Midwifery 60 (2018) 27–29

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/locate/midw

Teaching respectful maternity care using an intellectual partnership model in Tanzania

Karline Wilson-Mitchell, DNP, MSN, RM, RN, CNM Associate Professor[a,*], Jamie Robinson, MA Candidate Project Officer, CAM Global[b], Mary Sharpe, RM PhD, MEd Associate Professor[a]

[a] Midwifery Education Program, Ryerson University, 350 Victoria Street, Toronto, Ontario, Canada M5B 2K3
[b] Canadian Association of Midwives, 2330 Notre-Dame W., Suite 300, Montreal, Quebec, Canada H3J 1N4

ARTICLE INFO

Keywords:
Respectful Maternity Care
Intellectual Partnership Model
Quality improvement
Midwifery education
Problem-based learning
Social equity

ABSTRACT

Objective: to develop and deliver a two-day Respectful Maternity Care workshop for midwives using Intellectual Partnership Model principles
Setting: rural Tanzania
Background: respectful Maternity Care is an objective, measurable indicator of quality maternal newborn care
Interventions: using the Intellectual Partnership Model, educators facilitated cocreation of solutions alongside learners for complex ethical and logistic problems in the workplace
Findings: the mean scores on a 10-item multiple choice test increased by 20% on average following completion of the interventions; however 2-year certificate learners were less prepared for critical thinking work and social innovations than those midwives who had 3 or 4 year formal training
Key conclusions: the implementation of the Intellectual Partnership Model revealed that midwife learners were creative, innovative, context specific in their social innovation creations related to Respectful Maternity Care when supported by respectful facilitators. Implications for practice: the Intellectual Partnership Model should be considered along with problem-based learning in the Global South, for pre and post-service education.

Background

Respectful maternity care (RMC) is an objective, measurable indicator of quality maternal and newborn care with respect to health facilities management and professional competency, according to systematic reviews and policy papers (Bohren et al., 2015; Population Council, 2017). The seven domains of RMC include activities that mitigate against the following abuses: 1. harm and ill treatment; 2. lack of informed consent and refusal and disrespect for choices and preferences, including companionship; 3. lack of privacy and confidentiality; 4. lack of dignity and respect; 5. inequality, lack of freedom from discrimination and inequitable care; 6. barriers to healthcare and the highest attainable level of health; 7. oppressive restrictions to liberty, lack of autonomy or self-determination, and coercion (White Ribbon Alliance, 2015).

Ideally, RMC should guide standards for midwifery regulators, practice guidelines for midwifery associations, and curriculum for midwifery educators. The expectation for educators is to teach learners to think critically in difficult, complex situations where there are ethical dilemmas, low resources and no clear best practice guidelines (Bharj et al., 2016). In environments with weak infrastructure, disrespect and abuse occur (Penfold et al., 2013). Researchers also observed in these circumstances declining job satisfaction, lack of desire to continue working, and decreased midwifery morale (Knight et al., 2013). It is challenging to teach RMC to midwifery students under these circumstances where modeling RMC in the clinical environment may be infrequent.

The Intellectual Partnership Model

According to Bailey et al. (2016), 'intellectual partnership' requires both the active, authoritative teacher and the passive, powerless learner to transform into partnership roles (See Fig. 1). Such transformation involves courage and risk-taking, but critical human rights proponents of the Intellectual Partnership Model (IPM) argue that knowledge and power are not solely owned by the educator. Instead knowledge, solutions and approaches to learning emerge through 'co-creation' by learner and educator (Bailey et al., 2016). The IPM creates communities of inquiry where adult learning is equitable, inclusive and empowering (Bailey et al., 2016; Wilson-Mitchell and Handa, 2016.

* Corresponding author.
E-mail addresses: k.wilsonmitchell@ryerson.ca (K. Wilson-Mitchell), jrobinson@canadianmidwives.org (J. Robinson), msharpe@ryerson.ca (M. Sharpe).

https://doi.org/10.1016/j.midw.2018.01.019
Received 2 December 2017; Received in revised form 20 January 2018; Accepted 31 January 2018

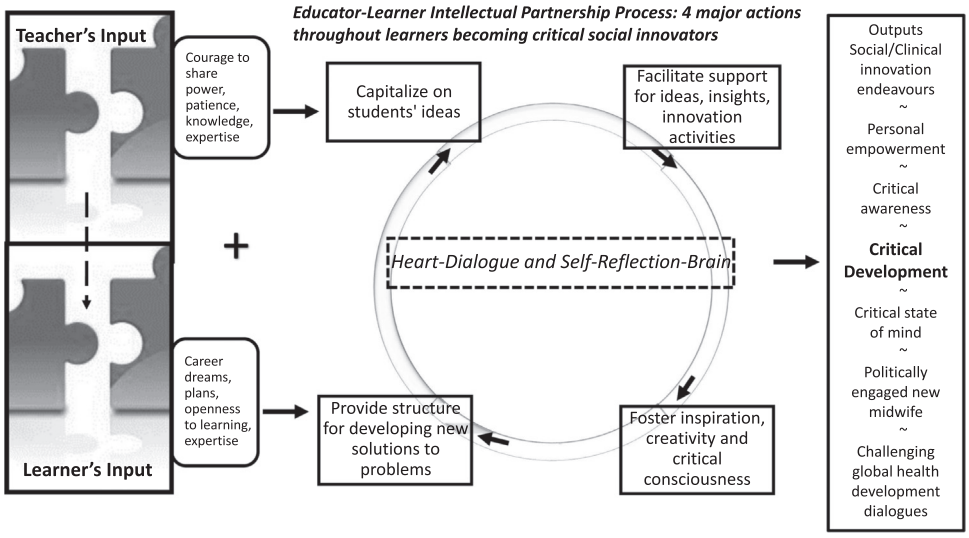

Fig. 1. The Model of the Learner Becoming Social Innovator Through Intellectual Partnership Process (modified with permission from Bailey et al., 2016. The audacity of critical awakening through intellectual partnerships, In Teaching as Scholarship: Preparing Students for Professional Practice in Community Services).

See Fig. 1). Allowing learners to practice teaching or sharing their intellectual creations provides group sharing and discovery found in cooperative learning (Megahed and Mohammad, 2014). Although the educator facilitates as a catalyst, the learners eventually own the class and the learning. The facilitator can appoint a learner-facilitator and learner-energizer. Also included in IPM are group problem-solving, brainstorming, problem-based learning (Dolmans et al., 2010) and self-reflection activities.

A case-study: Applying the IPM to teach RMC to midwives in Tanzania

This paper focuses on the challenge of humanizing midwifery education in a low-resource country where, hitherto, the focus had been on clinical excellence and psychomotor skills development in the midwife. The goal was to incorporate 'soft skills' (Gangopadhyah, 2012) into clinical management. These skills include but are not limited to: respectful and shared decision-making with clients, conflict resolution (particularly in regions rife with civil war and unrest), interprofessional collaboration in a workplace characterized by power differentials, as well as differences of culture, language, religion, tribal affiliation, and socioeconomic status that exist in a post-colonial, neoliberal Global South (GS). Problem-solving skills are required for working with clients with clinical complications and for midwives practicing in complex working conditions. In these cases it is necessary to prioritize the use of limited space, equipment, and resources.

A model for teaching RMC, informed by the IPM, and using a two-day long continuing education workshop format was implemented with groups of Tanzanian midwives. These workshops were funded by Global Affairs Canada, developed in collaboration with the Tanzanian Midwives Association, the Canadian Association of Midwives, AMREF Africa, JPIEGO, and the Ministry of Health Community Development, Gender, Elderly, and Children (Robinson, 2017).

Six IPM two-day workshops were run from July to August 2017. Over 170 participants from the Lake and Western Zones of Tanzania participated in testing the effectiveness of infusing RMC principles into clinical management. Modalities included lectures, videos, small group discussions (pair-and-share; cluster groups), RMC role playing of complex, ethical decisions with limited resources or preparing clients for uncomfortable procedures (e.g. manual extraction of placenta). Throughout the two days, facilitators gave midwives a platform to share experiences and to deconstruct the phenomenon of abuse. Each workshop involved three facilitators and 12–35 participants. One goal was to create changes in attitudes which are learned best when applied to scenarios that replicate real-life. This suggests helpful qualities that the midwife facilitator could possess. The facilitator should be knowledgeable, skilled, compassionate, and experienced in the fullest scope of midwifery for the country in question. Also, the facilitator should be up-to-date on prevention and management of complications using best practices and the ability to recognize when consultation and referral are necessary (ten Hoope-Bender et al., 2014). Ideally a facilitator would be a member of faculty and/or the national professional association and willing to be trained in group facilitation.

How well did the model work?

The midwives who participated in the workshops were well-versed in the challenges of working in rural Tanzania. Consequently, the IPM solutions to complex problems in low-resource settings were created jointly by learners and educators. On day two of the workshop, facilitators guided a 4–6 hour session of small group activity where the participants developed their own versions of various interventions suggested by RMC researchers (Population Council, 2017). These were social innovations such as: a mediation program; staff debriefing program; starting a facility Open Maternity Day or Open House; community engagement projects; and a community facility management board with membership of key community stakeholders, businesses and political leaders.

In an attempt to measure the effectiveness of these workshops, the participants took a 10-item multiple choice quiz about their understanding of RMC both before and after their workshop. Their knowledge, attitudes and motivation as expressed in their responses were compared, and on average, participants scored 20 per cent higher on the same quiz following RMC training. They planned to become patient advocates and to share what they had learned with their work-mates. In verbal and written workshop evaluations, these midwives described feelings of alarm, regret, and powerlessness after witnessing disrespect and abuse in facilities. In contrast, they reported feelings of empowerment and a sense of agency after their group presentations of innovation projects to combat disrespect.

We note that participants with three or four years of formal midwifery training were more confident in their ability to incorporate and advocate for what they had learned. They seemed to be more likely to develop solutions that were self-directed, independent, and creative than those with two years of formal midwifery training.