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Review

Just and sustainable global nurse-midwifery clinical education exchanges: Lessons learned

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The severe shortage of skilled maternity care providers in countries with low resources results in a staggering number of maternal and newborn deaths annually. University nursing and nurse-midwifery programs are especially well-equipped to participate in multi-lateral and bi-lateral education collaborations to address this shortage. This paper presents a perspective on how universities in well-resourced settings especially can share their education capacity with globally distant institutions with chronic unmet needs for well-prepared nurse faculty and skilled midwifery professionals. Start-up administrative, operational and initial site visit considerations were described. Best practices for academic programs and accreditation requirements were reviewed, as well as recommendations for selecting students who are likely to be successful participants. Guides to program success are promoted such as cultural humility, mutual respect, courtesy, and close attention to health, safety, and emotional balance.

Key words: Global midwifery, education collaboration, ethics, best practices, education system strengthening.

INTRODUCTION

The purpose of this article is to provide guidance for planning and implementing just and sustainable global nursing and nurse-midwifery clinical education exchanges. Collaboration between global university nurse education programs is critical if the global crisis in maternal and newborn care is ever to end. The International Council of Nurses (ICN) has called for a new framework of collective action of nurses and midwives to address these issues directly in 2011 to 2015. The International Confederation of Midwives (ICM) has also called for implementation of well-designed and sustainable global education collaborations as imperative to achieve long-term health development and stability (ICM, 2010). Global Standards for Midwifery Education and Companion Guidelines (2011) were subsequently released to guide education program development. The ICN and ICM may have called for collective global action in education, but it could be asked whether the end of the global maternal-newborn health crisis requires the active participation of university midwifery education programs? There are many voices that argue that educational institutions have long neglected social accountability.

Horton (2010) argued in a Lancet Commissions Commentary that large sections of the health professions have for too long betrayed the communities they pride themselves on serving.

Rather than focusing on knowledge and research for its own sake, what specifically is the universities responsibility to address the health needs of people? Current university nurse-midwifery and midwifery program faculty members know that change is afoot in both the methods and the goals education for health professionals for the 21st century. The Lancet Commission on Education's Health Professionals for a New Century has called for many instructional reforms (Frenk et al., 2010). This multi-professional expert panel charts a future global course for the education of the health workforce. Educators are called to exploit the power of information technology for learning, and to promote a new professionalism based in both competencies and a common set of values for social accountability. All university health worker programs are now challenged to educate the next generation of professionals who can simultaneously adapt to rapidly

changing local conditions and draw on global resources. This provides a new framework for global midwifery clinical education engagement. Many universities envisage creating long-term global education collaborations and clinical exchanges.

Jeffers and Mitchell (2010) highlight the essential elements of bilateral-engagement rather than having a focus on unilateral benefit of one party. Equity and sustainability over the long term in global nursing partnerships are critical for an ethical foundation. Best practices for uni-versity short term study abroad programs have been described by Donnelly-Smith (2009). The recommended practices include: (1) starting with clear academic content, (2) faculty that are competent with experiential teaching, (3) integration with the local community, (4) including lectures from the host country, and (5) required ongoing individual and group reflection.

Levi (2009) reviewed the Ethics of Nursing Student International Clinical Experiences. Lessons learned included the need for appropriate supervision of health worker students, cultural humility, and an appreciation of the complexities of global health. The overarching question was asked about the value of itinerant providers, particularly if the kind of care provided is not continued, and if no supportive care would be available. Finally, Bermele and Kostovich (2011) described some general mistakes in global education program design, implementation, and travel arrangements, as well as how to prevent them The first published midwifery project report described a small bilateral program (Walsh, 2003) but there is little published information available specifically regarding the specific start-up and evaluation of global nurse-midwifery and midwifery clinical programs. It is the goal of this paper to begin to address that gap. The recommendations in this paper are based on experiences with both a US originated global nurse-midwifery clinical education program which continued for 5 years, and a program that failed to launch.

Collaborative global engagement relationships can take many forms. They may be bilateral, mutually self-arranged between universities at a distance, or the universities can be members of a multi-lateral network, such as the World Health Organization (WHO) Collaborative Nursing Centers. Currently, there are over 800 WHO Collaborating Centers in over 80 member states; however, of this total, there are only 44 global Nursing and Midwifery Collaborating Centers.

The most just and equitable nursing education collaborations are characterized by the long term bilateral exchange of faculty and students in both directions between the partner institutions. No distribution of education resources is just when one party uses the other party as a means to its own end. At the present moment global communities may be on one side or the other of a global resource divide, but justice, equity, and compassion all require that educators use the resource levers available to them to dissolve this division. For universities to accumulate knowledge without attention to wide distribution and translation of knowledge into action is ultimately empty and meaningless. The Millennial Development Goals and simple justice all require that the health outcomes of the most vulnerable women and newborns around the globe be improved. It is time for willing and able global university nurse-midwifery and midwifery programs to partner with one another. Twenty-first century pedagogy requires that educators take the initiative to strengthen each other through joint teaching, learning, shared instructional design, faculty mentoring, and developing continuing education.

Problem statement

Nurse and nurse-midwifery programs worldwide have a responsibility to combat global maternal and newborn deaths. High-income nations have exacerbated this problem by the recruitment of international medical and nursing providers to more affluent countries. It has been long recognized that there is a negative impact on the donor country when limited local resources are utilized to educate health workers who migrate to high income countries. WHO has long documented that there is a shortage of at least 4.3 million health workers worldwide. They have argued that global health worker capacity development has reached a crisis point. The crisis is not only in overall numbers of health-workers, including nurses and midwives, but in their unequal distribution of workers, lack of training, and international migration from poor countries to rich countries (Chatterjee, 2011).

As a result, health systems in the countries of workforce out-migration are even more weakened. The WHO's Code of Practice on the International Recruitment of Health Personnel (2010) now stipulates that the interests of the countries of origin, destination countries and health workers must be balanced. Health professional education systems have a clear mandate to contribute to developing education capacity and infrastructure in countries with fewer resources; sharing clinical and professional skills promotes a just workforce. In fact, the WHO Global Code of Practice on the International Recruitment of Health Personnel promulgated by the sixty-third World Health Assembly (WHA63.16, May, 2010) clearly stated that "developed countries should, to the extent possible, provide technical and financial assistance to developing countries and countries with economies in transition aimed at strengthening health systems, including health personnel development.

Why would educational programs have any responsibility to reduce global maternal and newborn deaths? The answer is that no university, midwifery educational program, and no well-prepared graduate student were ever spontaneously self-generating. The accumulated

resources of civil society are necessary for any higher education program to offer any highly qualified student an education, even in a “private” institution. The resulting health professional education is not private property which the graduate has purchased. That professional health worker education comes with not only rights, but with responsibilities. As a matter of elementary logic, educational resources must be entrusted to those who can ensure that they are most widely disseminated and used where needed. What is the purpose of mid-wifery education? An entity which focuses on per-petuating itself and which forgets it original goals and purposes is not defined as a profession; it is the standard textbook definition of a bureaucracy (Merton, 1957).

It may once have been considered sufficient for nurse-midwifery and midwifery programs to focus on the training of technically competent practitioners. However, within the university framework of graduate education, today’s students and faculty are not focused on merely devising, teaching, and learning health care processes; it is imperative for educational institutions to contribute to the improvement of health outcomes.

Every aspect of contemporary midwifery education is focused on teaching evidence-based practice and improving outcomes. The midwifery student today learns that even though procedures are followed, the job is not done until outcomes are considered and improved. Furthermore, midwifery programs today are fully aware of global maternal-newborn health issues; in fact, many US students are motivated to become professional midwives with precisely those needs in mind. Midwifery students actively seek an education that prepare them for future global collaborations.

Although there has always been great potential in developing global health partnerships in midwifery education, few programs have succeeded, as reported by Latta et al. (2010). In their survey of US Certified Nurse-Midwifery and Certified Midwifery Education program directors, they discovered that the most common reason for not developing midwifery global clinical collaborations was financial constraints. They found out that 29 of 38 program directors (76%) who responded to the survey, only 9 (31%) offered inter-national clinical experiences. Of the 20 programs reported which had no available international experience component at that time, the majority (80%) were interested in providing this type of experience.

NURSE-MIDWIFERY ADMINISTRATIVE START UP WITH US PARTNERSHIPS

Nurse-midwifery education programs in the US are accredited by the Accreditation Commission for Midwifery Education (ACME) which requires students to have a Certified Nurse-Midwife or Certified Midwife (CNM/CM) as their primary on-site clinical supervisor. Global volunteer programs in which nurse-midwifery or midwifery students conduct care without qualified on-site faculty supervision do not meet the minimum standards for attaining clinical competence (ICM, 2011). In clinical exchanges, partner US universities usually grant clinical faculty appointments to visiting or host preceptors who hold degrees equal or higher to the degree which the visiting students will receive.

When practicing overseas, US midwife preceptors may be required to have both appropriate current local country (or state) licensure and regulatory approval to practice in the host country. Likewise preceptors coming to the US would also need national, state, and institutional credentials to practice in the location of the host clinical exchange. If conducting births, US credentialed faculty and students must have current provider’s qualification in the American Academy of Pediatrics (AAP) Neonatal Resuscitation Program (NRP, 2013) and Health Insurance Portability and Accountability Act (HIPAA, 2013) training. Finally, US faculty credentials must be up-to-date in Family Education Rights and Privacy Act (FERPA).

When a clinical education partnership is being arranged, the intended visiting university faculty supervisor will conduct an initial site visit to the proposed global host. If possible, the faculty nurse-midwife practices as a team member in the clinical setting where the students will be. It is vital that the proposed visiting faculty experiences the clinical situation first-hand. A visiting faculty practitioner must gain insight into the host’s health care system, recognize the setting’s informal and formal practices, and determine if it is an appropriate setting for students. A visiting faculty nurse-midwife should be prepared to contribute to the formal educational mission of the host clinical site if invited by the hosts. Guest lectures, skills simulations and train-the-trainer workshops are often very welcome. When planning the site visit, it is important to communicate in advance about resources that may be required for educational contributions and ways to present information with cultural sensitivity.

STUDENT SELECTION CRITERIA

When selecting students for global clinical practice, references must be obtained from clinical faculty who have direct knowledge of how a candidate student acts in stressful, complex, and culturally-diverse settings. A student who can manage a large amount of new information with ease will have an advantage over a student who likes to be in control. A student who prefers experiences that are familiar and predictable will not do well in a remote clinical placement. Likewise, students who have demonstrated strong team skills should be given priority over those focused on maximizing their own learning experiences. Global partners in low-resource

countries may or may not have a preference that participating students be selected on the basis of a sincere future commitment to return to that region to practice after graduation. If they do have a preference, it is important to take it into account when selecting students. It is highly desirable for faculty and students to be well versed in cultural expectations and to speak the language of care providers and patients in the globally distant setting. Students and faculty should participate in pre-service culture and language proficiency course work if necessary. Otherwise, a local professional translator with knowledge of culture and health care terminology should be utilized. A glossary of essential maternity care clinical phrases in the language of the clinical host can be useful in common clinical situations such as evaluating early labor, establishing fetal well-being, or conducting a delivery.

PROGRAM DESIGN

Depending on the setting and experience level of the preceptor, the maximum number of students per faculty should not exceed four or five, especially in a labor and delivery unit. Nurse-midwifery faculty should identify the specific type of clinical experiences students require: intrapartum, postpartum, newborn, primary care, gynecology and/or women's health care. All students should possess a basic level of full-scope clinical competencies prior to the global clinical experience. Nurse-midwifery students should have also completed theory and clinical skills courses to handle the volume and complexity of experiences in their global setting. Visiting faculty and students work with the host institution's care team as guest providers, and utilize the host site's clinical practice guidelines and consultants. Student opportunities for reflection and faculty support are important to help them understand the meaning of their experiences, to develop in their professional roles, and to cope with the emotional impact.

OCCUPATIONAL AND TRAVEL HEALTH AND SAFETY

All students and faculty in a bilateral exchange should have a health provider visit prior to travel. Local health travel departments are often an excellent source for country specific immunizations as well as in advance of travel check on-line information regarding specific state and local outbreaks as well as Center for Disease Control (CDC) country specific immunization recommendations. For example, in the US state of Washington, there is currently a pertussis epidemic and all health care providers must be immunized. (Washington State Department of Health, 2012). Another example is that prophylaxis for common diseases such as malaria may be required in tropical regions. Many countries currently require proof of yellow fever vaccination in order to enter the country. The individual travel medicine provider should also be reminded that participants in nursing clinical experiences will have greater risk of exposure to disease than casual tourists (WHO, 2010). Travelers have an elevated risk to parasitic and bacterial infections, because they lack local acquired immunity. Travelers anywhere should be aware of the precautions to prevent food and waterborne illnesses and also carry routine treatments for common maladies. In areas with high background HIV seropositivity rates or exposure to respiratory infections, guest providers should carry the requisite post-exposure prophylaxis and NIOSH-approved filtering face-piece respirators, respectively. If need be, these treatments and devices may be applied immediately (Clark and Fitzgerald, 2007).

Students who intend to participate in global clinical exchanges must be advised well ahead of time to avoid becoming pregnant; the degree of risk of viral, bacterial, and parasitic infections is greatly increased for fetuses and pregnant women. Participants should be expected to use sound judgment during time off, and to follow safety recommendations of hosts. In any country, one should be aware of safe routes, means of travel, and whether travel at night is advisable.

Local cell phones are often inexpensive, versatile, and highly useful. Many remote global locations have excellent cell phone service. Finally, local cultural and dress norms should always be respected, and students should be notified in advance about these expectations. Insensitivity to local norms undermines professional image; lack of cultural humility puts the effectiveness of the clinical exchange program at risk, and possibly the safety of participants. Student opportunities for reflection and for faculty support are important to help them understand the meaning of their experiences and to develop in their professional roles.

CONCLUSION

Through a careful process of planning and respectful mutual collaboration, nursing and nurse-midwifery education programs can create long-term partnerships with global clinical sites. Students, education programs, women and newborns can all benefit from thoughtful, just, and sustainable global nurse education clinical partnerships.

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