MIDWIFERY EDUCATOR CORE COMPETENCIES ADAPTATION TOOL
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The impetus for the World Health Organization (WHO) to produce practical tools to assist Member States in their endeavours to strengthen midwifery services is provided by the global consensus “that the availability of a health provider with specific midwifery skills and competencies, particularly the lifesaving functions of basic emergency obstetric and neonatal care, working within a supportive and enabling environment, is acknowledged to be a key component of any safe motherhood strategy” (Fullerton et al., 2011).

In many countries there are critical shortages of midwives, and many pre-service education programmes are less than optimal, primarily due to a lack of competent midwifery educators. Consequently, the WHO undertook a year-long process to achieve global consensus on the essential competencies needed by midwifery educators. The quality and competence of educators affects the quality and competence of graduates from midwifery programmes, from in-service programmes (continuing professional development) and from programmes to update providers.

Without a sufficient number of competent educators, it is almost impossible to prepare the additional practitioners, leaders and researchers needed. Achieving consensus on what a competent midwife or midwife educator should be able to do and how he/she should be prepared, is an urgent concern being addressed by many countries, as well as by WHO and other international agencies.

There is, however, an international definition of midwife agreed by the governing body of the International Confederation of Midwives (ICM) and last revised 15 June 2011, which can be found at the following link: http://www.internationalmidwives.org/who-we-are/policy-and-practice/icm-international-definition-of-the-midwife/. International standard definitions have been used in this tool, where available, to define the core competencies of a midwifery educator.

It is recognized that Member States are looking urgently at the total workforce needs and that childbearing women and neonates need competent care providers beyond those with midwifery skills. However, the remit of this tool is confined to assisting countries wanting to strengthen their midwifery education programmes using the WHO Midwifery educator core competencies. Nevertheless, the tool also can be used as a resource for those working on transforming the education and preparation of other health-care providers.

Although this tool is designed specifically to address the use of the WHO global midwifery educator core competencies due to the shortage of midwives globally, the tool can also be used to implement new competencies for nursing educators or educators of other health-care providers.

This practical guide was developed primarily to assist those responsible for midwifery education in countries – whether educational institutions, regulatory bodies, or ministries of health or education – to adopt, adapt and use the global core competencies to strengthen the preparation of midwifery teachers, and to use evidence-based approaches to competency-based teaching, learning and assessment strategies. The competencies can also be used to strengthen the links between midwifery theory and practice.

1 The concept of “competence” and the links between competence, competencies and performance and the quality of services are now well established. For a more detailed discussion on competence, competency and the difference between competence and competencies see Fullerton et al., 2011. A summary of the current discourse on these issues is given in Section 3.
Selected list of tools/resources that have been found useful for strengthening midwifery education


- **Global standards for initial pre-service education of nurses and midwives.** WHO, 2009. As part of the global action plan for nursing and midwifery, *The Strategic Directions for Strengthening Nursing and Midwifery Services 2002–2008*, and following a further resolution in 2006, a special taskforce was established to develop global standards that would act as a blueprint to help countries move towards a competency-based outcome for nursing and midwifery to better fit the needs of an increasingly complex and rapidly industrializing world. http://www.who.int/hrh/resources/standards/en/

- **Global standards for midwifery education.** ICM, 2010; amended 2013. This is part of a set of global documents (resource pack) that can be helpful for strengthening midwifery education. http://www.internationalmidwives.org/core-documents

- **Key documents from WHO on maternal and newborn health and midwifery.** http://www.who.int/maternal_child_adolescent/documents/en/


SECTION 2. WHY THIS TOOL IS IMPORTANT FOR THE ADOPTION AND USE OF THE WHO MIDWIFERY EDUCATOR CORE COMPETENCIES

The 2011 World Health Assembly (WHA) resolution, WHA 64.7, calls on WHO to support Member States in a number of strategies for strengthening midwifery and nursing. This includes, among others, “participating in the ongoing work of WHO’s initiatives on scaling up transformative education and training in nursing and midwifery” (see www.who.int/hrh/nursing_midwifery/en). This tool has been designed to complement WHO’s ongoing efforts to fulfil this mandate.

Purpose of the Tool

The tool aims to:
1. Help Member States to adopt and apply the Midwifery educator core competencies published by WHO, a document agreed globally through a consensus process.
2. Assist international midwifery education consultants, midwifery experts, educationalists and others in reviewing, adopting and implementing the Midwifery educator core competencies at the country or regional level.
3. Be a resource for non-midwifery health-care provider educationalists in their efforts to transform pre-service education programmes for health professionals.

Lessons for strengthening midwifery that were learnt through the consensus building process can be adapted and applied to transforming the preparation of educators for nurses and other health-care providers.

Need for the Tool

WHO has been working with key global actors and with academics, researchers and leaders of midwifery around the world to develop a number of tools. Some of these tools include global standards for the health-care professions, including identifying areas of best practice and core competencies for practitioners, educators and preceptors/clinical teachers.

There is evidence that in the majority of countries midwifery as a profession is faced with an imbalance between supply and demand, poor working conditions, a lack of professional status, and the consequent absence of a midwifery voice when it comes to decision-making in the health sector. To redress this situation, there is need to increase both numbers and, in many instances, the quality of midwifery practitioners, leaders and researchers. Such increases depend on having adequate numbers of competent, highly motivated educators/teachers at all levels of the education and health systems. Quality, competent teachers need to understand and have capacities to design and implement competency-based curricula. They also need to understand the many challenges in the practice areas, in management, and at the policy and regulatory levels in order to ensure that the education system and processes at all levels are “fit-for-purpose” in a given country.
Despite the many advances in midwifery, there appears to have been a lack of investments at national and sub-national levels in the preparation of midwifery educators and preceptors/clinical teachers. Too often it is assumed that the students with highest grades or marks will make the best teachers, or that an excellent practitioner will automatically be a good teacher, which is not always the case. Additionally, the need to be specifically prepared for the role of educator, in either the classroom (theory) or in a practical situation, is too often given insufficient attention.

With the above in mind, the term “trainer” is not being used in this document, as this term is generally used to refer to one who is responsible for guiding others primarily in skill development. The global education community has often used the term “teacher” and “trainer” interchangeably, though this is incorrect. Therefore, in order to draw the proper attention to the need to strengthen midwifery education and as this document addresses the formal preparation of midwifery educators, the word “educator” is used instead of “trainer”.

The Use of the Competencies

By identifying a universal set of core competencies for midwifery educators and those who provide in-service updates, Member States will be in a better position to prepare the midwifery educators needed to strengthen their health systems and meet the demand for high quality sexual and reproductive health services, including childbearing services. It is critically important that these core competencies are agreed by a wide community of academics, leaders and researchers.

Although there is global consensus on the minimum core competencies for midwifery educators, each country will have its own specific needs, priorities and cultural complexities. As such, it is essential that an individual country does not just take these global documents and try to implement them without first reviewing them for understanding and for applicability to the local context. What is important in reviewing and contextualizing the global competencies is not to lose the essence and quality dimensions that make them a benchmark. This being the case, none of the agreed competencies should be eliminated. Additional competencies are welcomed and encouraged where there is evidence to support their inclusion.

Having a common benchmark, such as the global Midwifery Educator core competencies, against which performance of midwifery educators and preceptors/clinical teachers can be measured is useful for a number of reasons. Not the least of these is to identify, based on best evidence, what a competent midwifery educator and clinical preceptor or mentor should be able to demonstrate in their teaching. Having such agreements also permits comparisons of professional competencies of providers to be made between countries; fulfils regional agreements for approval of professional practice between countries; allows free movement between countries based on reciprocal agreements for the right to practice; and facilitates research studies on what is best practice.

Although there is a need for common or core competencies for midwifery educators across countries, especially countries within the same region, there are often some distinctive variations, especially where there is diversity in socio-economic situations and educational systems. It
is these variations that need to be addressed when reviewing and adopting the global core competencies to make them national norms. If these issues are not taken care of adequately during the adoption and implementation process, the specificity needed to make the practitioners “fit-for-purpose” will be lost, which could lead to agreeing changes that in the end do not address the specific needs of a country.

An example of this would be that it is agreed to move all health profession education to the graduate level. This could lead a country to having educators concentrate on academic theory or research to the exclusion of teaching and assessment strategies. The net result would be that educators lose their practical/clinical competency.

Finally, this tool is not intended to be a blueprint that must be followed exactly. Rather, the intent is to be a reference point that will supplement the expertise of those charged with the responsibility for regulation and preparation of midwives and midwifery educators, as well as a resource for informing others who will be involved in the process.
Without clear definitions of terms, it is not possible to have a common understanding. Many of the terms used in the area of education and training of health practitioners are often used interchangeably, or can be used in different ways in different contexts, which can lead to confusion and/or misunderstandings. As such, it is useful to define key terms and their meaning as used in this document.

**Competence:** There is general agreement among academics that there is no consensus on a universal definition of competence, especially within the midwifery and nursing fields (for further discussion on competence and competencies see Fullerton et al., 2011). Generally, competence is linked to the combination of the knowledge and psychomotor, communication and decision-making skills that enable an individual to perform a specific task to a defined level of proficiency (Fullerton et al., 2011; ICM, 2011).

Competence is measured through a process of structured assessment, using objective standards of professional practice (knowledge, skills and abilities) as the criteria of quality, in order to document an acceptable level of performance. What constitutes competence is not static. Rather, competence is differently defined over the professional lifetime of individuals as they move from beginner to expert practitioner and as they respond to technological changes and progress in the research and science that underpins their work – whether practice or teaching. The midwife will need to acquire new information and new skills in order to continue to provide safe, high quality midwifery care (WHO, 2011d). The same applies for midwifery educators in order to be able to support a quality midwifery education or in-service training programme.

In short, **competence** is the ability to do the job, or task, properly to an agreed standard at a given point in time. For example, a midwife provides prenatal care with competence because she has learned and applied the needed prenatal knowledge, skills, and attitudes/behaviours (competencies) correctly.

**Competencies:** Although linked to competence, competencies are different. **Competencies** are 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. These are sometimes referred to as core competencies. As such, competencies can be used as a standard or benchmark to measure an educator’s competence.

**Competency domains:** Competencies for any professional group are made up of many individual components, such as a set of practical psychomotor skills, scientific, professional and behavioural knowledge, professional behaviours, personal attributes, as well as critical thinking, decision-making and judgement skills. **A competency domain is the umbrella term used for these components.** For example, the 19 midwifery educator core competencies developed by the WHO Task Force have been described as falling under 8 domains: 1. Ethical and legal principles of midwifery; 2. Midwifery practice; 3. Theoretical learning; 4. Learning in the clinical area; 5. Assessment and evaluation of students and programmes; 6. Organization management and leadership; 7. Communication, leadership and advocacy; 8. Research. In describing midwifery or midwifery educator competencies, others may have described them slightly differently using different headings for the domains, but all have some similarities.

**Curriculum:** Many definitions of a curriculum exist, and there is no one universally agreed definition. However, the definition that has been used in midwifery and nursing fields in many
English-speaking countries is based on the one by the educationalist Kerr, as follows: “All the learning which is planned and guided, whether it is carried on in groups or individually, inside or outside the institution” (Kelly, 1999).

A curriculum is more than a list of topics to be covered by an educational programme, for which the more commonly accepted word is “syllabus”. Another definition of curriculum is, “a planned course of studies; the designated programme of theoretical and practical experiences to be acquired over a period of time, leading to intended learning outcomes” (WHO, 2011a). Yet another definition, from the International Confederation of Midwives, refers to curriculum as “a systematic process that defines the theoretical and practical content of an education programme and its teaching and evaluation methods” (ICM, 2011).

In this document, a curriculum is defined as the sum, or collection of all the activities, experiences and learning opportunities for which an institution (such as the society, school, university, health sector or professional body) takes responsibility—either deliberately or by default, to shape and reinforce the development of core competencies for a profession, irrespective of the setting in which the learning takes place.

Competency-based curriculum: The basic or essential elements of a competency-based curriculum consist of functional analysis of the occupational roles or tasks of those to be educated, and translation of these roles/tasks (“competencies”) into learning outcomes within an educational programme designed to allow the learner to meet these outcomes. These learning outcomes include the knowledge, skills, attitudes/behaviours and accurate decision-making expected in each competency domain. Assessment of learner progress in achieving these outcomes is on the basis of demonstrated performance, i.e. a valid assessment of the learner’s competence in each domain during and at the end of the programme.

Progress through a competency-based curriculum is defined solely by the competencies achieved and not on the underlying processes or time served in formal educational settings. A competency-based education programme, applying a competency-based curriculum, can, therefore, be seen as the teaching, learning and assessment activities that are sufficient to enable students to acquire and demonstrate a predetermined set of competencies as the outcome of learning (ICM, 2010).

Fit-for-purpose curriculum model: A “fit-for-purpose curriculum” is one where the inputs, processes and outcomes are based on what knowledge, skills, attitudes/behaviours and experiences are needed to proficiently practice according to the defined scope of practice (or standards) within the prevailing context/country where the programme is being delivered. When using a “fit-for-purpose” curriculum model, it is important to start by systematically considering the context for the inputs, the processes and the desired outcomes of the curriculum (see Fig. 3.1). Contexts include: the epidemiological and health situations; religious and cultural issues; the context in which childbearing takes place; and the belief systems attached to and surrounding sexuality and reproduction. These contextual issues, along with the existing health system, prevailing health policy, current technologies being used in the provision of health services for sexual and reproductive health (especially for pregnancy, childbirth and postnatal and neonatal care), are critical for ensuring that the graduates from the programme will be able to function effectively. The technologies and resources available for teaching and learning and the beliefs around professional ideologies (i.e. ethics and philosophy around midwifery), will also influence the curriculum and, thus, are also seen as “inputs”.

Based on an assessment of these inputs, decisions can be made about which competencies are required and, subsequently, the curriculum content and design. Using a fit-for-purpose model to construct a midwifery curriculum ensures that the midwives who graduate have the requisite professional competencies. It also ensures that they will be able to base their practice

1 “Responsibility” in this sense means the “institution” is accountable for the programme. The issue of accountability – being able to hold the institution to account – is important in this definition and as such makes the need for core competencies vital. Core competencies can thus be used as one of the measures to demonstrate to the public/wider community that the institution is meeting the agreed standard.
on an agreed midwifery philosophy and model of care\(^2\), and will have the appropriate cultural competencies. The fact that there will be consistency between what the students learn and what they are expected to do after they exit the programme should lead to better prepared midwives, who are not just knowledgeable and skilled, but also motivated and more likely to remain in practice – and able to practice with confidence.

Midwives who have completed a well-constructed *fit-for-purpose curriculum* will contribute to better health indicators, in particular improved maternal and newborn health indicators. They also contribute to improved quality of care and, therefore, improved client satisfaction, and in many cases increased uptake of services. Furthermore, because they have competency and life-long learning skills, they are better able to adjust to changes in users’ needs and changes in practice due to evidence-based innovations. Thus, they are a long-term cost-effective human resource. (See Annex 1 for a schematic representation of a fit-for-purpose curriculum.)

**Educator versus teacher:** Often, and incorrectly, these terms are used interchangeably. An educator is frequently defined as “one trained in teaching; a teacher”. However, increasingly educationalists would argue correctly that the term educator is used to define “a specialist in the theory and practice of education”. As such, a midwifery educator would be someone who is a specialist in the theory and practice of midwifery education.

Strictly speaking, a teacher is someone who imparts knowledge, instructs how to do something or serves as guide for learning. As such, a midwifery teacher does not have to be a specialist in education, although a midwifery educator does have to be a competent midwifery teacher. Midwifery educators and teachers need to be experienced, proficient clinical practitioners who have been prepared to support and guide students in the clinical area in which they are demonstrating competence. To avoid confusion, the word *educator* is used most commonly throughout this document unless otherwise stated, but it is intended to apply to those who are specialists in midwifery education, as well as clinical teachers (preceptors) who support students in the clinical area or skills laboratories.

**Standard:** A standard is an agreed level of performance to achieve a specific outcome. It is what would be considered by an authority or by general consent to be a basis for comparison or for assessment for approval. As such, the global core competencies for midwife educators are a standard in some countries.

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2 A midwifery philosophy is the values and beliefs on which practice is based. It requires appreciation of the woman’s own ability to reproduce and an understanding that only a small percentage of women will require medical/obstetrical interventions. See, for example, the ICM position statement on *Midwifery philosophy and model of care*, 2008, developed by ICM and based on consensus across its member associations (available at http://www.internationalmidwives.org/assets/uploads/documents/CoreDocuments/CD2005_001%20ENG%20Philosophy%20and%20Model%20of%20Midwifery%20Care.pdf).
Fig. 3.1 Diagrammatic representation of a fit-for-purpose curriculum model

**INPUTS**
- Demographic and epidemiological context of SRH
- Needs of women throughout the life cycle
- Needs of newborns and young children
- Prevailing societal norms and ethical frameworks
- Cultural beliefs surrounding SRH, especially childbirth
- Current research, knowledge and technologies related to quality SRH services
- Professional ideologies and regulatory frameworks

**PROCESS**
- Fit-for purpose curriculum
  - Design based on the ICM core competencies for a midwife using competency-based teaching and learning processes

**OUTCOMES**
- Competent midwives:
  - have skills based on best available evidence
  - are competent, meet the standards for professional practice
  - are confident
  - are committed to empowering women
  - use participatory approaches to work with the community and health team/medical service

- Improved quality of care, including improved user satisfaction and increased uptake of services
- Improved health indicators
- Lifelong learners; with capacity to adjust to dynamic changes in service delivery
- Cost-effective human resource tailor made for the country/nation

SRH: sexual and reproductive health.

1. The curriculum is fit-for-purpose in the country where it is being delivered; thus, consideration of all inputs must be country-specific and take into account all existing diversities within the country.
2. The term “women” is used to include all women, adolescents and young women of all ethnic and religious backgrounds. Needs include physical, psychological, emotional and spiritual.
3. Needs of newborn and young children include the neonate at birth, during first 28 days of life and up to 1 year of age or older. This depends on the midwife’s scope of practice, which will be determined by country needs/regulations.

Source: Adapted from Sherratt, 2009.
Preparatory phase

Many countries, especially those in low-income/resource-poor settings, share many similarities. However, each country has a unique context and combination of cultural, epidemiological, economic, and historical factors that influence the country’s health system, the way it functions and its capacities. Most often these differences are found in the specificity of the country’s health, education and regulatory systems. Thus, it is important to consider carefully and systematically the following information from the outset.

**CONSIDER COUNTRY CONTEXT**

- Determine who and which body has the legal authority\(^1\) (legitimacy) to:
  
  i. Approve the core competencies for education of midwives. Most often it is a midwifery council or similar body that has the authority for regulating the profession. Sometimes, however, the person/body that has the authority for regulating educators may not be easy to identify. For example, where the education programme for midwives takes place in a university or similar institution of higher education, authority for defining competencies of midwifery educators may fall under control of a specialist higher education authority or the education ministry, or it may lie within both higher education and the ministry of health/department of health. Sometimes, there can be confusion over who has the ultimate responsibility. In such cases there needs to be agreement between the regulators of the midwifery profession and any other involved body/authority about who has authority for what. For example, the professional body regulating midwifery practice may be responsible for the professional standards and competencies of midwifery educators, leaving the specific education competencies to the higher education authority. Ideally, midwifery regulatory authorities should also be responsible for the competencies of midwifery educators.
  
  ii. Commission the work to review and recommend adoption of the core competencies.
  
  iii. Decide who can or has the capacities to conduct the work. The people that conduct the work are often separate from, but accountable to, the regulatory authority. However, an officer or representative of the regulatory authority can be part of the group which conducts the work, but would share equal accountability to the steering committee and/or regulatory authority as the other members of the group.

- Decide who the stakeholders are who will be affected by the midwifery educator competencies and what should be their level of involvement.

- Decide what resources are available in-country that could be useful in this process. For example, recent health-related reports, a list of who has already been working on preparing, upgrading and supporting educators of health practitioners, including

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\(^1\) The legal authority means who has the statutory responsibility for defining and agreeing the right to practice, including the scope of practice, as a midwife.

**SECTION 4. STEP-BY-STEP GUIDANCE ON HOW TO USE THE WHO MIDWIFERY EDUCATOR CORE COMPETENCIES**
midwives, and reports of recent meetings of interest and lessons learnt from such work could all be useful. In particular, it is important to review any assessment of capacity for midwifery (a capacity assessment) that has been conducted within the country, in order to determine the action needed.

- Consider what are the strengths and weaknesses of using internal versus external consultants, including respective costs.
- Consider the issue of regional reciprocity. Although the preparation of midwives must be tailored to meet national demands and competencies for educators/teachers, increasingly there is a need to consider regional reciprocity. If the national government considers it important or has signed agreements for regional reciprocity, it must be known at the outset, even if such agreements have yet to be implemented. These have to be taken into consideration during the review and adoption phase of the midwifery educator competencies.

**STEP 1:**

A. **Set up the committee to oversee the work** (i.e. establish an oversight group/steering committee)

- Membership of this committee should be at a high strategic level to give guidance and monitor the work plan. Membership should include representatives from the following:
  - midwifery regulatory board/authority(ies);
  - at least three senior officers from the ministry of health/department of health (MOH/DOH), one responsible for reproductive health services, one from human resources for health (HRH) department, one from hospital services;
  - at least one representative from the ministry of education with responsibility for preparation of educators, and/or a representative from the regulatory authority for higher education (if appropriate);
  - at least two midwifery educators (ideally they should be from different institutions);
  - a senior member of staff from at least one university with responsibility for midwifery programmes;
  - a senior educator from one of the institutions responsible for midwifery programmes (where pre-service midwifery education takes place outside of a university setting);
  - at least one representative from the midwifery associations, where they exist, or if more than one, then one from each (where combined nursing and midwifery professional associations exists, then the representative must be a practising midwife);
  - a senior member of staff from a public health institution;
  - at least one experienced midwife in clinical practice;
  - additional representatives may include representatives from service users, and depending on the midwife’s scope of practice in the country, it may be necessary to have others specialist service representatives, e.g. obstetrics, child health, intensive care, mental health.

A capacity assessment, sometimes referred to as a “gap analysis”, looks at what elements of the competencies may be missing, and also what potential there is for correcting these gaps. It is not always feasible to fill all the gaps at once – it may take a step-by-step approach to reach all the elements (knowledge, skills, attitudes/behaviours) of each of the competencies. A number of countries have already conducted a capacity assessment of their midwifery providers and educators, and the ICM has tools that can assist on its web site.
The steering or oversight committee is responsible for advice and strategic leadership for the work and for approving and sometimes selecting who will conduct the work, including determining the terms of reference. They often delegate day-to-day responsibility to an operational committee, in which case the steering or oversight committee will also appoint or approve members of the operational committee.

It is important that the committee or steering group established to oversee the work is properly constituted and has the required legitimacy for the task, and that it includes key influential people who will help with the final approval needed, and then with implementation. Failing to involve all the key stakeholders from the beginning may result in long delays or even resistance from some.

It is also vital that this group has the necessary expertise and is representative of diversity within the country. If left to a select few at the central level, the results may be seen to lack credibility and applicability at the field level.

B. Set up an operational committee:

Even if recruiting a specialist team to undertake the work of reviewing and adopting the midwifery educator core competencies, it is advisable to have a small operational committee responsible for day-to-day administration and reporting to the oversight/steering committee.

Representatives of the operational committee should be from:

- MOH at programme level (human resources for health and client services)
- the midwifery regulatory body(ies)
- senior midwifery educator(s)
- where appropriate, members from WHO and or other development partner(s) interested in this work.

Note: The exact make-up of both the oversight and operational committees will be determined at country level according to local protocol. However, there must be experts from midwifery in each committee when looking at core competencies for midwifery educators.

Finally, it is important from the outset to have some consideration of the impact the new midwifery educator core competencies will have for future preparation of educators/teachers, as well as for implementing plans (see next section). This consideration of impact should not unduly restrict the process of adopting the new educator competencies, including adopting those that are not currently included for the preparation of midwifery educators.

Any additions or changes to the educator competencies need to be based on sound evidence. Keeping in mind how they will be implemented can help keep the adoption process and outcomes realistic.

STEP 2: START TO CONDUCT THE WORK, FIRST REVIEWING THE COUNTRY/NATIONAL CONTEXT

Before even looking at the global midwifery educator core competencies, it is important to consider all the influencing factors needed for ensuring quality midwifery care within the country/national context. These factors are the same as the inputs for a fit-for-purpose curriculum (see Fig. 3.1).

- Factors to consider include:
  1. Epidemiological and health data:
2. Demographic data: age, life experiences and background of potential recruits into midwifery educator and/or teacher preparation programmes.

3. Current health workforce profiles: age of existing educators and preceptors, including clinical teachers, as this may influence their willingness to engage with and use new technologies, distance learning methodologies, etc.; plans from the human resources for health department to determine how many new educators will be needed – this may help in making decisions about how radical proposed changes can be, or if the changes need to be based on existing competencies of the current staff; how long existing educators and clinical teachers have been in their posts and what updating the average educator/teacher has had – this will help ascertain how familiar they are with new teaching and learning technologies, as well as with evidence-based clinical practice; a review of competencies in current/existing educators and clinical teachers – this may require taking a sample of educators and using a standard tool to assess their competencies.

4. Any reports that highlight client’s/user’s perceptions of midwifery services or health services in general. These may help to highlight areas of quality that need to be specifically addressed, especially in relation to ethical, cultural and communication-related domains.

5. Current, and where possible, future health policies and plans, especially if any health reforms are in the pipeline. This may help indicate future competencies needed in educators of health practitioners, but also human resources needed for health development plans.

6. Existing midwifery practice standards, especially the date of last revision/updating. This is important to ensure that the competencies for educators/teachers are based on current best practice for both education processes as well as clinical care.

- Consider the prevailing educational processes used for preparing midwives and midwifery educators; these are usually shaped by the general education system. In particular, consider if there are any constraints that may be placed on the curriculum in order to fit into a higher education system with academic credits (which can value theory over practice). It is important to consider if the prevailing processes are suitable for competency-based programmes. Educational processes should be based on up-to-date evidence of educational methodologies that are needed for the preparation of competent practitioners – which in short requires a competency-based curriculum and educators who use competency-based teaching, learning and assessment strategies (see Section 5).

- Ensure that there is clarity about the end product. It is important to first clearly understand the competencies expected of new midwives (the graduates) when establishing the midwifery educator core competencies. This will help to check that those involved in preparing midwifery graduates have the required clinical competencies to assist students. It is also important to find out if there are any studies or reports on existing staff, especially on how well new graduates are received by clients and managers to ascertain how well they are performing. This will help not only to identify gaps in existing competencies, but will also help to prioritize action when it comes to implementing the new educator competencies.

- Identify available resources: It is vital to consider if there are any in-country resources that can help with the work, including those with experience in transforming the education process or the introduction of competency-based programmes in other health or related areas. In many instances there is a wealth of information and tools that are available to the country in addition to this tool and other documents mentioned. There is also a wealth of resources now available on the Internet that can be used to strengthen and transform midwifery education and, thus, midwifery educators.
STEP 3: REVIEW OF THE MIDWIFERY EDUCATOR CORE COMPETENCIES

Based on the information collected in Step 1 and, possibly, Step 2 (although sometimes Step 2 is added to the terms of reference for conducting Step 3 and beyond), a small task force, or a few consultants should review the WHO Global midwifery educator core competencies in detail, including the general domains and the individual components and elements (knowledge, skills, and behaviours), and then grade each competency according to its applicability in the country.

An example of such a grading system is given below in Fig. 4.1.

Grading example:

A. Those competencies that are fully in line with existing national programmes, i.e. those that current educators are supposed to have, including all knowledge areas, skills and behaviour components.

B. Those competencies which, if adopted, would be new to current educators.

C. Those competencies which are generally in line with national programmes, but some additions, deletions or adjustments are required, i.e. there may be components which are not yet included, or maybe it is not yet considered the norm for the midwife educators in the country. If so, discussion with any relevant stakeholders is needed in order to be in a position to agree to them. In some instances the competency statement may be generally in line with national norms, but there are additional components/elements needed to the ones in the global document, in order to meet the specific country/national context.

Finally, make a list of any competency domains or additional competency components that should be added to meet the country/national context.

Once grading has been completed, a matrix can be developed and action can be recommended for each component (see below). This matrix becomes the basis for a larger discussion with stakeholders to gain consensus.

FIG. 4.1 Matrix for reviewing the global Midwife educator core competencies

<table>
<thead>
<tr>
<th>LIST EACH COMPETENCY (INCLUDING COMPETENCY NUMBER) IN APPROPRIATE GRADED BOX</th>
<th>COMMENT</th>
<th>RECOMMENDED ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A graded statements; Example: #1. Behave in ways that reflect the ethical standards of the teaching and midwifery profession # 6. Select and use effective teaching and learning materials/resources # xx ..........</td>
<td>Example: All components are already included in the existing preparation of educators/teachers, although some wording is slightly different.</td>
<td>Example: Consider if wording/terminology of the global statement needs to be changed to make it more understandable in country. Propose change to wording of: knowledge component to ....... behaviour component, change term fundamental ethical principles to basic principles of...</td>
</tr>
</tbody>
</table>
LIST EACH COMPETENCY (INCLUDING COMPETENCY NUMBER) IN APPROPRIATE GRADED BOX | COMMENT | RECOMMENDED ACTION
--- | --- | ---
A. graded statements
# 9. Foster individualized experiential learning
# xx ........................ Experiential learning methodology is not in common use in most schools of nursing and midwifery. Prepare a briefing note, based on the evidence, on the definition and on the value of experiential learning. This will be presented at the consensus meeting to agree if it will be included.

B. graded statements
# 8. Facilitate a safe and effective learning environment in the clinical setting
# xx ........................ In terms of one of the skills listed, it is not routine practice for faculty to “obtain free and informed consent for student involvement in care”. This is considered to be covered by the agreement made between the school and the clinical area, so it is not clear what this statement means or if this is a skill that all educators/teachers should have. Prepare a question for the consensus meeting based on how educators/teachers should ensure they protect the human rights of clients and, therefore, if this should remain in the skills list or be changed.

Additional Competency(ies)
Draft new competency(ies) including components. Give rational (and evidence) to support the addition of each. Present to the consensus meeting for discussion, including the evidence that supports the new competencies.

If action is recommended to change the wording of a component (knowledge area, skills or attitudes), or especially to change a whole competency statement, it is important to look at the evidence and to ensure that any change is evidence-based.

**STEP 4: CONSENSUS MEETING WITH STAKEHOLDERS**

As mentioned earlier, it is vital to ensure that all stakeholders are given an opportunity to consider and comment on the midwifery educator core competencies. Ultimately, it will be the profession itself which will make the final decision on competencies that are essential for their educators/teachers. However, without the involvement of others in the health and education system, it may prove difficult to implement the competencies smoothly. Involving a wide multi-stakeholder group, including public consultation, in adopting national core competencies has many benefits beyond making sure that there is wide professional expertise. It can, as demonstrated by the Australian experience, also stimulate awareness and respect for the roles of all primary maternity service providers (Homer et al., 2012).

**STEP 5: GETTING FINAL APPROVAL**

Involving regulators (those who have the authority to give final approval) from the beginning as a key stakeholder will help to get the final approval of the midwifery educator core competencies speedily and without undue barriers and blockages. The process for submission for final approval/ adoption will vary from country to country, depending on the existing protocols. However, regardless of the process followed, it is essential to present the process as well as the evidence to support the competency statements in a timely manner so that those who make decisions will have time to consider them carefully.

In presenting the competencies for approval (formal adoption), it is important to present at the same time a proposed outline for how they can be implemented and a timeline, especially how and when they should be monitored and evaluated, and by whom.
SECTION 5. IMPLEMENTATION

Adopting country-specific midwifery educator core competencies is the first step in transforming the educational process to improve the quality of midwifery services.

If the steps for adoption are followed, as identified in the previous section, the midwifery educator core competencies will meet the specific needs of a competency-based curriculum to prepare or update/retain midwives or others requiring midwifery competencies. However, success is dependent on these competencies becoming the norm throughout the country. As such, implementation, including follow-up and regular periodic action-orientated monitoring for compliance, is vital (see Fig. 5.1 and Fig. 5.2.)

Fig. 5.1: Summary of actions needed for implementation of midwifery educator core competencies

<table>
<thead>
<tr>
<th>STEPS FOR IMPLEMENTATION</th>
<th>RESPONSIBILITY</th>
<th>STAKEHOLDERS</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>The midwifery education core competencies have been formally adopted and approved for use in the country.</td>
<td>Regulatory body responsible for midwifery within the country (See Section 4 for proposed process.)</td>
<td>MOH/DOH, Professional associations representing midwives, Universities/higher education institutions, Development partners</td>
<td>Set of approved country-specific midwifery educator core competencies that all stakeholders are aware of and agree with.</td>
</tr>
<tr>
<td>Capacity assessment/gap analysis of existing midwifery educators.</td>
<td>Regulatory body responsible for midwifery within the country</td>
<td>MOH/DOH, Universities/higher education institutions, Midwifery educators, Service managers and other reproductive health team members, Development partners</td>
<td>Consensus on: (i) gaps and (ii) proposal for the way forward, including budgetary requirements for the plan of action.</td>
</tr>
<tr>
<td>Implement approved plan of action for strengthening midwifery educators, (including programme for new and existing educators).</td>
<td>Selected universities/higher education institutions (with consultant/external team as needed).</td>
<td>Regulatory body, MOH/DOH, Professional associations representing midwives, Development partners</td>
<td>Midwifery educators practising with core competencies.</td>
</tr>
<tr>
<td>Regular periodic monitoring and time-bound evaluation.</td>
<td>Regulatory authority and the MOH/DOH</td>
<td>Universities/higher education institutions, Professional associations representing midwives, Student midwives, Service users, Service managers and representatives of reproductive health team</td>
<td>Competent, highly motivated midwifery graduates capable of meeting reproductive health needs of the population.</td>
</tr>
</tbody>
</table>
Create budget for implementation

Having in mind how to implement the new core competencies from the start of the work will help to ensure that the outcomes remain realistic and applicable throughout the country. In addition, consideration of the implementation process from the early stages will give time to identify the resources needed for the implementation phase.

Identifying a realistic budget necessary to produce the expected results is critical for success, yet can be difficult, given that in many countries public expenditure on the education of health professionals is often woefully inadequate (Frenk et al., 2010). Advocating for resources during the approval process, while simultaneously stimulating interest in the benefits of having competent midwifery educators, can allow time for sufficient resources to be identified.

Provide wide distribution

If the final document is available only to the regulators, or those who have been involved in the process, the new core competencies will not help to improve health services or redress the imbalance noted in many countries of access to universal health care due to a lack of competent midwives. Therefore, it is imperative that the final approved core competencies are well known to all involved in the production of midwifery educators, as well as to all institutions providing midwifery programmes.

Create and implement a plan of action

Once all stakeholders have agreed the national competencies for midwifery educators/teachers, there is need for a well thought out plan of action. Such a plan should always start with a clear understanding of needs based on a structured “needs assessment”.

Fig. 5.2 Action cycle for a time-bound evaluation

![Action cycle for a time-bound evaluation](image-url)
POINTS TO CONSIDER:

- Adopting global competencies for midwifery education and educators (both initial pre-service and ongoing continuing education) is a critical step in improving the quality of midwifery health services.
- Adopting global competencies should always include a plan for how they can be implemented.
- Implementation of competencies for midwifery educators/teachers must be in line with, and complement, other actions to strengthen midwifery services, especially implementation of evidence-based clinical standards.
- The purpose behind developing the midwifery educator core competencies is to transform the education and preparation of midwives so that it focuses on competence. Remember, change is always inevitable, as is resistance to change from some areas. Often, resistance to prioritize and focus on practice comes from higher level university authorities who are not health professionals and who place more value on theoretical knowledge and research than clinical (hands-on) practice. Such resistance is often due to the limited information of those who resist.
- Plans for implementation must build on existing competencies of educators and teachers and should not be used to demotivate or downgrade existing staff.

Preparatory phase: assessment of gaps

It is essential that the action plan is based on identifying what competencies the current teachers have and do not have, as measured against the new competencies. Once any gaps are identified, a programme can be developed to address the missing competencies and build on or update existing competencies. This is essential in order to ensure that all current as well as future educators/teachers have the competence/abilities to teach in line with the new national standard.

- A number of tools already exist for assessing the qualifications and competencies of teachers of midwifery. For example, a tool to assess midwifery teachers can be found in Annexe 4 of Module 6 of the WHO Strengthening midwifery toolkit (WHO, 2011c). This tool could easily be adapted for assessing competencies against the new midwifery educator core competencies. Any assessment should be based on all the components for each of the competencies, i.e. knowledge, skills and behaviour. It is important to ensure that as educators/teachers they have all the midwifery practice competencies, as in some countries midwifery educators are not expected to update or maintain their clinical practice skills, or they only work in one specific area, for example antenatal care, and may be lacking in the other clinical competencies. An example of a tool for self-assessment of clinical competencies based on ICM essential competencies is available from ICM (http://www.internationalmidwives.org/assets/uploads/documents/Global%20Standards%20Comptencies%20Tools/English).

Suitable methodologies for conducting an assessment of the competencies of a midwifery educator:

- in-depth interviews (individual) with students, clinical staff, educators/teachers, recordings of interviews to be transcribed for analysis;
- focus group discussions;
- observation of teaching and assessment-related events, in both clinical and classroom settings;
- questionnaires, both semi-structured and free text, postal or anonymous paper-based;
- assessment of teachers using scenarios and checklists;
- educators/teachers self-assessment using the gap analysis framework listing the midwifery educator core competencies.
Ideally a combination of three of the above would be best, as this would give the opportunity for triangulating results and, therefore, increasing reliability.

In choosing which methodologies to use, it is important to look at the advantages and disadvantages of each methodology and choose a selection in which the disadvantages of each method can be overcome. The final decision of which tool and methodology to use may well depend on feasibility, including time and costs. Once the assessments have been completed, the core group needs to review the outcomes in order to design and plan the implementation of the needed changes.

Note: It is not necessary to look at the competencies of all midwifery educators/teachers, but it is important to have a representative sample. This is essential where there are sub-national variations in provision of health services. If only educators/teachers competencies in the central training institutions are assessed, this may lead to missing gaps for those working in remote or rural areas. In the Cambodia midwifery review, for example, a 10 percent random sample of all operational districts in the country outside the capital were assessed. A sample of teachers from the capital was also assessed, but for comparison reasons these results were not aggregated into the overall assessment (RGoC MoH, 2006).

**Assessment of competencies of midwifery teachers in Cambodia, Lao People's Democratic Republic and Mongolia**

Many countries have already undertaken an assessment of their nursing and midwifery teachers (although done before the global consensus of midwifery educator core competencies). Lao People's Democratic Republic with the assistance of United Nations Population Fund, and Mongolia with the assistance of WHO, used similar tools, which were based on tools developed for the comprehensive midwifery review in Cambodia (LPDR MOH, UNFPA, 2008; Kildea at al., 2012; RGoC MoH, 2006).

“The assessment of the teachers comprised a self-assessment questionnaire, a skills test (using standardized checklist) and short interview... The teacher tool was completed as a self-assessment questionnaire, with many yes/no questions about curriculum, teaching methods, attitudes” (LPDR MOH, UNFPA, 2008).

Design phase: preparing midwifery educators/teachers to ensure they have the required new competencies

Having completed the preparatory phase, it is important then to look at the existing programmes for the preparation of educators/teachers and make any necessary changes.

It is important to simultaneously develop a programme to update existing educators/teachers, as well as new educators and clinical teachers/preceptors, to ensure that all those responsible for midwifery education and in-service programmes have the necessary competencies. Unless both are undertaken simultaneously, it may be difficult to make the desired transformation in educational programmes, as new educators will be influenced by existing staff.

It is important to give time to consider the gaps identified and remember that some of them may be more related to gaps in clinical knowledge or lack of practice skills. If this is the case, it is important that these are addressed, either as a separate module which precedes a more formal educator preparation programme, or as an integral part of a formal programme.
The WHO *Strengthening midwifery toolkit, Module 6: Developing effective programmes for midwife teachers* (WHO, 2011c) is a helpful resource for those charged with designing programmes for midwifery educators and clinical teachers. Other programmes and resources are available, but most have similar content to that of the WHO toolkit, Module 6 (see extract in Annex 1).

**Suggested elements of the midwifery educator curriculum**

It is always a challenge to respond to country requests for an exact curriculum to implement a new approach to education of any health profession, including the preparation of midwifery educators and clinical teachers, which is the focus of this tool. All curricula, as discussed in Section 3, are very context- and country-specific, and must be developed by the educators who will carry out the design. This way the developers will understand why and what decisions were made regarding the content, the learning activities, and the teaching and assessment strategies. The following are the steps to design an effective curriculum (see both WHO *Strengthening midwifery toolkit* (WHO, 2011c) and *Model curriculum outlines for professional midwifery education* (ICM 2012b)).

1. Select a core group of midwifery educators who are familiar with competency-based education.
2. Review the gap analysis of current midwifery educator competencies, so that the emphasis in the curriculum will focus on those in some detail.
3. Design the content and processes of the educator curriculum.
4. Implement the educator curriculum with ongoing evaluation of effectiveness.

A suggested approach to developing the content of a midwifery educator curriculum based on the adopted WHO *Midwifery educator competencies*, 2013 is offered below. The following points provide an outline of the essential elements the drafting group should take into consideration when developing a formal programme to prepare competent midwifery educators/teachers.

- Agree a statement of mission and a philosophy of the programme consistent with the institution hosting the programme.
- Agree expected programme outcomes for educators (use WHO educator competencies).
- Organize content to include all the Midwifery educator core competencies. For example, the drafting group may decide to group content by the eight competency domains, e.g. ethical and legal principles of midwifery, learning in the clinical area.
- Depending on the available time for educator programmes, or whether it should be done in a series of workshops, determine what content will be grouped together based on a logical flow of information, similar content area, etc.
- Decide how content is to be learned (learning activities: e.g. self-study modules; teaching methods: e.g. case studies, seminars; microteaching in front of peers for competency demonstration).
- Decide assessment strategies including tools and timing for each content area, with emphasis on self-assessment throughout the learning process.
- Decide the time frame for each content area based on gap analysis data; missing competencies will require more time than competencies already demonstrated.
- Agree who will teach what content and when.
- Confirm participants.

The plan of action needs to be presented and have the approval of the oversight committee before the implementation phase can commence.

A monitoring and evaluation plan is vital, as this forms a crucial element of the implementation phase, with an agreed timeline for a periodic review of the competencies to ensure they remain in keeping with best practice and new research/evidence.

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1 Although this is specifically for developing programmes for educators of midwifery programmes, the same can be applied to nursing programmes, although some changes in technical content will be required.
2 A more detailed guide for developing a curriculum to prepare midwifery educators, based on the midwifery educator core competencies is being prepared by WHO and will be available at a later date.
IMPLEMENTATION PHASE

Implementation is best undertaken on a phased basis before the programme is rolled out fully, with evaluation of the first few “graduates” to ensure the educators are practising according to the new competencies.

In many countries, the time available for preparing midwifery educators is limited due to time educators must spend away from teaching responsibilities. Therefore, a country may decide to hold a series of workshops rather than a concentrated 4 to 5 months of study. Other countries have had success in preparing new midwifery educators/teachers in a one-year academic programme of study. Whatever time frame is decided in a given country, the important point is that every midwifery educator/teacher and preceptor requires formal preparation for the role, and the WHO Midwifery educator core competencies provide the essential content for such a programme.

An evaluation report from the first group (as agreed with the oversight committee at the planning stage) should be prepared, presented and discussed with the oversight committee. Action agreed with the oversight committee for modifications to the implementation plan and/or curriculum, based on the evaluation findings must then be carried out.

MONITORING AND EVALUATION

A structured monitoring and evaluation plan should be developed from the beginning. Such a plan should allow for regular periodic assessments and for changes to be made based on findings.

A qualitative approach is best for such monitoring and evaluation, rather than relying on quantitative data (i.e. how many educators/teachers are performing which competencies). The qualitative approach seeks not only to identify which competencies are being performed, but to understand the reasons for non-compliance. These reasons may be due to structural issues, lack of equipment, organizational structures, demotivating environments, or other factors, rather than the fact that the educator/teachers does not, or has not yet developed the specific competencies. Addressing these barriers to compliance must then be included in the revised plan of action.

Finally, a date must be set for when the Midwifery educator core competencies should be reviewed. This is usually done after five years, or can be done sooner. This review will assess if there has been any new evidence for best practices in teaching or changes in practice.
REFERENCES AND OTHER DOCUMENTS USED TO PREPARE THE TOOL


5.5.1 MIDWIFERY STUDIES

“It is essential that midwife teachers have an in-depth knowledge of midwifery and related subjects and are skilled practitioners, in order to teach midwifery theory and practice effectively. The programme should be designed to build on and extend existing knowledge and skills. The knowledge and skills required by midwife teachers are outlined below, but countries may wish to add or delete subjects to meet their own criteria for the selection of curriculum content. These competencies for midwifery teachers are based on the midwifery philosophy, values and model of care (Thompson, 2002). They are consistent with expected competencies promoted by educators of other health-related disciplines (Yeates, Stewart & Barton, 2008; Duvivier et al., 2009; Molenaar et al., 2009; da Silva Campos Costa, 2010; Stenfors-Hayes, Hult & Dahlgren, 2011; Srinivasan et al., 2011).”

1 An updated version is available from PAHO. The only change to the previous version is updated references.