
**A model for direct entry midwifery education and deployment
in Ethiopia: Transforming rural communities and health care to
save lives**

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requirements for the admission to the degree of Masters of
Midwifery (Research)**

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CERTIFICATE OF AUTHORSHIP/ORIGINALITY

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

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TABLE OF CONTENTS

TABLE OF CONTENTS	III
ABSTRACT	VII
ABBREVIATIONS	VIII
TABLES	IX
FIGURES	IX
PREFACE: A VISIT TO A HEALTH CENTRE IN RURAL ETHIOPIA	XI
1 INTRODUCTION	13
1.1 BACKGROUND	14
1.2 MATERNAL MORTALITY	14
1.3 REDUCING MATERNAL MORTALITY IS ACHIEVABLE	17
1.4 MIDWIVES ARE THE PRIMARY SKILLED BIRTH ATTENDANT.....	22
1.5 ETHIOPIA: A BRIEF COUNTRY PROFILE	25
1.6 MATERNAL MORTALITY IN ETHIOPIA:.....	26
1.7 A MIDWIFE SHORTAGE AND MATERNAL HEALTH IN ETHIOPIA	28
1.8 THE HISTORY OF MIDWIFERY IN ETHIOPIA.....	29
1.9 THE HAMLIN COLLEGE OF MIDWIVES.....	32
1.10 MIDWIFERY EDUCATION AND THE ‘DIRECT ENTRY PATHWAY’ IN SUB SAHARAN AFRICA.....	33
1.11 MIDWIFERY EDUCATION: THEORETICAL KNOWLEDGE AND CLINICAL COMPETENCY	36
1.12 MIDWIFERY EDUCATORS.....	37
1.13 SELECTION OF MIDWIFERY STUDENTS	38
1.14 ACCREDITATION OF HIGHER EDUCATION INSTITUTIONS FOR MIDWIVES	39
1.15 MIDWIFERY REGULATION IN ETHIOPIA:.....	39
1.16 THE STRUCTURE OF THE ETHIOPIAN PUBLIC HEALTH SYSTEM	40
1.17 DEPLOYMENT AND RETENTION:.....	41
1.18 HOW THIS STUDY CAME ABOUT.....	41
1.19 JUSTIFICATION FOR THE STUDY	43
1.20 THE STUDY AIMS	44
1.21 THE RESEARCH QUESTIONS.....	44
2 LITERATURE REVIEW	45
2.1 MIDWIFERY EDUCATION AND CURRICULUM DEVELOPMENT.....	49
2.2 RECRUITMENT OF STUDENT MIDWIVES	52
2.3 MIDWIFERY EDUCATORS AND PRECEPTORS AND CLINICAL COMPETENCY	53
2.4 COLLABORATION AND MIDWIFERY EDUCATION IN AFRICA.....	58

2.5	DEPLOYMENT, MOTIVATION AND RETENTION OF MIDWIVES IN RURAL AREAS OF AFRICA	58
2.5.1	<i>Professional supervision in improving retention and motivation in rural areas</i>	59
2.5.2	<i>'Bonded' service programmes</i>	60
2.5.3	<i>Financial incentives to attract and retain midwives in rural areas</i>	61
2.5.4	<i>The enabling environment to retain midwives in rural areas</i>	63
2.5.5	<i>A 'sense of calling' to serve others in rural areas</i>	64
2.5.6	<i>Rural practice and professional autonomy and experience</i>	65
2.5.7	<i>Non-Financial incentives and support for working in rural areas</i>	65
2.5.8	<i>Other factors affecting attraction and retention in rural areas</i>	67
2.5.9	<i>Motivators, incentives and retention of midwives and health workers in LMIC outside of Africa</i>	67
2.5.10	<i>Conclusion</i>	69
3	METHODS	70
3.1.1	<i>The Study Aims</i>	70
3.1.2	<i>The Research Questions</i>	70
3.1.3	<i>The Methodology</i> :.....	71
3.1.4	<i>The Research Design</i> :.....	72
3.1.5	<i>Single study mixed methods design</i>	75
3.1.6	<i>Participant selection</i>	76
3.1.7	<i>Participant characteristics</i>	77
3.1.8	<i>Interview locations;</i>	78
3.1.9	<i>Selection of Health Facilities</i>	78
3.1.10	<i>Data Collection</i>	78
3.1.10.1	<i>The Qualitative Data collection</i> :.....	78
3.1.10.2	<i>The Quantitative data collection</i> :.....	80
3.1.11	<i>Data analysis</i>	80
3.2	ETHICAL CONSIDERATIONS.....	81
3.2.1	<i>Critical self-reflection:</i>	83
4	FINDINGS	86
4.1	THE QUALITATIVE DATA	86
4.2	AN OVERVIEW OF THE QUALITATIVE DATA	88
4.3	THE JOURNEY TO MIDWIFERY.....	90
4.3.1	<i>Gender and Education</i> :.....	93
4.3.2	<i>Motivation to become a midwife</i>	96
4.3.3	<i>Candidate selection for midwifery</i>	100
4.3.4	<i>Summary</i>	105
4.4	BECOMING A MIDWIFE, FROM NOVICE TO EXPERT.....	108

4.4.1	<i>The student phase in becoming a midwife</i>	111
4.4.2	<i>The graduate phase in becoming a midwife</i>	116
4.4.3	<i>Summary</i>	128
4.5	INNOVATION AND TRANSFORMATION	131
4.5.1	<i>Challenging gender inequality and a girls' right to self- determination</i>	133
4.5.2	<i>Innovative curriculum in the education of midwives</i>	134
4.5.3	<i>Enhanced midwifery deployment through the enabling environment</i>	150
4.5.4	<i>Community engagement for improved maternal health care</i>	153
4.5.5	<i>Summary</i>	162
4.6	THE QUANTITATIVE DATA	163
4.6.1	<i>The Health Centres</i>	163
4.6.2	<i>Supervision</i>	164
4.6.3	<i>Community awareness</i>	164
4.6.4	<i>Demographic information</i>	165
4.6.5	<i>Family Planning activity</i>	165
4.6.6	<i>Antenatal care</i>	169
4.6.7	<i>Births managed by the HCM midwives and referrals to the next level of care</i>	171
4.6.8	<i>Summary of the findings</i>	174
5	DISCUSSION	175
5.1	INTRODUCTION	175
5.2	KEY AREAS FOR DISCUSSION	178
5.2.1	<i>Educate girls – transform communities:</i>	180
5.2.1.1	<i>Early marriage and education</i>	183
5.2.1.2	<i>Midwifery as a career choice for girls</i>	186
5.2.2	<i>Innovative and supportive midwifery education</i>	186
5.2.2.1	<i>Deployment focused recruitment - a big picture approach</i>	188
5.2.2.2	<i>Midwifery centred, context specific curriculum</i>	189
5.2.2.3	<i>Early clinical engagement, competency and preceptorship</i>	191
5.2.2.4	<i>Problem Based Learning</i>	191
5.2.3	<i>The enabling environment</i>	193
5.2.3.1	<i>Peer support in midwifery</i>	195
5.2.3.2	<i>The role of the midwife supervisor</i>	195
5.2.4	<i>Innovative 'woman- centred' midwifery – transforming maternal health care in rural communities:</i>	196
5.2.5	<i>Rural communities – Transformation from within</i>	197
5.3	LIMITATIONS OF THIS STUDY	197
5.4	IMPLICATIONS FOR PRACTICE, POLICY AND EDUCATION	198
5.5	CONCLUSION	202

6	REFERENCES.....	203
7	APPENDICES	222
7.1	APPENDIX I: HAMLIN COLLEGE OF MIDWIVES - CURRICULUM OUTLINE	223
7.2	APPENDIX II: RESEARCH INFORMATION SHEET	253
7.3	APPENDIX III: RESEARCH CONSENT FORM.....	254
7.4	APPENDIX IV: UTS ETHICS APPROVAL LETTER	255
7.5	APPENDIX V:TABLE OF KEY ARTICLES FOR THE LITERATURE REVIEW.....	256
7.6	APPENDIX V: FAMILY PLANNING ACTIVITYFROM 2009-2010 AND 2010-2011	268
7.7	APPENDIX VII: HEALTH CENTRE ANTENATAL ACTIVITY FROM 2009-2010 AND 2010-2011.....	269
7.8	APPENDIX VIII: THE LABOUR AND BIRTH ACTIVITY DATA PRE AND POST DEPLOYMENT OF THE HAMLIN MIDWIVES ...	270

ABSTRACT

Background: In Ethiopia, a landlocked country in the horn of Africa, only 10% of women give birth with a skilled attendant and the health workforce meets an estimated maternal and reproductive need of only 32%. Midwives save lives, however most midwives live in cities, while 83% of the Ethiopian population live in rural areas. There is therefore an urgent need to scale up the number of midwives and deploy them where they are needed. The aim of this study was to examine the outcomes of a new midwifery educational and rural deployment model which was implemented at the Hamlin College of Midwives in Ethiopia.

Methods: A mixed methods design was used to investigate stakeholder experiences and associated health service and outcome data. A thematic analysis of qualitative semi structured interviews with students, new graduates and staff members of the College was undertaken. A descriptive analysis of selected health service data was also undertaken before and after the deployment of Hamlin midwives.

Results: Three major themes emerged from the analysis. These are: the journey to midwifery; becoming a midwife; and innovation and transformation. These themes revealed the challenges in accessing and pursuing education for rural girls, the transition academically, culturally and socially for midwifery students from rural areas, the passage of 'novice to professional' midwife as well as the emergence of professional midwives who are innovative and passionate advocates for women's health within their own communities.

Conclusion: Midwives who are recruited from rural areas, educated to fulfil the international competencies, thoughtfully deployed, supported and enabled with resources and referral networks can provide highly skilled, culturally sensitive woman centred care. Maternal health service usage and community engagement can be enhanced by the employment of local midwives who not only provide an important service but can be an agent of change through their action as a role model for girls, young women and their communities.

ABBREVIATIONS

Antenatal Care	ANC
Basic Emergency Obstetric Care	BEmOC
Evidence Based Practice	EBP
Ethiopian Federal Ministry of Health	EFMOH
Ethiopian Federal Ministry of Education	EFMOE
Emergency Obstetric Care	EmOC
Ethiopian Midwives Association	EMA
Higher Education Institution	HEI
High Income Country	HIC
International Confederation of Midwives	ICM
Intimate Partner Violence	IPV
Low Income Country	LIC
Millennium Development Goal	MDG
Maternal Mortality Rate	MMR
Midwives	Mw
Post-Partum Haemorrhage	PPH
Skilled birth Attendant	SBA
State of the Worlds Midwifery Report	SOWMy
Traditional Birth Attendant	TBA
United Nations Population Fund	UNFPA
World Health Organization	WHO

TABLES

Table 1: A comparison of the health status of woman in Ethiopia and Australia.....	27
Table 2:Literature review inclusion and exclusion criteria	48
Table 3: Participant Characteristics	77
Table 4: Demographic information.....	165
Table 5:Family Planning activity from 2009-2010 and 2010-2011	167
Table 6: Health Centre Antenatal activity from 2009-2010 and 2010-2011	170
Table 7: Summary table for labour and birth activity from 2009-2010 and 2010-2011	172
Table 8: A summary of percentage changes for family planning, antenatal care and births managed in the health centre	173
Table 9: Key areas for discussion	179

Table 1: A comparison of the health status of woman in Ethiopia and Australia.....	27
Table 2:Literature review inclusion and exclusion criteria	48
Table 3: Participant Characteristics	77
Table 4: Demographic information.....	165
Table 5:Family Planning activity from 2009-2010 and 2010-2011	167
Table 6: Health Centre Antenatal activity from 2009-2010 and 2010-2011	170
Table 7: Summary table for labour and birth activity from 2009-2010 and 2010-2011	172
Table 8: A summary of percentage changes for family planning, antenatal care and births managed in the health centre	173
Table 9: Key areas for discussion	179

FIGURES

Figure 1: A Hamlin College student Midwife on clinical placement.....	13
Figure 2: A description of the process of the single study research design.....	75
Figure 3: Mapping the journey to improving midwifery care	87
Figure 4: The journey to midwifery.....	89
Figure 5: The journey to midwifery - mind map	92
Figure 6: Becoming a Midwife, from Novice to Expert.....	107

Figure 7:The dynamics of becoming a midwife: Mind map.....	110
Figure 8: Innovation and Transformation	130
Figure 9: Key areas of Innovation and transformation.....	132
Figure 10:Total numbers of family planning consultations 2009-2010 & 2010-2011	168
Figure 11: Mean number of family planning consultations pre and post deployment of Hamlin Midwives	169
Figure 12:Total number of Antenatal Care (ANC) consultations pre and post deployment of the Hamlin College midwives	170
Figure 13:Mean Antenatal care consultations each month pre and post deployment of Hamlin College Midwives.	171
Figure 14: Number of births at each health centre pre and post deployment of the midwives 2010 – 2011	173
Figure 15: Mean number of births managed in each health centre pre and post deployment of the Hamlin Midwives	173

PREFACE: A VISIT TO A HEALTH CENTRE IN RURAL ETHIOPIA

The dust billowed from under the 4WD filling the cabin and our lungs as it negotiated its way along the pot-holed road. Our destination was a small village in the semi-arid and mountainous area of northern Ethiopia. Local health officials were accompanying us on a visit to assess the maternal health work in a rural health centre. Occasionally, we passed farming families walking to the weekly market; the women, donkeys and camels laden with produce and wood. At one point, our capable driver miraculously squeezed past an enormous boulder that had come to rest in the middle of the road, having recently rolled from higher up the mountain.

The new health centre stood out in the ancient village of stone tukals (traditional house). The young midwife, Alemnesh* greeted us and explained that a woman had given birth less than two hours previously. My midwife colleague and I asked if we could be of any assistance and permission was given by the new mother for us to enter the delivery room. We were encouraged to see the midwife assisting Mary* to breast feed her baby but confused to find her still lying on the very narrow delivery 'couch' and not on the more comfortable 'postnatal bed'. Alemnesh explained to us that at 34 years of age Mary was an 'old primip' and she feared that she would have a postpartum Haemorrhage (PPH) – because of this, Alemnesh had instructed Mary to lie flat with her legs crossed as she had been taught by an older nurse in the health centre. Despite her fear Alemnesh had not however examined the placenta, palpated Mary's uterus, checked her blood pressure, pulse, her blood loss or assisted Mary to empty her bladder, all of which are normal practice. Alemnesh's fear was compounded by not having many resources such as essential drugs, intravenous fluids or a means of transporting a woman in an emergency.

We gently worked together carrying out a full postnatal check and assisting Mary off the 'couch' to empty her bladder and wash. We discussed the normal postnatal physiological process and management along with the risk factors, signs and symptoms of a PPH. It was a privilege to work alongside Alemnesh and to witness her genuine care and concern for Mary and Mary's baby. Alemnesh had a passion for midwifery, the women of the area and was keen to learn and to share her own experiences.

Alemnesh explained that she felt anxious and stressed each time a woman came to the health centre as there had not been much work and she still lacked confidence with her skills. She also explained that as a student she had very little clinical instruction or experience and like many of her peers had graduated and was registered after having assisted with only two births. Alemnesh was not from the area where she was assigned and did not speak the local language; she felt that traditional beliefs, a lack of trust in her as an outsider and in modern medicine in general, prevented many women from coming to the health centre.

When it came time to leave, crying Alemnesh explained that this had been the first time since her graduation that she had worked with colleagues and she asked when we would come back to visit and work with her again.

Some months later we learnt that Alemnesh did not finish her 'service' in the health centre and like so many health workers in rural areas she moved to a city closer to family. Sadly the health centre was left without a midwife for more than a year after her departure.

*Names have been changed.

A personal account from a visit to a rural area in northern Ethiopia 2008

Note: Alemnesh was not a graduate from the Hamlin College of Midwives