer to Figure 5.10), an AI participant expressed. As presented in Section 5.6.2, the power of political support relates to the view that,

Governments say that midwifery is important for humanity (Participant 11).

Confirming the need for governments to take responsibility for midwifery education, Bharj *et al.* (2016:6) state,

"Building infrastructure and capacity for midwifery education must be elevated on the global agenda, including increased resources for midwifery education in all education and practice settings. A pervasive lack of infrastructure and adequate classroom space and skills labs as well as a lack of adequately trained clinical teachers in low resource countries have been reported".

Participants in this research confirmed the need for a review of the need for equipment, such as simulation equipment. The WHO midwifery survey mentioned in the framework for action, reveals that educators are less confident about clinical education, and did not have access to clinical settings and simulation equipment. In addition, the WHO survey found a shortage of needed facilities. Midwifery schools sometimes lacked water and sanitation, which was not reported in this research (WHO, 2019:18, 19). There were, however, no specific questions regarding the necessary infrastructure of facilities in my questionnaire.

Participants expressed the need to revive clinical departments in hospitals and clinical areas – establish a centre for clinical accompaniment, with dedicated staff from an education institution, remunerated by healthcare facility. Both groups of participants emphasised the value of a clinical department in facilities where students will be placed, which led to the inclusion of this element in the transformative framework.

The need for an enabling environment for midwifery education should be addressed. A survey of elements lacking in the enabling environment will ensure that needs, as identified, can be addressed.

7.5.4 Building block 3: Capacity building

Thirdly, after compliance with global standards and a review and provision of an enabling environment, follows the step of addressing CPD needs. As mentioned, this is an urgent step, which is of significant importance.

National capacity building based on gap analysis

Figure 7.6 Third step of the transformative framework

Radical thinking, as required by the WHO Framework, is to strengthen faculty to international standards. Due to a lack of investment in midwifery education, many educators struggle to maintain their competence (WHO, 2019:32) – participants reported that this was the case in both data sets. The element that midwifery educators brought forward most frequently in the two phases was the need for development and capacity building, including international-level exposure.

A national gap analysis, based on WHO Core Competencies for Midwifery educators, is a step suggested in the WHO framework to strengthen midwifery education, and this need was confirmed by the findings of the gap analysis. Gaps in some of the WHO Core Competencies for midwifery educators are summarised in Section 7.4.4, and Table 7.3. Considering the gaps identified and reported by midwifery educators themselves, the required continued development requires the midwifery educators to acquire competencies they lack in order to implement quality care for women, newborns and families (Bharj, Luyben, Avery, Johnson, O'Connell, *et al.*, 2016:4). The gap analysis confirms this as an element of the WHO framework to strengthen quality midwifery education (2019); it is part of the radical thinking 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, the gap analysis could have contributed to the required assessment as urged by WHO. However, the response rate was 31.1%. The multiple levels of permission required to approach midwives, as well as a lack of computer access by potential participants, might have affected the response rate negatively. The research barriers, such as obtaining multiple levels of permission, even led to the exclusion from participation in this study of all public education institutions in KwaZulu-Natal.

After a national gap analysis, a national accelerated capacity development plan based on gap analysis should be developed and sustained. In both data sets participants voiced concern about their inadequate access to CPD. Access to CPD echoes the view that is a global concern, namely, that resources are not allocated to ensure that midwifery educators maintain their competence (WHO, 2019:32).

To strengthen 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, such as FUNDISA and the office of the chief nursing officer. Professional associations, such as the 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 retain a national strategy with monitoring and evaluation implies that the transformation will be ongoing.

7.5.5 Building block 4: Midwifery education competence

Secured by the previous building blocks in the enabling frame of the context, we find the last building block, which is MEC. The focus of the educators' competence is now on education, which captures more than educators, but also the context of midwifery education.

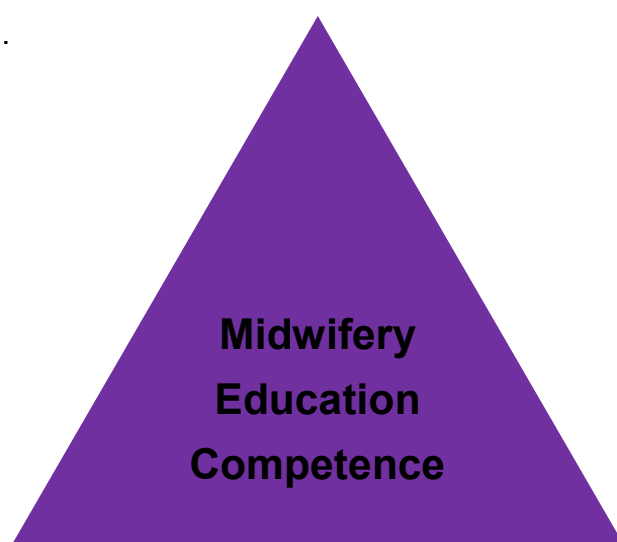


Figure 7.7 Fourth step

The last building block, after compliance to global standards, an enabling environment for midwifery education, the gap analysis and accelerated programmes, is the collection of 19 competencies listed in the WHO core competencies for midwifery educators.

Participants voiced the need for midwifery education to be offered by competent midwives. Therefore, competencies should guide the appointment, capacity building and deployment of midwifery educators. The WHO core competencies for midwifery educators covers 19 competencies in eight domains (as explained in Section 2.3.4). All the competencies (of both the educator and the basic midwife) should be incorporated in education preparation for midwife educators to provide quality midwifery education. The inclusion can be ensured by robust regulation, and support systems, such as the employers of educators and midwives (Bharj, Luyben, Avery, Johnson, O'Connell, *et al.*, 2016:5).

Educators should ensure that they are actively involved in clinical service. Midwifery educators who render midwifery care will empower themselves with clinical competence. Mentoring and integration of theory and practice, contribute to a greater transfer of learning if educators are competent (WHO, 2019:18). Collaborations between educators and clinical placement areas should be created; educators need to be active partners in the collaboration to ensure quality clinical education (Bharj, Luyben, Avery, Johnson, O'Connell, *et al.*, 2016:5).

Students will benefit from mentoring and integration of theory and practice, leading to an increase in transfer of learning. Transfer of learning and student success were among the most appreciated elements in the AI.

The triangle touches the upper part of the frame, where empowerment of women is situated. Women, as recipients of quality midwifery care from midwives who were prepared to international standards, may be empowered to take agency for themselves and their families (Cadee & Wiklund, 2020:1877).

7.5.6 Reciprocal process arrow

The final element of the transformative framework is an arrow that is intended to indicate that the process of transformation is ever-evolving.



Figure 7.8 Process of the transformative framework

All the individual elements of the framework are connected in a reciprocal process. Transformation is a continuous process that is seldom completed. In the South African context, transformation is connected to social justice. Barnes (2019) reminds us that South Africa is an excellent example of a country where, after the political landscape had been transformed, a constitution based on global conventions was developed. Despite the constitution, social injustice did not reduce, but, in some cases, even worsened; examples include high unemployment, with income inequity, poor service delivery, and high levels of violence, including gender-based violence, racism, sexism, homophobia and xenophobia (Barnes, 2019:303). Considering the ontological foundation of the transformative paradigm, multiple realities that are socially constructed, are influenced by many factors, including social issues that are related to power, economic factors (Mertens, 2007:216) and, in the current stage, a global pandemic that redefined life as we knew it on all levels.

Consequently, each increase in a component will positively influence the bigger frame of empowering women and normalising pregnancy, labour and birth, by decolonising midwifery. Women, as recipients of care, and midwives, both male and female, who have greater agency can demand the elements needed for the profession and themselves.

7.6 INFERENCE QUALITY

The importance and ways of ensuring quality in mixed-method research can be debated on a continuum of a "contingent-flexible versus a universal-fixed" view.

Quality is centred in both the conceptualisation and operationalisation of the research (Fabregues *et al.*, 2019:425). Design quality, that is, the way the research was planned to influence the quality of mixed-method research, was discussed in Section 4.5.2.

Strategies to integrate data sets should be responsive to the design of the research and the needs of stakeholders in the research (Mertens, 2018:7). Integrating the data also qualifies the research as mixed-method research (Anguera *et al.*, 2018:10). In this research, mixed methods ensured the expansion of the inquiry to appreciate the strengths and determine how educators rated their confidence and competence of the MEC (Doyle *et al.*, 2016:624; Schoonenboom *et al.*, 2018:272).

The scholars in mixed-methods research have different expressions of inference quality. Recent research indicates that, across disciplines, there are similarities in how researchers view and review quality (Fabregues *et al.*, 2019:435). Creswell and Creswell (2018:246), for instance, refer to quantitative and qualitative validity, use conventional measures, such as trustworthiness, and construct validity as descriptors of each. Polit and Beck (2017:597) coined the term inference transferability, which corresponds with Creswell and Creswell. As indicated in Section 4.5.2, the individual concerns of quantitative and qualitative research were considered in this research. Fabregues *et al.* (2019) compared four disciplines – nursing, psychology, education and sociology– to ascertain how these disciplines, as significant contributors to mixed-method research, perceive quality. Researchers from nursing and psychology were found to be more inclined to a universal and fixed perspective of determinants of quality in mixed-methods research. However, researchers from sociology and education favoured a contingent and flexible stance (Fabregues *et al.*, 2019:440).

Plano-Clark (2019) considers four strategies, which are also mentioned as elements in the research of Fabregues *et al.* (2019). The first is to consider the research questions asked, or the planning of the research. In this research, the sub-questions guided each phase. Secondly, the data sources should be aligned. This step confirms the importance of researching with meticulous attention to the qualitative and quantitative processes. After the initial analysis, an attempt was made in this chapter to align the data with a combined interpretation. The third strategy, identification of the point of integration, occurred in this research after analysis, as depicted in Figure 4.1

The inference and meta-inference were positioned after independent data analysis per phase.

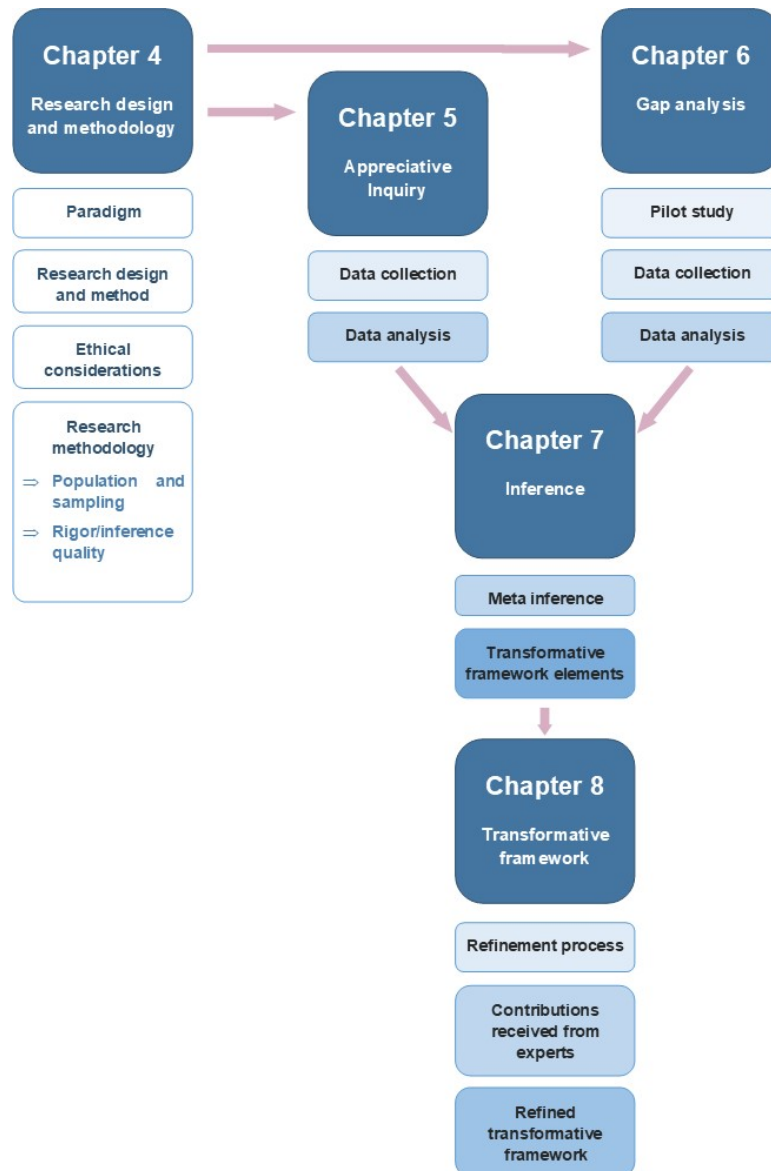


Figure 7.9 Steps followed in research methodology

Lastly, in this research, developing a meta-matrix or joint displays served as a strategy that was accomplished by tables for elements that were indicated to transform competencies. The transformative framework that was developed is a meta-inference

that was built on the data and triangulated literature, which can be disseminated to stakeholders (Fabregues *et al.*, 2019:430; Plano Clark, 2019:10).

While I reflected on my personal journey with the research, and how the planning, the completion of the different phases, the interpretation of the findings and preliminary dissemination took place, I found that the fixed, universal approaches often made me uncomfortable. My personal preference was to be more flexible; I was probably influenced by the philosophical grounding and paradigm of the study. Ultimately, I reviewed my work against the guidelines described by Bergman (2008).

Bergman (2008) proposes that interpretative rigour should be maintained in the process and outcomes, to ensure inference quality. The interpretations and conclusions can be guided by design quality, however, in the final product, interpretive rigour should be maintained (Bergman, 2008:113; Polit & Beck, 2017:216). Criteria for interpretative rigour, formulated by Bergman (2008), were considered and the application of these criteria in the inferences of the research include, first, **interpretive consistency** between the data and the interpretations, which is increased if triangulated with literature. It was considered that meta-matrixes were possible with similar data from the AI and the gap analysis, and that triangulating with literature and theoretical constructs affirms the interpretive consistency. From both data sets, the data on gender inequality confirmed **theoretical consistency**. Literature on feminism and from the midwifery fraternity confirmed that, although they are not always recognised, midwifery educators, through their interpretation and the elements they identified, face gender inequality at professional and sociocultural levels. The confirmatory data from the AI and gap analysis made the **integrative efficacy** seamless, as the participants confirmed the same categories and elements. Conclusions based on both data sets were incorporated into the transformative framework (Bergman, 2008:113–115; Polit & Beck, 2017:596).

The last two considerations, **interpretative agreement** and **interpretative distinctiveness**, which refer to peer agreements and reliable, plausible conclusions being drawn from inferences (Bergman, 2008:113), were, first, triangulated from literature and the theoretical foundation. Subsequently, experts refined the transformative framework. This process and outcome will be described in Chapter 8.

7.7 CONCLUSION OF THE INFERENCE

Analysing the data from the AI and the gap analysis provided me with a deep appreciation for the contributions made by the participants of the two phases. Categories and themes from the AI touched me and confirmed deep, personal convictions, such as the need to be passionate about being a midwifery educator. The two data sets provided findings that confirmed each other. The interface of merged findings flowed naturally, as the findings from the two phases showed convergence. No divergent findings were found (Creswell & Creswell, 2018:246). Participants provided the essential elements that formed the building blocks of the transformative framework. Additional confirmation was found in literature, theory and current discussions in midwifery. To enhance the interpretative agreement and engage a wider stakeholder group, an expert group was invited to refine the transformative framework through a Delphi process, which will be described in Chapter 8.

Chapter 8

Transformative framework



CHAPTER 8 TRANSFORMATIVE FRAMEWORK

"Lack of education is disempowering, reducing opportunities for career progression and leadership. This is combined with limited professional autonomy. Additionally, institutional hierarchies of power inhibit midwives from being able to practise to their full ability, or from accessing further education to increase their knowledge and leadership skills. All these factors overlap and reinforce each other, leading to burn-out among staff, and poor quality of care for women and newborns" (WHO, 2019:21).

8.1 INTRODUCTION TO THE TRANSFORMATIVE FRAMEWORK

A transformative framework that would ensure development opportunities and reduce institutional power inequities in midwifery education was developed in the previous chapter. The converging interface and discussion of the two datasets were presented. Information provided by participants informed us what gives life to their work and what they need to strengthen their competencies as midwifery educators. Their stories also echoed the need for professional autonomy, education and compliance with global standards. This chapter describes the process of refinement of the transformative framework.

8.2 REFINEMENT PROCESS

After development, the draft transformative framework was circulated electronically to a panel for comment and refining through a non-consensus Delphi process. The Delphi process provides the opportunity to pool group judgement, which is more reliable than individual opinion (Zervas, 2014:66). The non-consensus method was deemed suitable for a transformative paradigm, because all the inputs could be considered (Brady, 2015:1). As discussed in Section 4.5.1.3, stakeholders and experts in the profession and interprofessional fields in the country and experts in midwifery education from a regional and global level were invited to participate.

An explanation of the research phases and elements of the framework was provided. The experts were requested to offer open-ended critique that could contribute to

refinement of the draft transformative framework. Options per item were placed on a Likert scale with three evaluative considerations; participants could respond whether the element was essential for transformation; useful if it would be adapted, or could be omitted.

[Element of the framework]	Essential for transformation	Useful with adaptation	Can be omitted

If they selected the "useful with adaptations" option, participants were requested to make suggestions for improvement. In an attempt to reduce the likelihood of experts opting for the middle and remaining neutral (Grove & Gray, 2019:358), this addition was made to the neutral choice.

8.3 EXPERT GROUP

In Section 4.5, the expert population, sampling, and eligibility criteria were explained. The experts included obstetricians, midwives, regulators of practice, and officials from the national Department of Health, firstly, to provide balanced input for the refinement and, secondly, to facilitate action, after the final research products and recommendations would be disseminated. Midwifery experts were identified from the sub-region, and midwives at the global level (Avella, 2016:307).

Each expert was contacted individually via email to protect the quasi anonymity of experts (Avella, 2016:307; Keeney *et al.*, 2011:9). The request and the document (included as Annexure C) to review, was attached to the email. Experts were requested to return the document within two weeks. A reminder was sent via email after a week. After the second reminder, no further reminders were sent.

The matrix of experts and numbers that contributed are shown in Table 8.1.

Table 8.1 Matrix of experts and contributions received

Level of expertise	Location	Profession	Number of experts	Number of contributions received and response rate	Gender
Obstetricians: members of the ministerial committee on maternal health	Provinces of South Africa	Obstetrician	9	n=7: 78%	Female= 2 Male=5
Family medicine, rural health and obstetrics	University level	Family Physician	1	n=1: 100%	Male=1
Officials in maternal health directorate and office of the chief nursing officer	The national Department of Health	Midwife Medical doctor	5	n=2: 40%	Female=1 Male=1
Regional and global midwifery experts	Sub-region and global level	Midwife	7	n=6: 86%	Female=6
National midwifery and education experts	Based in South Africa	Midwife	3	n=3: 100%	Female=3
			25	n=19, 76% Midwives (n=10, 55%) Medical (n=9, 45%)	Female (n=12, 63%) Male (n=7, 37%)

I perceived the response rate of 76% as confirmation of the importance and relevance of the research topic and the research product. The sub-group with the lowest response rate (40%) was the group of officials from the national Department of Health. As the non-consensus Delphi process consisted of only one round, the average attrition associated with a Delphi was not a consideration (Keeney *et al.*, 2011:13; Zervas, 2014:67).

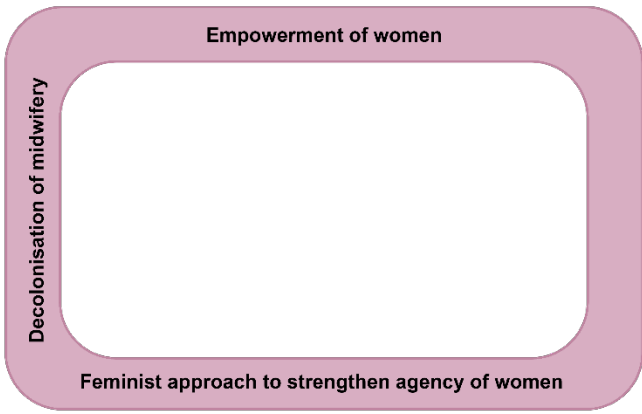
8.4 CONTRIBUTIONS RECEIVED FROM EXPERTS

The experts completed the document electronically. Every document was coded with a unique code, in compliance with quasi-anonymity, which allows the researcher who receive replies to identify experts by code and not their names (Brady, 2015:3; Keeney *et al.*, 2011:10). Hence, the detail of how unique codes were comprised will not be shared. The contributions were analysed individually and consolidated in one table. The contributions were all considered and discussed with the research supervisor. The analysis was aimed at the consideration of all experts' comments on the transformative framework. Finding commonalities and suggested refinement from the opinions (even extreme opinions) provided insights into the final framework (Brady, 2015:4; Keeney *et al.*, 2011:28).

8.4.1 The frame comments received

The responses, as applied to the frame of the framework, are presented in Table 8.2.

Table 8.2 Responses relating to the frame

The Frame	Essential for transformation	Useful with adaptation	Can be omitted
	4	5 <i>Not too clear about the difference between feminist approach and women empowerment (NMM)</i>	0
1 The framework of profession , encompassing midwifery educators, midwives, students, and recipients of care.	16	3 <i>Recipients of care include the family or partner (JMO)</i>	
2 The 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.	10	8	
3 Decolonisation of midwifery focussed on normalising pregnancy, labour and birth. Midwifery care to be restored from epistemicide (the killing of knowledge systems). Knowledge democracy or decolonisation acknowledges the importance of multiple knowledge systems).	11	5	2
4 The focus on agency and subsequent decolonisation of midwifery will increase empowerment from within midwifery and midwifery education and the transformation in society.	11	5	2

Nine of the experts reacted to the frame itself, with four affirming its use and five suggesting adaptation. One indicated that they did not have clarity on the difference between the empowerment of women and the feminist approach. The framework itself was affirmed by 16 participants, and three participants suggested adaptations, however, a suggestion that it is adapted was not always accompanied by a suggestion for adaptation. One expert (JMO) commented in the block, and suggested that recipients of care should include family members or the partner. Using the feminist approach was confirmed by 10 experts, of whom eight suggested adaptations and no omissions. One of the contentious concepts was decolonisation. Both items were accepted by 11 experts; five suggested adaptations and two suggested omitting it. The adaptations suggested are captured in Table 8.3.

Table 8.3 Adaptations suggested for the frame

AM – Framework could be improved upon by being cycling in nature to show continuous interaction for the transformation
EO – Decolonisation is more long-term and will require educators to be comfortable and skilled to work in varying environments. This will require change in attitude. This will be a great challenge, thus it is important that an accelerated plan is implemented. This will need supervision and mentoring. The current human resource base is shallow within the country (SA) [South Africa].
EMM – Where do we fit in the transcultural care of the pregnant woman?
HF – I think there is a major problem with using the popular phrase of "decolonisation" within this context. Although I truly believe that pregnancy and childbirth should be managed as "naturally" as possible and should not be "medicalised", the term decolonisation implies that anything defined as "colonial" be removed. In this context that would/could include feminisation and the concept of empowering women to be "themselves" in any culture. Clearly the concept of "decolonisation" needs to be balanced with the understanding of "influence from the outside" (e.g. ICM, WHO) that may well be necessary and good.
KMD – the approach to introducing these principles into the training should take on methods applied in "improvement science" (AI, Lean, Model for Improvement etc.)
MWM –Transformation need to be driven on governmental level too in terms of registration and legislation to professionalise midwifery and therefore midwifery education.
MYM – Empowerment of women could be moved to the right side of the framework with "Framework of profession" at the top serving as heading for the framework. Decolonisation is not used correctly. Demedicalisation is more appropriate in this context.
NMM – There are a lot of concepts embodied in decolonisation. That will leave a lot of room for readers to misunderstand what is meant. Concepts of

• Colonisation • Epistemology • Normalcy of labour vs over medicalisation? • Democracy There might be an advantage in decongesting the descriptor for ease of reading and understanding. There might be an advantage in clarifying the difference between the feminist approach and women empowerment in the frame
NMO – Decolonisation is not a good word to use in the South African context as it has racial connotations, which I don't think is what is intended here. What is I think intended is to imply evidence-based care, moving away from obstetric dogma, particularly the idea that obstetric care should be physician/obstetrician-led. Using the term "Decolonisation" might suggest care by traditional birth attendants following cultural practices, (African vs Western practices) rather than evidence-based scientific processes. Perhaps "evidence-based obstetric care led by midwives" would be a better term The term feminist is problematic especially as midwives may be male, and male partners of the pregnant woman may be important participants in quality care. The term "respectful care for women and their carers" is more appropriate Agency does is not directly dependent on the feminist approach. I am not sure that the term agency is well understood. I prefer something like "empowerment"
BPO – Please note a pregnancy can only be described as normal once the baby is born healthy at term, is a week old and the mother is well. There needs to be a lot of attention paid to detecting abnormalities, and not to normalise event that may be abnormal. All studies on midwifery only units have a slightly higher mortality and complication rate than maternity units, however, maternity units have a much higher intervention rate. A balance must be found and the On-site Midwife run-Birthing unit (OMBU) is the perfect solution for this.
JMO – decolonisation is not the term I would use... It is too political and defers on what is trying to be achieved
SFO – Ensure midwifery care decolonised to see childbirth as a normal process but essential it also recognises that in some women it carries risk (can cause death) and this aspect requires the team approach with obstetric medical professionals
SNM – No matter how the approach is going to be, female midwives are preferred compared to males. However, male educators do not have a problem. Culture dictates it.
WMM – Maybe divide point 2 into; • Feminist approach seeks more agency... for women as care recipients. • Feminist approach seeks more agency that is inclusive for both male and female midwifery practitioners.

Three comments advised on technical and layout issues, with AM, MYM and WMM suggesting a cyclical format (AM), moving concepts (MYM) and dividing concepts (WMM). Two other comments clarified and added training suggestions. EMM asked if this was where transcultural care would fit in. KMD suggested that the ideal training

model should incorporate “methods applied in ‘improvement science’ (AI, Lean, Model for Improvement, etc.)” – the terminology used was not clarified with the expert. As the suggested additions elaborate on a training model that can be adopted once the transformative framework is implemented, it did not invalidate the framework element as presented. One expert, MWM, placed the responsibility for transformation at the level of government and saw registration and legislation of midwifery education as critical elements for transforming midwifery education and increasing the professionalism of midwifery.

Seven of the experts commented on decolonisation, of which three elaborated and four had reservations about the word choice.. One expert (EO) indicated that decolonisation is a long-term goal that might need educators to be skilled and able to work in varied environments. The attitudes and what they refer to as a “shallow human resource base” require an accelerated implementation plan with monitoring and evaluation. The opinion expressed is echoed in the recommendations of the maternal death reviews, the Saving Mothers reports. The strategies are captured in the figure.

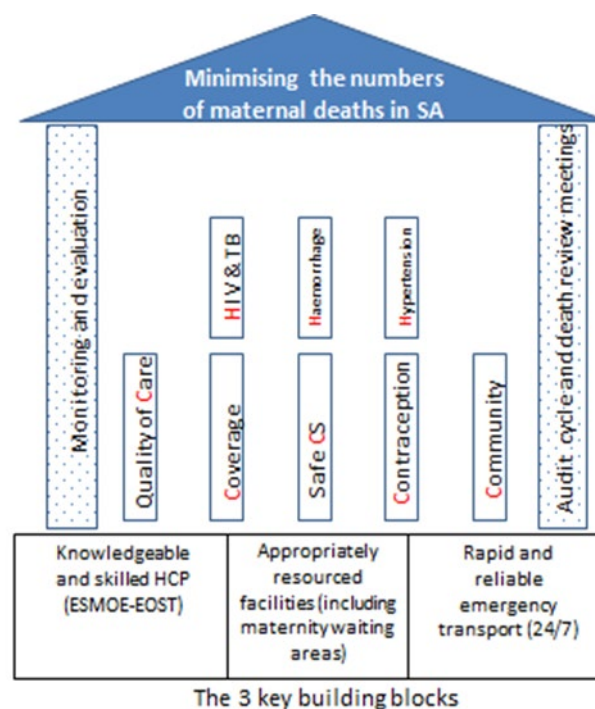


Image 8.1 The 3 key building blocks

Source: Pattinson and Moodley (2018:9)

The proposed strategies, as identified by the NCCEMD, identify the need for competent healthcare providers as one of three fundamental building blocks. The importance, as suggested by EO, of monitoring and evaluation, is also captured as needed to reduce the maternal death burden (Pattinson & Moodley, 2018:9).

Another expert indicated that it might help to unpack certain terms, and highlighted colonisation, epistemology (possibly epistemicide?), "normalcy of labour vs over medicalisation" and democracy. As the full discussion on the theoretical underpinnings of the research, the literature review and the data analysis were not shared with the experts; this comment is valuable for future dissemination. In Section 6.8, the comment by a participant in the gap analysis who connected the epistemicide of normal midwifery with colonisation was followed with an exposition of the comments and how it interrelates to previously mentioned concepts, such as medicalisation of birth, in Section 2.3. The experts did not have access to the full discussion as captured in the thesis, but as indicated in Annexure C, a discussion explaining building blocks were provided.

Four of the experts (HF, MYM, NMO, and JMO) warned against using the word decolonisation due to its political connotations, which might imply that all "colonial" connections are irrelevant. Two experts, DM and ECM, also referred to decolonisation in the additional comments (refer to Table 8.4). The medicalisation of childbirth and that it is not the ideal birth model was confirmed by the experts, even if the term was to change. MYM suggested using demedicalisation rather than decolonisation. As elaborated in Section 6.6.3, the decolonisation concept is much more comprehensive than demedicalisation. The described epistemicide kills the knowledge system of normal midwifery care that should be rendered by a midwife who complies with the global standards within a philosophy and care model that respects normality (ICM, 2014c:1, 2017:1; Ten Hoope-Bender *et al.*, 2014:1). The benefit of the midwifery-led model of care is well described (Hattem *et al.* 2009:16; ICM, 2011b:1) and confirmed by the comments of the experts. Except for the critical consideration of the normality of the midwifery-led model of care, decolonisation adds the concept of knowledge democracy. The richness of decolonisation, linked to knowledge democracy, is captured in the following statement:

"The concept of knowledge democracy acknowledges the importance of multiple knowledge systems, such as organic, spiritual and land-based systems, frameworks arising from social movements and the knowledge of the marginalised or excluded. It is about open access for the sharing of knowledge, making it a powerful tool for taking action in social movements to deepen democracy and to struggle for a fairer and healthier world" (Hall & Rajesh, 2017:6).

The intention of decolonisation is to restore knowledge democracy, in this case, to the way midwifery is perceived under hegemonic power control (Bennett, 2007:4) of over-medicalisation of maternal healthcare (also refer to Section 2.3). Respecting the woman's human rights, which are supported by a midwifery-led birth, is counteracted by epistemicide, which negates women's inherent ability to give birth. To embrace knowledge democracy recognises the organic and optimal condition for care, which is midwifery care (Hatem *et al.*, 2009:16; ICM, 2011b:1, 2014b:1).

Examples were given by the experts to confirm their strong support for promoting the normality of birth. HF stated: *I truly believe that pregnancy and childbirth should be managed as "naturally" as possible and should not be "medicalised"* (HF). Another participant added, *"What is I think intended is to imply evidence-based care, moving away from obstetric dogma, particularly the idea that obstetric care should be physician/obstetrician-led"* (NMO).

Both the statements concur with the increased move to a midwifery-led model of care. Caution was expressed around the negative connotations of decolonisation, as it might have racial (NMO) and political (JMO) innuendos connected to it. HF added:

"I think there is a major problem with using the popular phrase of "decolonisation" within this context. Although I truly believe that pregnancy and childbirth should be managed as "naturally" as possible and should not be "medicalised", the term decolonisation implies that anything defined as "colonial" be removed. In this context that would/could include feminisation and the concept of empowering women to be "themselves" in any culture.

Clearly the concept of "decolonisation" needs to be balanced with the understand of 'influence from the outside' (e.g. ICM, WHO) that may well be necessary and good".

In the reflection of the well-intended caution about using the word decolonisation, the decision was made to include it, with the addition of a description. None of the experts objected to the foundational concept. Their valid concerns were connected to the politicisation of the word, which is, at times, perceived as meaning a removal of all Westernised influences or concepts. The literature confirms, however, that decolonisation is rooted in knowledge democracy. At the core knowledge democracy, lies support for the epistemological origin of knowledge. The relationships between those "knowing" and others is equally important (Hall & Rajesh, 2017:7; Mertens, 2015b:59). Knowledge democracy or decolonisation regards the epistemologies of all people, including indigenous people and those marginalised due to gender, race, or sexuality, as important (Hall & Rajesh, 2017:7). In the context of this transformative framework, the knowledge system that supports the normality of birth, with a midwife as first-choice provider of care, is the focus of decolonisation (Hattem *et al.*, 2009:16; ICM, 2011b:1).

Furthermore, working within the transformative paradigm, the social transformation drive is enhanced by choosing terminology that originates, firstly, from the realm of social justice and change and, secondly, from the research participants. To dilute the meaning of the word and avoid the strong connotations to it will not be congruent with the paradigm of the research. The addition of "restoring knowledge democracy" of midwifery was added below "decolonisation of midwifery" to clarify what was meant by the concept.

Lastly, three experts elaborated on feminism (WMM, NMO and SNM), and advised an elaboration on empowerment and linkages with agency, and distinguishing clearly between women as recipients of care, and between female and male midwives. One participant (SNM) commented, *female midwives are preferred compared to males. However, male educators do not have a problem. Culture dictates it.*

This statement was interpreted as "distancing", to indicate that, due to cultural factors, male midwives are less preferred than female midwives are. The same sentiment was

expressed by participants in the AI and gap analysis, namely, that men do not fit in. The interpretation of gender bias and distancing was, again, connected to the statement, and confirms that gender inequality for male midwives is a stark reality.

Additional comments were made, and are captured in Table 8.4.

Table 8.4 Additional comments on the frame

DM – On Decolonisation: I think this is a sum up statement rather than an element. The content is very useful, may need a space elsewhere
EO – The current approach to midwifery education will need to change drastically, divorcing general nursing education from midwifery education. As experienced a few years ago during the ICM congress, political forces may connive to frustrate this approach. It is also important that midwifery educators be involved in the education of staff that provides care to women in general. This will include the training and mentoring of medical and postgraduate specialised cadres
ECM – 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 – this statement is not clear, especially the addition of "or male or female midwifery practitioners" – is the focus on women or the practitioners? Revisit this statement Decolonisation of midwifery focussed on normalising pregnancy, labour and birth. Midwifery care to be restored from epistemicide (refers to the killing of knowledge systems. Knowledge democracy or decolonisation acknowledges the importance of multiple knowledge systems) – The word "decolonisation" sounds too strong and in some settings it has negative connotations.
HSM – This is good, I was at first not sure what to do with the other side of the frame that is blank, but I have not suggestion. My next point or question was what inspired the colours of the framework? I would use green as a shade of the frame and a lighter green shade as the background. I think midwifery is associated with green
MWM – Good framework!
MYM – Arrows can be added interlinking the concepts
WMM – The aspect of feminist approach that seeks agency for midwifery practitioners is also very important, yet it does not feature strongly in the frame.

A comments was made on the use of the colours (HSM). The expert participants did not receive a key or explanation of the use of specific colours in the framework, as discussed in Section 7.5. As this was the only comment in this regard, it was decided to keep the colours as they are. The green colour of midwifery, mentioned by an expert from outside South Africa, could be associated with the green epaulettes that were worn by midwives with single professional registration and the green bar added to

epaulettes for midwives with multiple registrations. I chose to keep the feminine colour, for me, that is, pink.

Another comment was the suggestion to add arrows to link concepts in the frame (MYM). The wording was rearranged to flow in a circle, which creates a dynamic cycle, as arrows would also bring. The need to confirm the agency of midwives by stating it more overtly was another comment (WMM). This suggestion was incorporated by adding a special focus on the agency of midwives within the feminist approach. Two participants (HSM and MWM) commented that it was a useful framework.

8.4.2 Building blocks: Comments on compliance with global standards

Within the frame, the first block and foundation urge for compliance with the global standards, as discussed in Section 7.5.2. The comments received are summarised in Table 8.5.

Table 8.5 Comments on the first building block: Compliance with global standards

First building block: Compliance with global standards	Essential for transformation	Useful with adaptation	Can be omitted
Compliance with global standards for education, regulation and essential competencies for education	3	2	
1 Compliance to ICM global standards for education.	16	3	0
2 Compliance to ICM global standards for regulation	16	3	0
3 Compliance in a national curriculum to ICM essential competencies of the basic midwife.	17	2	0

None of the experts excluded the ICM global standards for education and regulation. The majority of the comments (AM, EMM, NMO, HF and SNM) were to ensure that the global standards and national curriculum comply with local health needs. One expert (KMD) suggested that strategies to monitor and evaluate the compliance should be implemented.

In the additional comments, one expert (MSO) suggested that competence in the WHO signal functions should be captured in the regulatory framework. The maternal and neonatal signal functions are captured in the essential competencies for basic midwifery education. One of the experts said, *All the groundwork is done, it's all right there at ICM. Backed by multiple evidence. We living in exciting times for midwifery (MWM).*

As the experts all agreed that compliance with global standards of education is essential, and that regulation is essential for transformation, the block remains in the framework, due to this reliable justification for its inclusion. The elaborations alluded to content to be captured (signal functions) and ensuring that local health needs be respected as global standards are embraced.

8.4.3 Second building block: Enabling environment

The second building block (refer to the full discussion in Section 7.5.2), of ensuring an enabling environment, was supported, as none of the experts deemed omission as necessary. The discussion (refer to Section 7.5.2) of the original inclusion of the element includes reference to the importance of a review of the human resource needs of midwifery education. Equipment needs, with special mention of simulation equipment, was considered as part of the enabling environment. Lastly, several participants in the AI and gap analysis mentioned reviving the clinical departments as a need. Table 8.6 displays consolidated feedback of experts on this element.

Table 8.6 Enabling environment responses

Second building block: Enabling environment		Essential for transformation	Useful with adaptation	Can be omitted
Enabling environment for midwifery education		3	0	0
1	Review human resource needs for midwifery education	17	2	0
2	Review the need for equipment like simulation equipment	14	5	0
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).	13	6	0

None of the items was regarded recommended to be omitted. Strong support was offered for human resource review (n=17), as by one expert said, *The shortage of staff, even among the MEs [midwifery educators] themselves, bodes ominously for the rendering of high-quality care* (EO).

The importance of reviewing equipment needs was confirmed (n=14), and an adaptation that was suggested is, *Review need for equipment to strengthen clinical competencies* (ECM).

Experts outside South Africa, who were not well conversed with the current and previous systems, did not find the comments about the revival of the clinical departments clear. Contributions focussed on the importance of the clinical role of midwifery educators. Fulfilling a clinical and educational role was seen as a crucial component for bridging the theory-practice gap. It was expressed well by WMM:

"Provided that the dedicated staff on joint establishment have dedicated hours to function both in the clinical service platform and are at the same time, assigned teaching hours at the education institution. This will strengthen/enhance both the knowledge base and skills set".

Experts based in South Africa, and who are all familiar with the clinical departments, reflected on how the abolishing of the clinical department sometimes contributed to less competent and involved midwifery education (EO, EMM, NMO, JMO and WMM). Moreover, the importance of interprofessional teams was mentioned by MWM. Clinical involvement will ensure that service provision is enhanced during provision of quality education, as described in Section 2.3.4.

The enabling environment building block was retained, as confirmed by all the experts. The focus on the clinical department is, instead, as suggested by the experts, to be on clinical involvement of midwifery educators.

8.4.4 Third building block: Capacity building based on gap analysis

The third building block (as discussed in Section 7.5.3) was a national capacity building of midwifery educators based on a gap analysis. The first component is that all midwifery educators should have the opportunity of doing the gap analysis. Based

on the results, a national accelerated capacity development plan should be developed. The implementation of the plan should be monitored. The responses of the experts are summarised in Table 8.7.

Table 8.7 Capacity-building responses

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		3	1	0
1	Do gap analysis based on WHO Core Competencies for Midwifery educators	18	1	0
2	Develop national accelerated capacity development plan based on gap analysis	18	1	0
3	Monitor core competencies for midwifery educators after development plan implementation	19	0	0

The building block for the capacity building of midwifery educators was well received. No suggestions for its omission were recorded. Additions suggested were valuable elaborations on implementation, and a statement that a strategy, rather than a once-off plan, should be secured to ensure that the process continued (NMM). The one official from the Department of Health added to further implementation strategies: *Work with NDOH [national Department of Health] to obtain status of competencies and also distribution (deployment) of midwives in the service delivery platform* (KMD).

Other comments revolved around adapting the gap analysis to the context and needs of South Africa (NMO) and that midwifery educator should have at least five years of clinical experience before venturing into education (MYM).

One of the other comments from an obstetrician was the following:

"Need to consider delinking midwifery education from nursing education or specialisation to promote autonomous, independent practice ethics and avoid philosophy clashes with nurses following doctors' orders. Dedicated tutoring time and extended practice required to develop and maintain competence (MSO)".

This statement by an obstetrician echoed the views expressed by the participants of the AI and gap analysis, which called for an autonomous midwifery profession.

Experts (AM and NMM) recommended that educators' competencies should be a prerequisite for relicensing annually. Furthermore, EMM remarked: *Check on the passion, knowledge and skill from the individual educator.*

This comment featured in each of the research phases, and, as mentioned, provides a personal confirmation of my perspective that passion is a crucial component in midwifery and midwifery education.

The element was retained as is, congruent with the experts' opinions. With the SANC still implementing CPD requirements, the suggestion to base the renewal of the annual practice certificate on competence development emanating from the gap analysis, will be shared in the final dissemination of the research.

8.4.5 Fourth building block: Midwifery education competence

The fourth building block, as explained in Section 7.5.4, is represented by a triangle that rests on the previous blocks, and pointing into the frame on midwifery education competence. The expert feedback is captured in Table 8.8.

Table 8.8 Midwifery education competence building block

Fourth building block: Midwifery education competence	Essential for transformation	Useful with adaptation	Can be omitted
Midwifery Education Competence	2	1	0
- Midwife educators' competencies should guide appointment, capacity building and deployment of midwifery educators.	17	2	0
- Midwifery educators need to be clinically competent.	19	0	0
- Women with midwifery care from a midwife prepared to international standards will take agency for themselves and their families	13	4	1

This block represents the importance of MEC as a guiding element for appointment, further education and deployment of midwifery educators. The importance of MEC was mentioned and appreciated in each phase of the research, and elaborated on in Section 7.5.4. As a central topic of the research, it represents the pinnacle of the transformative framework. The golden thread of clinical competence, as confirmed by Competency #3 of the WHO competencies and the three phases of the research was accepted unanimously by all experts.

The last component (item 3 as presented to the experts) referred to the connection between the agency that women can gain if they are cared for by a midwife prepared to international standards. One of the experts (WMM) expressed that the agency had not been stated strongly enough. Four others (AM, DM ECM, and WMM) suggested amendment. The suggested improvement offered by WMM and DM is: *Women **receiving** midwifery care from a midwife prepared to international standards will take agency for themselves and their families* (WMM).

The suggested adaption clearly states the importance of midwifery-led care and confirms women's human rights, and how midwifery-led care empowers women. Midwives, as defenders of human rights, can be instrumental in women claiming their agency (Cadee & Wiklund, 2020:1877; Hatem *et al.*, 2009:16; ICM, 2014c:1, 2014b:1).

The confirmation of all the experts about clinical competence was mentioned in additional comments. Comments on clinical competence include the following:

"This will take some time and a lot of resources for equipping the current community of MEs [midwifery educators]. This lies at the basis of change in midwifery education in South Africa. A national initiative and summit needs to be convened as soon as the basic elements are in place (EO)".

"Educators should be practitioners – should be hands-on (KMD)".

"Midwifery educators need to be clinically competent and based in the maternity units or labour wards (BPO)".

"Midwifery educators should continue to have a clinical role with some clinical responsibility in order to keep in touch with clinical realities on the ground (i.e. not just be educators) (SFO.)"

The additional comments in this section were vibrant, and confirmed the importance of quality midwifery education by well-prepared clinical competent educators. A contribution was made to the wellbeing of women:

"When women see that it is possible to have satisfying experiences in decolonised environments, they will assist in promoting for a change and dignity. They will become active partners in the process of pregnancy care, childbirth and the puerperium (EO)".

With this statement, EO captures the importance of decolonised midwifery care and how that empowers women. Dignity is evident, as empowered women take partnership roles in the continuum of reproductive healthcare. Other statements alluded to the importance of competent midwifery educators.

"Educate the educators! Brave issue to tackle. It is sad as that there are midwifery educators out there who are not even real midwives themselves...! Also, how can we work towards a system that educators have time to also stay hands-on involved with and therefore competent? (MWM).

Indeed, it was brave to tackle this issue. However, within the transformative paradigm, the elements needed for transformation should be the focus and not only those elements that seemed secure. The encouragement of NMM confirmed that the work needed to be done: *There is evidence of intense work having been done leading to the production of a very context specific piece of work. Congratulations. Thanks for privileging me with contributing to its finalisation (NMM).*

The expert that felt that the element could be omitted motivated their recommendation as follows: *Not sure what is meant in statement 3 – We need to remember the need for interprofessional care where pregnancies are complicated*" [expert recommending possible omission of element 3].

Reflecting on the motivation provided, the expert referred to a need for an interprofessional team to care for complicated pregnancies. Referral of any complications is supported in the ICM Philosophy and Model of Care (ICM, 2014c:2). Therefore, the expert's concern is not regarded as a rejection of the item, but rather, possibly, as a partial understanding. Hence, the suggested adaptation to the third element is accepted, as the content of the opinions of the four comments suggesting amendment were supportive, and expressed the original intent better.

8.4.6 Comments on transformative framework process

Transformative work such as this framework proposed to strengthen, midwifery educators' competencies; should continually transform continuously. The importance of the transformative process was elaborated on in Section 7.5.5. Only 16 of the 19 experts responded. In the final review element, the experts were asked to reflect on the expression of the process in Table 8.9.

Table 8.9 Expert feedback on the transformative process

Process	Essential for transformation	Useful with adaptation	Can be omitted
	1	0	1
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	12	3	1 <i>This may well be perceived as "colonial" and therefore would be thrown out in the decolonisation process (HF)</i>

One comment was received, and made in the section to explain why the process should be omitted. The concern was connected to the decolonisation proposed in the

frame (refer to Section 8.4.1). The reciprocal process might be perceived as a colonial process and might be disregarded in the decolonisation process. Considering literature on knowledge democracy, the importance of accelerating movement towards improving social justice is a crucial consideration (Hall & Rajesh, 2017:6). The intention is to continue applying reflexivity, as a critical component of transformation and social justice, and as confirmed in the ethical comportment (discussed in Chapter 4) intended by the research (Nel & Govender, 2019:350). Experts did not all answer this section, but 12 experts confirmed the use of the process. After reflection on the comment as being reasonable and supporting the intended process, the process arrow, representing the importance of the continuing transformative process was kept.

8.4.7 General comments: Elements not included

The last element was an invitation to make general comments to address any element that was not included in the transformative framework. All the comments received are captured in Table 8.10. The question was: **Is there any crucial element for the transformation of midwifery educators' competence that is not reflected in the transformative framework?**

Table 8.10 General comments

AM	Probably there is need to highlight role of Nursing & Midwifery Councils as Custodians of professional standards to be factored in in the continuous monitoring and accreditation of training institutions
EO	It will be useful to involve the MEs in the service delivery platform so they can appreciate the needs that their students will possible have in practice. This will also challenge the programme managers (hospital and nursing service managers (changing the terminology!) to advocate for resources for quality health care. With agency there is need for assertiveness skilling. This is sorely missing in the rendering of services. This lack makes it possible for doctors who are junior in experience to dictate to midwives what may be dangerous to women and midwives!!
ECM	Competencies focus on knowledge and skills – what about appropriate attitude? If it's in there then I have missed it.
EMM	The now training of midwives must be firm and fair to stay away from leniency when it comes to the clinical cases as the very midwives will end up choosing to be educators with no knowledge and skill in future (e.g. signing the register for the student midwife who has not perform the required procedure or performed it unsatisfactorily so)

HF	I am more concerned that each pregnant women and her offspring receive a respectful and respectable service within her context, than that an arbitrary standard of international guidelines is adhered to.
HSM	Well done for your hard work. I do not have any identified area that need to be part of the transformation. I actually would have loved to see more of the findings from the previous phases. The WHO competencies has other elements (including research and ethics) that I did not see in this framework, I understand this was an appreciative inquiry. Please remember to share your findings, it is a very good study and very relevant.
MSO	1. Regulatory framework allowing for direct entry midwives 2. Similar standards for all practitioners involved in midwifery, be it a nurse, medical practitioner or direct-entry midwife. 3. Adjust training to be aligned with the South African standard practice – a component of dedicated outpatient type care (antenatal and postnatal) that is practiced in clinics, practices etc. with the required skills to provide high-quality care and early identification of potential problems with early referral to an appropriately skilled practitioner; and a labour ward practitioner involved in the practical delivery process and management of labour/early puerperal emergencies including baby resuscitation and breastfeeding care. 4. Priority focus on identification of the at-risk mother-infant pair to prevent/reduce infant/under-5 morbidity and mortality
NMO	Need to review human resource needs for midwifery service, not just for midwifery education. Need for ongoing education even of qualified midwives needs to be factored into human resources requirements for service
SFO	Midwife educators need to keep up to date with new evidence and international policies/ guidance on maternal health... i.e. ensure a dynamic curriculum Midwifery educators need to have representation on community/district/facility health forums so as to understand the expressed needs of communities
WMM	As stated earlier Feminist approach seeking agency for midwifery practitioners is discussed but it does not feature strongly on the framework and is in my opinion, implied rather than expressed.

Final comments by the experts confirmed previous statements and data from the participants in the previous phases and, as reflected in the joint displays and meta-inferences and Tables 7.1 and 7.2. The full definition of competence and the elaborate discussion would have answered questions stated in some comments. However, the majority of the comments confirm that a competent midwifery educator is regulated as a midwife and rooted in the human rights-based approach, which confirms agency and respectful care. The transformative framework is needed for midwifery educators. However, the needs of midwifery education also apply to SBAs and the broader clinical area rendering care to reproductive healthcare users.

8.5 REFINED TRANSFORMATIVE FRAMEWORK

The adapted transformative framework included guidance from the experts, and is presented in Figure 8.1.

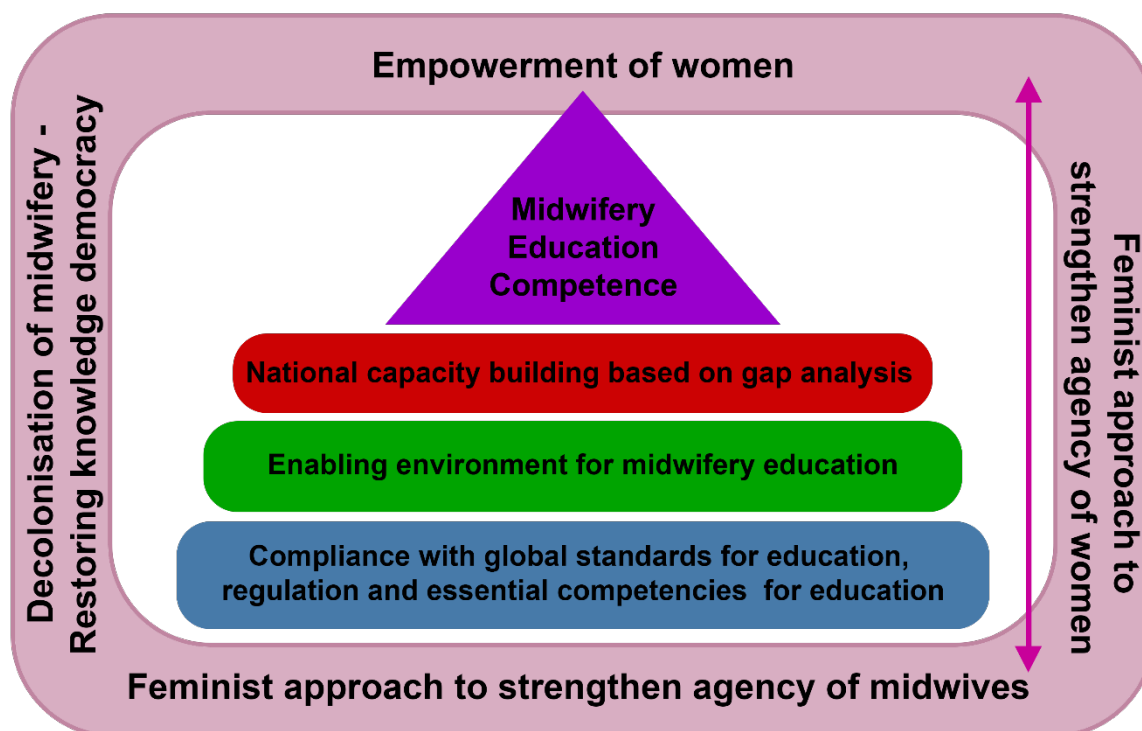


Figure 8.1 Refined transformative framework

The expert review process contributed to the refinement of the transformative framework. In spite of a 76% response rate, the comments and suggested adaptations improved the clarity of the framework. As suggested by the experts, the right-side area of the frame, which was initially empty, now confirms the importance of separating the feminist approach, to strengthen agency not only for women, but also for midwives. The addition of midwives to the bottom and foundational area of the frame serves as a reminder that male midwives are equally harmed by the systematic hegemony that contributes to lack of agency for female midwives.

Further comments by the experts suggest how the framework could be implemented. Some suggestions provided information, but did not advocate for the removal of any components.

8.6 CONCLUSION

The refinement process of the transformative framework developed in this research was humbling and satisfying. The methodological design and execution contributed to the quality of the inferences. Interpretative agreement was established, as peers agreed that the transformative framework elements were needed. This humbled me, as the confirmation of elements by experts confirmed the relevance of the transformative framework. Interpretative distinctiveness was enhanced by allowing experts in maternal healthcare, midwifery education and at the policy implementation level to refine the work, to ensure that reliable, plausible conclusions were drawn from inferences (Bergman, 2008:113) and incorporated in the transformative framework. The confirmation by the experts of the transformative framework and the echoes of what participants in the data collection voiced, represent a personal highlight in my career as a midwife educator, an association member and researcher.

Chapter 9

Final Supposition



CHAPTER 9 FINAL SUPPOSITION

"When women see that it is possible to have satisfying experiences in decolonised environments, they will assist in promoting for a change and dignity. They will become active partners in the process of pregnancy care, child birth and the puerperium" (EO - Delphi expert).

9.1 INTRODUCTION

In this final chapter, the pinnacle of the study is reached by a critical reflection on the process and outcome of the research. Confirmation offered by one of the Delphi experts, stated above, evoked deep appreciation. As midwives and midwifery educators, we work to ultimately impact the way women experience pregnancy, birth and motherhood. The incredible, enabling relationship between midwives and mothers have the power to provide the mother with dignity and give her the ability to make choices that ensure an optimal reproductive journey. Ideally, the environment for such a relationship is one where knowledge democracy enables respect for women, their capabilities in childbirth and how a midwife, prepared to global standards, can provide this empowerment to women. Competence of midwifery educators is key to producing the midwives needed, as was elaborated in the section on quality midwifery care.

MEC, and how that can be strengthened in South Africa, was the core topic of the research. The conclusions, captured in this chapter, revisit the motivations and decisions made in the planning and execution of the research. As recommended by Trafford and Leshem (2008:170), the factual conclusions, resulting inferences and the final conceptual conclusions are presented.

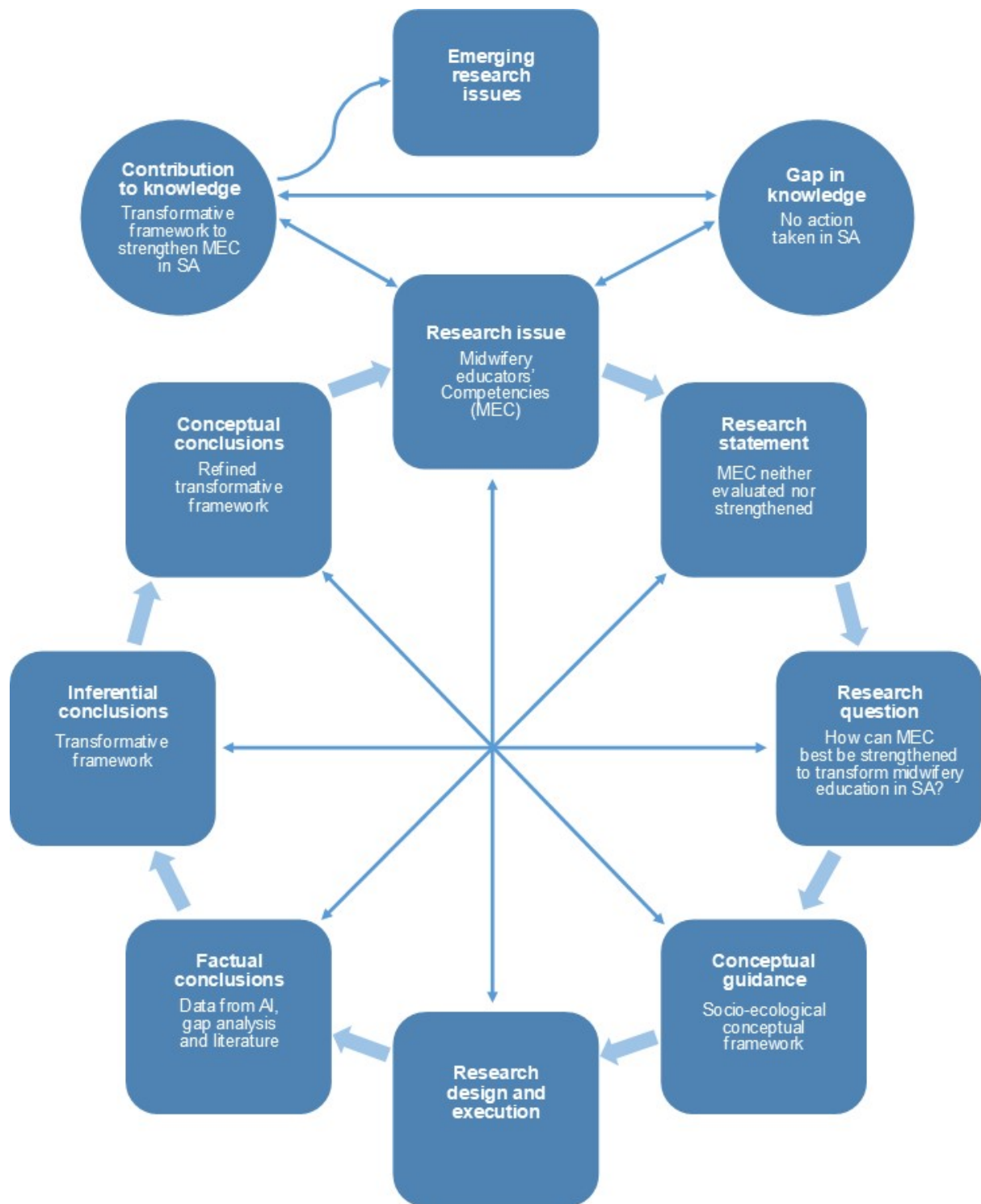


Figure 9.1 Conclusion map

Adapted from Trafford and Leshem (2008:170).

Elements captured in the conclusion map illustrate the synergy between the processes and outcomes that contributed to meta-inferences and new discernment on midwifery education competence.

9.2 RESEARCH STATEMENT MAP

At the onset, the research topic was compelled by an absence of concerted action to determine and ensure competent midwifery educators who produce the midwives needed for quality midwifery care for childbearing families in South Africa. The conflation of nursing and midwifery, which decreases the autonomy of the midwifery profession, was identified as a constraining factor. Furthermore, the gendered nature of midwifery is globally recognised as a limitation in relation to achieving targets in maternal healthcare provision. Motivated by the social justice factor of gender inequality, a transformative paradigm was considered most relevant. Flowing from the paradigm the theoretical perspective of feminism contributed to insights on how systemic patriarchal constructs impact on quality midwifery care and education.

The research aim was to develop a transformative framework to strengthen MEC in South African midwifery education. Within the transformative paradigm, the importance of designing and completing the research, while simultaneously embracing the participants and honouring their contributions as an active confirmation and strengthening of their agency, remained a driving force. Other paradigms, such as pragmatism, which are often selected in mixed-method research, might not have been able to "birth" a transformative framework as product of the research.

As I am a midwife, with a deep interest in intrapartum care, the transformative paradigm resonated well with how I would be present at a birth. Every birth is a process of the childbearing family and involves a new addition being made to their family. Midwives are instrumental for empowering the mother to birth her baby safely and with as little interference as possible during what I believe to be a divine process created for the well-being of the mother and baby. Midwives and mothers need to form a partnership relationship, to enable optimal well-being during the process of procreation.

The same intentions – that of enabling a process of strengthening MEC to birth quality midwives as required by South African childbearing families – needed a midwife. As researcher-midwife the transformative paradigm allowed me to enable an inherent process by employing research design and execution to strengthen midwifery educators' competencies.

9.3 RESEARCH QUESTIONS

The research question asked to strengthen MEC, was:

How can midwifery educators' competencies best be strengthened to transform midwifery education in South Africa?

To answer the main research question, three sub-questions evolved:

- i. What are the appreciated strengths of MEC of South African midwifery educators?
- ii. What are the current self-rated midwifery educators' competency gaps of South African midwifery educators?
- iii. What MEC strengths should inform a refined transformative framework that addresses the MEC gaps in South African midwifery education?

The questions guided the research design, processes and outcomes. Factual conclusions (which are captured in Section 9.6) were reached from the data collected during the different research phases, which were each informed by a sub-question. Inferential conclusions (elaborated on Section 9.7) were drawn through integrating of findings from the research phases, in answer to the overarching research question. The conceptual conclusions culminated in the refined transformative framework that is presented (in Figure 8.1) as a transformative solution to strengthen MEC.

9.4 CONCEPTUAL GUIDANCE

As the research followed an inductive path toward theory development, rather than being guided by a conceptual framework, the socio-ecological conceptual framework captured below and as presented in Figure 4.2, and discussed in the paradigm section, was chosen as a guide to ensure that the research process remained anchored in guiding concepts of the research.

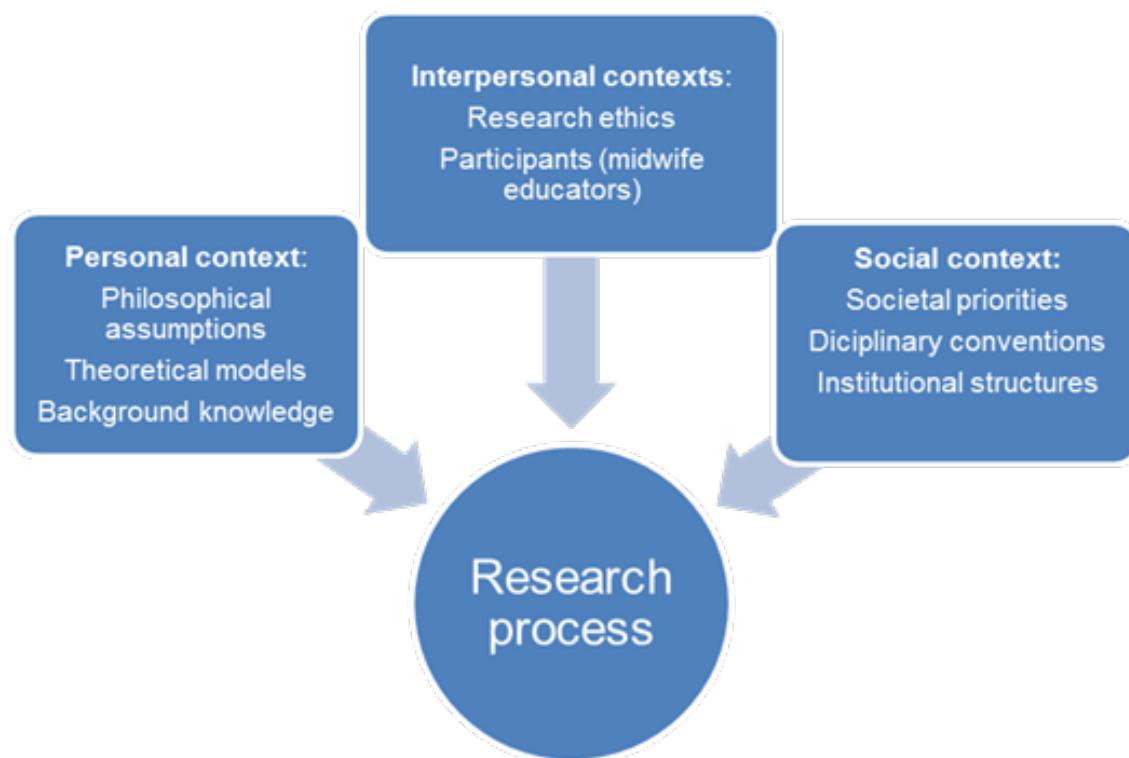


Figure 9.2 Guiding conceptual framework

Personal contextual elements and in this research, feminism within the transformative paradigm, shaped more than the research process. Once gendered inequalities were illuminated, agency and advocacy became more than a research process, but cascaded into all spheres of life. Informed by the personal context of the transformative paradigm, and feminism, the interpersonal context brought depth to the research ethics. Ensuring agency and respect for rights, was more than a research convention. In every phase of the research the overarching respect for and agency of participants

contributed to an increased awareness to myself and an escalation of how the contributions of participants built the episteme.

My research journey, which birthed a transformative framework for strengthening MEC, converged with the principles of respectful maternity care and a deep understanding of birth being a process that requires minimal intervention. The synergy provided by the socio-ecological conceptual framework created a seamless process among the three research phases. Subsequently, by respecting the conventions of the societal context, the transformative framework could contribute to addressing quality midwifery education.

The critical reflexivity brought about by the three components of the framework shaped my own perspectives and actions during the course of the research. Conversely, the bigger midwifery and maternal healthcare context might not yet be entirely perceptive to gender inequalities. Ultimately, the transformative process of continually improving social justice could also benefit from the socio-ecological conceptual framework.

9.5 CONCLUSIONS ON RESEARCH DESIGN AND EXECUTION

A concurrent mixed-method research design was best suited to answer the research questions. Moulded by feminism and social constructionism, the multiple perspectives brought from the three phases of the research facilitated a deeper interpretation of the meanings, consequently enriching the hermeneutics. This dialectic approach is true to the reflexive nature of transformative work in which the research issue is investigated from different angles.

As the qualitative component of the research, the AI session was incorporated to serve as a motivator for positive change, which created a transformative process, instead of merely collecting data. Furthermore, the strengths of midwifery educators were appreciated concurrently with a quantitative analysis of the MEC gaps taking place. In the quantitative component, the WHO Midwifery Core Competency Gap Analysis Tool was employed and was enriched by the addition of life giving and gender equality-focussed questions.

Analysis of each of the two data sets was performed independently. After the analysis, the findings were then integrated as point of inference. Integration followed a contingent and flexible approach, which again resonated with the uniqueness of each birth. The data sets guided the inferences that followed, and informed the product "birthed" through the process. Similar to the unique birth process of each baby, the inference that emerged from the flexible approach allowed a unique research project and findings.

To co-create a synergistic implementable final product, an expert Delphi panel, made up of representatives of various interest groups, refined the transformative framework. The inclusion of a strengths appreciation, juxtaposed against the gaps identified and the expert opinions, occurred within the space created by the socio-ecological conceptual framework.

A unique methodological synergy was created by not only the inclusion of AI, as a strengths-based approach, but also with the inclusion of questions in the gap analysis that flowed from the theoretical foundations of the study. AI created an impetus for change from within, with respect to enhancing agency and self-directedness and transforming competencies for the educators. Although determined as a need for all midwifery educators, completion of a gap analysis only would have lead to the opportunity of discovering their strengths being missed. As in childbirth, more is achieved by reminding the birthing mother of what she has already achieved and is capable of, than focussing on the problems alone. Finding the balance between appreciating and strengthening core processes, values and successes, and navigating the risks is needed for birth, as is a strengths-based appreciation.

9.6 FACTUAL CONCLUSIONS: ACHIEVING THE AIM

In discoveries of new knowledge in the research, from the first two data sets, the midwifery educators specifically confirmed how important they deemed producing midwives who are competent. The research aim of to develop a transformative framework to strengthen midwifery educators' competencies in South African midwifery education was shaped by the two data sets. Their own competence,

especially clinical competence, appeared not only in the first two phases, but also referred to by the expert opinions. The answer to the question of what are the appreciated competency strengths exposed how important it is for passionate educators in an enabling environment to shape students into being competent autonomous midwives. In addition, it was mentioned that strengthening educators' competencies could provide quality midwifery care via essential competencies for basic midwifery practice

Gaps in the MEC indicated that the preparation of midwifery educators, needs to be captured in all eight domains. Midwifery educators reported lower confidence and competence in several leadership and curriculum development and evaluation areas.

The last conclusions, as provided by the expert panel, confirmed the framework elements, and strengthened the transformative framework by suggesting implementation guidelines.

9.7 INFERETIAL CONCLUSIONS

A transformative framework was birthed after the processes of the research that had been designed had been completed. When a family welcomes a newborn baby, the baby is admired and family resemblances are noted. The resemblances of the research questions and the factual conclusions that had been reached previously, are very clear in the final product. Strengths discovered and formulated by the AI participants were captured in the framework. In various statements, participants acknowledged the importance of global standards and autonomy. A concept that emerged in every phase was a passion for midwifery education that enables empowerment of women, so that they claim their agency and strengthen agency in the profession.

The conflation of nursing and midwifery in South Africa contributes to fewer opportunities for midwifery educators to develop all the competencies. Knowledge democracy, which positions midwifery as an autonomous profession that is most

suitable to provide an ideal birth experience to a childbearing family emerged from data and literature as the need to decolonise midwifery.

Gaps that emanated from the self-evaluation of midwifery educators related to the existence of systemic barriers; their need for self-directed CPD is expressed and addressed in the transformative framework. Claiming knowledge democracy by decolonising midwifery and strengthening agency creates a trajectory for development and growing midwifery education competence.

9.8 CONCEPTUAL CONCLUSIONS: SOCIO-ECOLOGICAL CONCEPTUAL FRAMEWORK BRITHING A TRANSFORMATIVE FRAMEWORK

The transformative framework evolved from a process that was guided by the philosophical perspectives of feminism and enhanced by social constructionism. The context of midwifery education, as background knowledge and an element that provided conceptual guidance element via the socio-ecological conceptual framework ended up being influenced mostly by the lack of agency and knowledge democracy. The synergy between how the agency could be strengthened by a feminist approach and decolonisation of midwifery and the personal context elements in the socio-ecological conceptual framework is astounding. From the partnership relationship foundation of midwives and women, flowed the interpersonal contexts with research participants and ethics. The plausible products of the research were shaped by the societal context and what midwifery educators need to fulfil their unwritten contract with society, to produce midwives who are able to render quality care, and who can be instrumental in achieving universal health coverage by 2030.

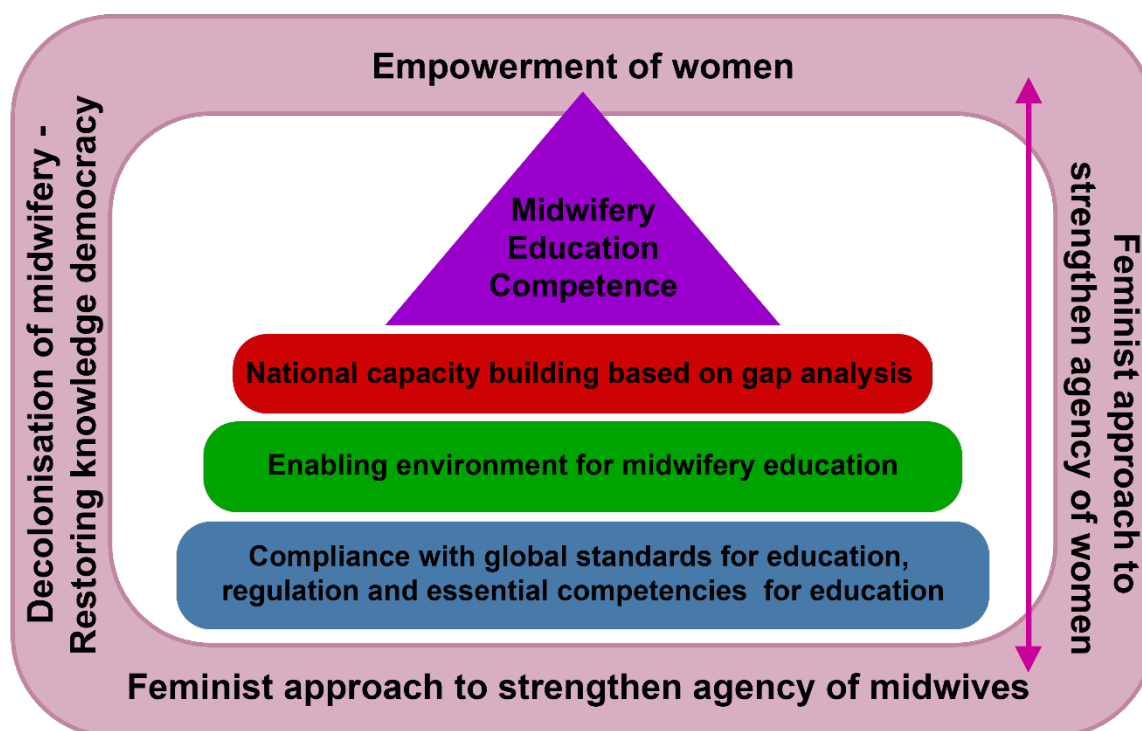


Figure 9.3 Final transformative framework

Birth preparedness is captured in a birth plan in which childbearing families can express their wishes, preferences and needs regarding the birth of their baby. If I consider the transformative framework as confirmed and refined by the experts, it represents to me the birth plan for quality midwifery education - our map to securing human rights-based care for childbearing families.

9.9 CONTRIBUTION TO MIDWIFERY KNOWLEDGE, VALUE OF THE RESEARCH AND RECCOMENDATIONS

The research developed and refined the theoretical framework of MEC by respecting the midwifery educators by involving them in co-creating the solution for strengthening midwifery education. Participants from a predominantly female profession found and explored solutions that would promote their empowerment and emancipation from within. Through a strengths-based approach, all stakeholders in midwifery education

can benefit from the research intervention of AI and a positive trajectory for change. This added value for each participant who attended, as she had the immediate benefit of changing practice, due to the principles of AI. The data informed the development of the transformative framework and facilitated the strengthening of the competence of midwifery educators.

Ultimately, the framework could form part of the accreditation of educators and educational institutions, to ensure quality midwifery education, which carries significance for all involved in maternal health. Furthermore, these interventions and proposed outcomes of the study address the real-life problem of unmeasured MEC and the absence of a framework to enhance it.

Empowering the midwifery educators to be competent on all the levels will enable them to educate midwives to respond to the need to have competent midwives for every woman and baby's birth. The framework can be shared in regional midwifery structures to strengthen the MEC in other countries that have similar contexts. The framework could therefore, contribute to achieving the universal health coverage targets by 2030.

Considering the contributions made during the conceptual phase of the research, a synergy between feminism, AI and core ICM documents was identified. This integration provides a platform for future research, which can draw from the combined strengths of the theoretical perspectives in midwifery to increase social justice for childbearing families and midwives.

These findings will be shared in midwifery journals, at congresses and in AI journals. The wider multi-professional AI community can benefit from the use of AI in this study. A unique contribution of this research is its focus on establishing the MEC and the co-creation of transformation using a transformative framework with midwifery educators in South Africa. The contribution to knowledge could transform MEC if concerted action is taken to implement the suggested transformative framework.

9.10 RECOMMENDED ACTION

Research findings will be shared via an executive summary for the office of the Chief Nursing Officer and the National Directorate of Maternal and Child Health in the Department of Health. Nursing education fora, such as FUNDISA and NEA will also be informed. Stakeholders in midwifery education, such as the SANC, would also be involved, as recommendations for midwifery education are within their regulatory mandate. An electronic stakeholder meeting to share the research and findings can be the first step of implementation.

In the future, the research will be presented at congresses, such as SOMSA and ICM. An abstract has been accepted for presentation at the 32nd ICM Triennial Congress in May/June 2021. In addition, as the research funding stipulations also require feedback to ICM, the completed thesis will be shared with the ICM office.

Because I am the current president of SOMSA, and I am responsible for working within the mandate of the Association. The strategic objectives inform the mandate and as the one strategic direction is focussed on midwifery education, the research findings can enhance some of the activities planned for the association. Within the mandate of the strategic directions, the research will be presented to key role players, such as the National Department of Health, office of the Chief Nursing Officer, as well as ministerial committees on maternal and newborn health, to ensure that the transformative framework could be implemented. Consultations with the SANC, through structures within the national maternal health division, will be progressed.

9.11 RESTRICTIONS

During the implementation of the research, certain limitations were identified. Presenting the AI session at the national SOMSA congress provided a relatively cost-effective way of accessing midwifery education stakeholders. Yet, the congress programme only made provision for an afternoon, while a full day without programme delays would have provided a better opportunity to finish the 5D process without the level of fatigue participants experienced, which might have hampered their creativity.

Furthermore, it would have been ideal to expose all midwifery educators to the personal value of AI.

The complex process of obtaining gatekeepers' permission, which applied to public NEIs, in particular, and which prevented educators at KwaZulu Natal colleges from taking part in the gap analysis, was a drawback, and could, at times, be perceived as unethical. In a critical reflection on the rights, as described by Polit and Beck (2017), that were elaborated earlier, the college head's refusal to allow the midwifery educators to participate is unethical. The critical question is whether a gatekeeper should diminish the right to self-determination and full disclosure by others. There was no mention of midwifery educators being consulted in the decision provided, which negates full participation. Not allowing midwifery educators to indicate whether they would like to take part in the research disregarded their right to self-determination. Deciding on behalf of others indicates a lack of respect for human dignity and removes their agency. Furthermore, it once again suggests that the conflation of nursing and midwifery can contribute to a disregard of the importance of research with midwife educators, which constitutes a lack of justice and a disregard of the right to fair treatment. As the workload of midwife educators is very high, and the general pressure on educators is significant, personal refusal to take part in research might be a self-preservation strategy. Any person who chooses not to participate is respected and the expression of their agency is admired. Individual permission and the right to refuse strengthen agency, however, gatekeepers who close the gate without consulting the potential participants reduces their autonomy.

Another hindrance was the poorly established and maintained electronic platforms of many public health NEIs, which possibly prevented access to or a response from all the midwifery educators for the gap analysis census. In addition, inadequate computer skills of some of the midwifery educators may have limited the response rate.

By applying the questionnaire developed by the consultants, its validity was maintained, however the questionnaire was reported to be very long. As all the elements are captured individually, it produced many options that participants had to choose from. For future use, the confidence levels could possibly be collapsed and similar concepts grouped together.

In the current SARS-CoV-2 global pandemic, the inequities relating to access to and availability of water and hygiene were highlighted in the media. The WHO report also highlighted the importance of adequate facilities, which would also include water and sanitation. The physical facilities of NEIs did not form part of the questionnaire, but information in this regard might have been useful, perhaps also investigating new realities of sanitising and social distancing. A proper audit of facilities and equipment might be valuable.

Working in the transformative paradigm, the inclusion of the participant (No. 29), who gave very limited answers complicated the final analysis of the quantitative data, but inclusion was important from the paradigmatic perspective.

9.12 CRITIQUE

In consideration of how the research could have been different and improved, the research process was evaluated. Every **paradigm, philosophical foundation**, research design and method raises many elements of critique. The focus on gendered social justice in this study, as captured in the transformative paradigm and feminism, might create the impression that men in midwifery and midwifery education were disregarded. Participants in both data sets did indeed mention some distancing elements. However, as concluded in the penultimate chapter, agency drawn from feminism will benefit all role-players in the context of midwifery.

In **mixed-method research**, the scholars hold divergent views on design, implementation, analysis and inferences. In the journey of this research, the intuitive midwifery approach that is guided by the birth, rather than by how experts see birth, was applied. From a quantitative and qualitative perspective, there could be several additions or comments are possible. The primary considerations of intrapartum care is the wellbeing of the mother and whether the baby and if the process of birth is progressing. This journey was navigated within the conceptual guidance of the research, the context of the profession, and its philosophical roots.

Research methods and, more specifically, in this research, AI is often critiqued for failing to acknowledge the problems within a research field. In response, the gap analysis did allow gaps to be identified. Additionally, the appreciation of strengths, from the AI perspective can review the gap analysis for a problem-focussed approach, which can be perceived as judgemental especially within the transformative paradigm. The inclusion of life-giving questions similar to the AI, attempted to balance the problem-focussed nature of the gap analysis.

The experts commented on the use of the concept decolonisation. The highly politicised connotations of the word meant experts warned about its inclusion. However, the core of the intended use of the construct was never contested and, in addition, the transformative intention is captured better by selecting terminology that promotes social justice. Using the term within the context of MEC could stimulate critical thinking and much-needed dialogue on issues that influence the profession negatively.

Experts provided valuable guidelines for implementing the transformative framework. Every contribution to strengthening midwifery education is appreciated. Scientific scrutiny of the review for examination purposes, as well as congress presentations and submission of articles for peer review can all contribute to enhancing refinement. Within the transformative paradigm, feminism and social constructionism, the continuous dialectical processes of including new insights and comments will contribute to a heightened meta-cognition and the transformation of MEC.

9.13 FUTURE RESEARCH PATHWAYS

Many possible research topics emerged as the process unfolded. In addition to the complete census gap analysis, as intended by the research, the following specific opportunities presented themselves:

- To have AIs with all midwifery educators and to focus on their agency only could bring exponential growth regarding claiming agency.

- A review of facilities and equipment of NEIs, starting from the electronic platforms needed and including simulation equipment and ability to use simulation technology, especially in the online environment, can contribute to enabling blended learning, which is needed in these times, when we are faced by a global pandemic.
- As suggested by one of the experts, a review of the human resource needs of midwifery service and midwifery education should be done.
- A refined gap analysis can be used to increase the self-directed process of performance and development as educators, as every midwife educator can identify developmental priorities and needs from a refined tool.

Moreover, this research is the first work in South Africa that approached the research issue from a transformative frame and that drew on the strengths of philosophical foundations in feminism and social constructionism. This integration opens creative pathways for more dialectic work to transform midwifery as autonomous profession in South Africa and to enable quality maternity care. Further transformative research on the issues negatively impacting on the profession of midwifery, including midwifery education is therefore needed.

The transformative framework should continue evolving. Each of the transformative framework elements and how implementation thereof transforms and shapes midwifery education and practice, consequently, provide research opportunities.

9.14 SUMMATIVE REFLECTIONS ON THE BIRTH OF A TRANSFORMATIVE FRAMEWORK TO STRENGTHEN MIDWIFERY EDUCATION COMPETENCE

In finally reflecting on the research processes and outcomes, the ethical considerations of the research and the traits and virtues that were highlighted in the process, it all elevated to a deeper metacognition of what a midwife educator should be. The research question asked:

How can midwifery educators' competencies best be strengthened to transform midwifery education in South Africa?

In a quest to answer the research question, while evolving through the efficacy of the design, the methodological choices of the research respected the participants and contributed to their beneficence as the research process unfolded. Although it was difficult, a transparent and open process was followed with integrity. In allowing flexibility and resourcefulness, the analysis of the data, inferences and triangulation with literature contributed to a research product that was scrutinised by experts and confirmed as a plausible solution for transforming MEC. Each element addresses an angle of inequality as a concern in midwifery education, the broader context of midwifery care and, specifically, MEC.

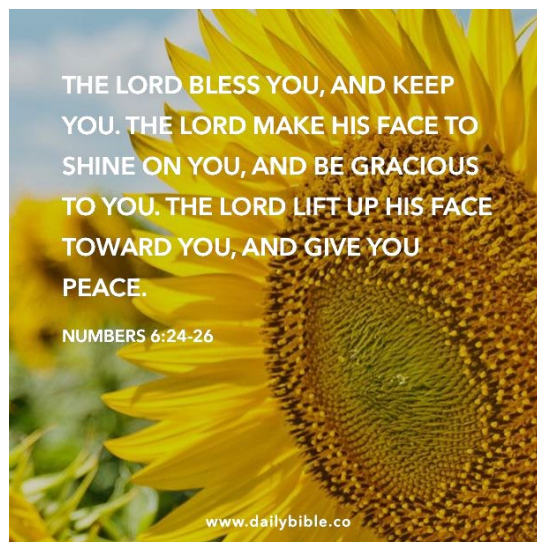
In addition, a reflexive stance contributed to personal transformation of the process. My values, through the deeper foundation of my devotion to my faith, gained more impetus during the research process and as I completed the thesis. Although I have always been driven by my passion for midwifery and midwifery education, as an expression of my personal devotion to my religious beliefs, the metacognition drawn from the research fuels my passion even more. The deep sense of the obligation that rests upon me to present the transformative framework as a solution for the problem drives me to expedite the implementation and transformation of midwifery education.

Answering the research question was a birth process in itself. As a midwifery education researcher, I reflected on the similarities of the intrapartum care and process of birth and the "birth" of this transformative framework. In the final stages of the research, I realised that at times I sometimes adopted the role of a midwife, similar to the way a midwife protects and promotes the birthing mother and her birth process. At other times, my perception was that of the mother giving birth to this transformative framework, with the same level of difficulty sometimes experienced during birth. The role of my supervisor, who guided and encouraged me through the difficulties, made her a midwife of the process. My significant others' could be compared to a helpless father who cared enough, but could not give birth. As all the elements and their position took shape, I experienced feelings analogous to those of a mother looking into the face of her newborn baby after a long and difficult birth. The refinement process was

an experience comparable to the welcoming of an infant in the bigger family. Finally, the "baby" is now being presented to the community, and the mother has the expectation that her baby will make a positive contribution to the community.

The transformative framework, as a co-created and refined product, is presented in an attempt to position every midwifery educator, as a self-directed, transforming and competent force who is realising her/his heliotrophic potential.

My ultimate blessing that I wish to pray over every midwife educator in South Africa and beyond especially in the global pandemic, is from the Bible, specifically Numbers 6:24-26. May this blessing elevate you to the true transformation, to a heliotrophic state intended for your professional and personal life, for now and eternity.



<https://tinyurl.com/y2dbg8yt>

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Annexures



LIST OF ANNEXURES

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Annexure H: Data Summary- Discovery

Annexure I: Data Summary Dream, Destiny And Design

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Annexure K: Research Award

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Annexure M: Declaration By Language Editor