

## Editorial

### **Consistent, quality midwifery care: how midwifery education and the role of the midwife teacher are important contributions to the Lancet Series**

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The recent Lancet Series on the contribution midwifery can make to the quality of care of women and infants globally (Renfrew et al 2014) makes it clear that consistent, quality midwifery care has a vital role to play in the reduction of maternal and newborn mortality. Outcomes are enhanced when care is led by midwives who are educated, licensed, regulated, integrated in the health system, and working in interdisciplinary teams, with ready access to specialised care when needed (Sakala and Newburn 2015:2).

The International Confederation of Midwives (ICM) for a number of years have published core competencies for basic midwifery practice and what should be expected outcomes of midwifery pre-service education and training (ICM 2013a). A person attaining all of the basic competencies is viewed by the ICM as a “fully-qualified” midwife (ICM 2013b). The ICM acknowledge that midwives can be taught the relevant knowledge and skills through a variety of different educational pathways such as education institutions, midwifery associations and regulatory bodies. The ICM have also produced a set of minimum standards for midwifery education (ICM 2013b) to be achieved by midwives in training in order to help reduce variation in qualification. These standards aim to embrace a common philosophy; provide a framework for the design, implementation and evaluation of the programme; promote safe practice; reinforce the autonomy of the midwife and foster continuous quality improvement.

The World Health Organisation (WHO) has further identified the importance of needing experienced, well-educated midwife teachers to deliver high quality midwifery education. They argue that the education and training of midwife teachers has taken on a much lower profile across the globe when compared to setting standards for training midwives. In attempt to address this, the WHO published in 2013, *Midwifery Educators Core Competencies*. This was a collaborative project involving many different stakeholders, and covered eight specific areas: ethical and legal principles of midwifery; midwifery practice; theoretical learning; learning in the clinical area; assessment and evaluation of students and programmes; organization, management and leadership; communication, leadership and advocacy and finally research. The aim being that core competencies can be used to develop innovative programmes and teaching approaches, emphasising the importance of linking theory to practice. The WHO recognise however, that there are many challenges to adapting and / or adopting the competencies across the globe partly because of a lack of

consistent approaches among regions within countries and the lack of resources to implement such programmes.

In the series of articles included in the special section on midwifery education in this issue of the journal, authors from different parts of the globe have explored how they have strived to meet the challenges articulated by WHO (2013) within their own institutions, with the aim to ensure care is led by midwives who achieve the outcomes identified by Sakala and Newburn (2014). Respectful partnerships with women are a unique aspect of midwifery care but as described in the commentary by Bharj and colleagues (2016) disrespect and abuse of women receiving maternity care is all too frequent. The paper by Gherissi et al (2016) eloquently articulates how disrespectful care by midwives to women can be challenged during the training of student midwives. A new model of education was introduced into one university in Tunisia, which challenged students to take control of their own learning. As a result of introducing the new model, students discovered qualities within themselves of empathy and tolerance, which enhanced their role as advocates for women. Rafat and colleagues (2016) in a paper from Pakistan describe that in the development of a new curriculum for midwifery education, clinical competence and accountability for the well-being of mothers and babies was emphasised, as was incorporation of the concept of the midwife-woman partnership. This is against the backdrop of a country where women have limited decision making rights and lack of empowerment.

Levers to drive change have sometimes occurred when countries have joined the European Union. Mivsek and Wilhelmova (2016) in a paper from Central Europe share how the adoption of the EU Directives facilitated the move from many aspects of midwifery education being taught obstetricians and nurses, to now being taught by practising midwives, competent and knowledgeable about their practice. However, this move to learning from an evidence-base has had the unfortunate consequence of widening the theory-practice gap, where much of the care provided is still by obstetricians and nurses.

A common theme within the papers is the importance of partnership working. This ranges from political partnerships with regulatory and professional bodies in order to provide a solid grounding for midwifery education standards as identified by O'Connell and Bradshaw (2016) from Ireland, to working across a number of midwifery schools in Flanders (Embo and Valcke 2016) in order to implement a more standardised competency framework. Vermeulen et al (2016) from Belgium show how working in partnership with colleagues from different professional disciplines enhances the quality of simulated perinatal learning. Let us not underestimate either the powerful contribution that women and their families can make when working in partnership with midwives. Gilkison et al (2016) in a paper from New Zealand describe how women and midwives worked together in the 1980s and managed to achieve legislative change that gave midwives autonomy as well as the separation of midwifery education from nursing.

A model adopted in the UK, using the role of the Lead Midwife for Education (LME) offers an example of a partnership approach that aims to provide consistency in the education of midwives and midwife teachers.

In the UK, the LME supports the development, delivery and management of midwifery education programmes. The Nursing and Midwifery Council (NMC), the regulatory body for UK nurses and midwives sets the standards for the role (NMC 2009) and is probably unique

in doing this. The LME should be an experienced, registered midwife who has completed an NMC approved teacher training programme (NMC 2008). University offering midwifery education programmes are required to use the LME for strategic liaison with external agencies such as organisations who commission midwifery education or provide clinical placements and for all matters affecting midwifery education. The LME must contribute to the internal systems of the employing university to promote the quality assurance of midwifery education programmes and provide professional input at strategic and operational levels within the university to ensure the NMC's requirements for due regard are met. Due regard means midwives deal with midwifery matters rather than being referred to other health professionals.

There are currently approximately 55 LMEs across the UK, one in every university where pre-registration midwifery education is taught. The LMEs work together and have formed the LME UK Executive, playing a significant strategic role in determining the knowledge, skill, proficiency and suitability of future midwives gaining registration. The Executive terms of reference include:

1. Collective responsibility for initiating, directing and responding to the strategic agenda at international, national, regional and local level on all matters related to midwifery education.
2. Expert advisory group to inform and respond to the various stakeholders on matters related to midwifery education through means such as attendance at meetings, publishing position statements, offering guidance, responding to consultations.
3. Ensuring the quality and standards for pre-registration midwifery education and midwifery related CPD are maintained, using evidence to inform continuous quality improvement and contemporary practice.
4. To be proactive and adaptable in a climate of changing landscapes in informing and responding to change.

Between meetings the LMEs communicate electronically where often weekly questions or concerns are raised and discussed. This has developed a means of promoting best practice and challenging problems that could impact on the quality of the training and education of future midwives to provide safe and effective care.

Although this model may not suit all countries there are advantages to having a collective voice in a minority profession. A united voice is often more effective at achieving change; a group with a common purpose can provide support to each other during challenging times and being involved in national agendas helps with being proactive rather than reactive. Qualified and highly experienced midwife educators, passionate about the profession and leading the way forward for midwifery education can only have a positive outcome for women and babies.

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