Midwifery Education in Practice

Capacity building of midwifery faculty to implement a 3-years midwifery diploma curriculum in Bangladesh: A process evaluation of a mentorship programme

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ABSTRACT

When a midwifery diploma-level programme was introduced in 2010 in Bangladesh, only a few nursing faculty staff members had received midwifery diploma-level. The consequences were an inconsistency in interpretation and implementation of the midwifery curriculum in the midwifery programme. To ensure that midwifery faculty staff members were adequately prepared to deliver the national midwifery curriculum, a mentorship programme was developed. The aim of this study was to examine feasibility and adherence to a mentorship programme among 19 midwifery faculty staff members who were lecturing the three years midwifery diploma-level programme at ten institutes/colleges in Bangladesh. The mentorship programme was evaluated using a process evaluation framework: (implementation, context, mechanisms of impact and outcomes). An online and face-to-face blended mentorship programme delivered by Swedish midwifery faculty staff members was found to be feasible, and it motivated the faculty staff members in Bangladesh both to deliver the national midwifery diploma curriculum as well as to carry out supportive supervision for midwifery students in clinical placement. First, the Swedish midwifery faculty staff members visited Bangladesh and provided a two-days on-site visit prior to the initiation of the online part of the mentorship programme. The second on-site visit was five-days long and took place at the end of the programme, that being six to eight months from the first visit. Building on the faculty staff members’ response to feasibility and adherence to the mentorship programme, the findings indicate opportunities for future scale-up to all institutes/collages providing midwifery education in Bangladesh. It has been proposed that a blended online and face-to-face mentorship programme may be a means to improving national midwifery programmes in countries where midwifery has only recently been introduced.

1. Introduction

The midwifery profession, as defined by the International Confederation of Midwives (ICM) Global Standards (Fullerton, Thompson, Severino, & International Confederation of, 2011; ICM, 2008/2013), is new to Bangladesh (Bogren et al., 2016; Bogren et al., 2015). As a response to the Bangladeshi government’s commitment to introduce professional midwives, a three-year diploma programme in midwifery started in 2013, with an intake of 525 students in 20 nursing institutes/colleges; by 2016, it had expanded to 38 institutes/colleges with a yearly intake of 975 students (Bogren et al., 2017). Only qualified and experienced midwives, not nurses, should be midwifery faculty staff members, however, in Bangladesh in 2013, only a few nursing faculty staff members had received midwifery diploma-level (Bogren et al., 2016). The consequences were an inconsistency in interpretation and implementation of the midwifery curriculum in the midwifery programme (Frei et al., 2010). The transition from teaching nursing practice and science to teaching midwifery practice and science was deemed challenging (Bogren et al., 2016). Recognising that the capabilities of the midwifery faculty staff members would affect the development of the midwifery profession in Bangladesh it was evident that highly productive and qualified midwifery faculty staff members were required there. According to accreditation standards and depending on the content of the midwifery diploma-level programme in Bangladesh, those registered as a nurse, after the three-year diploma in nursing and one and a half year of

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advanced midwifery education, could be certified midwives as per ICM standards (ICM, 2008, 2013). Thus a one-year blended web-based master's degree in Sexual, Reproductive and Perinatal Health Care, running part-time over a period of two years, was offered by a Swedish University, to existing faculty staff members in institutes/collages where a midwifery diploma-level programme was introduced (Erlandsson et al., 2016). A mentorship programme was kept distinct from the master’s programme.

Mentorship has been identified as a relationship between an experienced and knowledgeable mentor assisting and supporting a less experienced mentee to develop professionally and personally. Mentoring is aimed to promote the development of an individual to be successful in the fulfilment of his/her tasks, reinforcing and strengthening his/her competence and self-confidence. It requires support by the mentor that will lead to the mentee achieving transition in work, knowledge, thinking, and personal and managerial effectiveness (Ebert et al., 2016; West et al., 2016; Yagzaw et al., 2015).

Entering practice often poses major challenges in any profession. It is a formative period where the competencies attained during an educational programme are put into real use. It is a transition period which can be stressful as well as challenging, as new demands are made upon individuals who aim to consolidate their skills. It is therefore a period in which a professional is in need of guidance and support in order to develop confidence and competence (Chen and Lou, 2014; Huybrecht et al., 2011; Jones et al., 2010). With this background, a mentorship module was developed in Pakistan setting that targeted community midwives (Sayani et al., 2017).

A wealth of scientific literature states that mentorship means guidance, reaching a certain goal together as mentee and mentor (Ebert et al., 2016; Yagzaw et al., 2015) and can be applied to mentoring midwifery faculty staff members (West et al., 2016) or midwifery students (Ebert et al., 2016; Yagzaw et al., 2015). In this study, mentorship is conceptualized as being a process that equips midwifery faculty members so that they become confident and competent in their roles as midwifery teachers in a midwifery diploma-level programme. To address the extensive demands that were placed on the midwifery faculty staff members, an online and face-to-face blended mentorship programme was introduced in March 2017. The aim of this study was to examine feasibility and adherence to a mentorship programme among 19 midwifery faculty staff members who were lecturing the three years midwifery diploma-level programme at ten institutes/collages in Bangladesh. We present a process evaluation focusing on the design, implementation, context and, mechanisms of impact and outcomes of a faculty staff members mentorship programme. The underpinning assumption was that capacity-building by experienced midwifery faculty staff members from countries where midwifery is well-established, would trigger the midwifery faculty staff members’ motivation to deliver the Bangladesh national midwifery curriculum with more confidence and higher quality.

2. Method

2.1. Design

A process evaluation, inspired by Moore and coworkers (2015), was conducted to examine the feasibility and adherence of a blended online and face-to-face mentorship programme offered to purposely selected midwifery faculty staff members. Both qualitative and quantitative data have been reported for this intervention (Polit and Beck, 2012). In this study, the terms: teachers, participants and mentees are used interchangeably, referring to the Bangladeshi midwifery faculty staff members. The term “midwifery education” refers to a three-year midwifery diploma-level programme.

2.2. Study setting

Using a census sampling method (Polit and Beck, 2012) based on findings from a JHPIEGO needs assessment (JHPIEGO, 2016), the study was conducted among 19 midwifery faculty staff members at ten public institutes/collages out of 38 providing the three-year midwifery diploma programme. Each institute/college had 25 to 50 midwifery students per year. Sixty percent of the midwifery education took place in clinical setting, mostly at tertiary levels and district level hospitals. All 19 midwifery faculty staff members, one to two from each educational site, were master’s students in Sexual, Reproductive and Perinatal Health from a Swedish university. They were invited to be involved, and agreed to take part in the mentorship programme and to become mentees to two Swedish midwifery faculty staff members. Their work experience as nurses varied from fewer than five years to more than thirty years. More than 50% were above the age of 45, and all were master’s degree holders in nursing or public health. They functioned as didactic and clinical educators for midwifery students.

3. Material

To follow the process evaluation framework (Moore et al., 2015) a structured questionnaire was developed (Polit and Beck, 2012). The questionnaire, issued in English, was developed by researchers at the Swedish university. It was designed based on a literature review building on previous research on adherence to midwifery faculty staff members’ capabilities (McAllister and Flynn, 2016), and to pedagogical and student learning styles (West et al., 2016). The questionnaire was assessed for the content validity of each item based on relevance, clarity, simplicity, and ambiguity by the researchers. According to feedback from midwifery faculty staff members at the Swedish university, with teaching and research experience from Bangladesh, necessary modifications for further clarification were made (Polit and Beck, 2012).

This questionnaire consisted of a self-reported rating scale comprising 77 closed-response alternatives to be completed on adherence to the statement using a five-point Likert scale (Polit and Beck, 2012). The Likert scale alternatives were 1) strongly disagree, 2) disagree, 3) neither agree nor disagree, 4) agree and 5) strongly agree to a particular statement. The average for each response alternative was calculated and classified into levels of midwifery faculty staff members’ adherence to pedagogical and student learning styles. The questionnaire ended with the following open questions: “What are the most beneficial aspects of a mentorship programme?” and “In what areas of midwifery is mentorship mainly required?”

The Swedish midwifery faculty staff members mentored their Bangladeshi colleagues and used field notes from site visits and during each online mentorship session they focused content, feasibility and adherence to the mentorship programme. At the follow-up visits to the ten institutes/collages, the communication between the Swedish mentors and the 19 Bangladeshi mentees focused on the content and structure of the mentorship programme and the way forward.

3.1. Data collection procedure

The mentorship program took place during a period of eight months in 2017. Data were collected throughout the period, building on the questionnaire and field notes. The full schedule and layout are presented in Table 1. Data were kept in a computer belonging to the Swedish university accessible using personal codes. Only the Swedish midwifery faculty staff members involved in the mentorship programme had access to the data.
Table 1
Full schedule and layout of the mentorship programme.

<table>
<thead>
<tr>
<th>Section</th>
<th>Content</th>
<th>Causal assumption</th>
</tr>
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<tbody>
<tr>
<td>Initial visit in Bangladesh</td>
<td>Day 1</td>
<td>Meetings with faculty and managers at the institute</td>
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<td></td>
<td></td>
<td>- Discussions regarding curricula implementation</td>
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<td></td>
<td>- Assisting the individual faculty members on their present need for support</td>
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<td>- Meetings with the management of the institute/college and assessing the need for support regarding development of documents, in-service training, guidelines etc</td>
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<td></td>
<td>Day 2</td>
<td>Meetings at the clinical site</td>
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<td></td>
<td>- Meetings with managing director of the hospital about the mentorship program and the need for implementation of the Midwifery Diploma Curricula at the clinical site</td>
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<td>- Meetings with clinical staff supervising midwifery students</td>
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<td></td>
<td>- Meetings with students from 1st to 3rd year</td>
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<tr>
<td>Net-based mentorship</td>
<td>Session 1-25</td>
<td>Supporting faculty in implementing the deductive and clinical course syllabuses in classroom teaching, skills lab sessions and in clinical setting</td>
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<td></td>
<td></td>
<td>- Create awareness of the midwifery curriculum and expectations of their own clinical supervision and expectations on the hospital staff’s supervision</td>
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<td>- Ensure students’ assessment tools are functioning in clinical setting and follow the implementation of these assessment tools</td>
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<tr>
<td>Follow up mentorship visits in Bangladesh</td>
<td>Day 1</td>
<td>Meet with the principle and with the manager at the at the clinical site to request a time and place for a sensitization meeting</td>
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<td>Plan with the mentees for sensitization meeting with hospital managers and staff</td>
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<td></td>
<td>Day 2</td>
<td>Attend or prepare class room teaching and/or skills lab sessions, giving feedback and input regarding teaching methodologies</td>
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<td></td>
<td>Day 3</td>
<td>Perform sensitization meeting with midwifery faculty, hospital staff and managers: The mentees present power points on “Midwife and her scope of practice” and “Content of the 3-years midwifery curricula and implementation”</td>
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<td>Day 4</td>
<td>Visit to clinical sites together with mentees and in personal communication motivate and orient hospital staff on students’ learning outcomes and assessment tools</td>
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<td></td>
<td></td>
<td>Visit to clinical sites together with mentees providing input regarding the mentees clinical supervision and assessment of midwifery students</td>
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<td></td>
<td>Day 5</td>
<td>Make a development plan for each of the mentee and way forward for the mentoring and mentee relationship</td>
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<td>Performing individual interviews</td>
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3.2. Analysis

Responses to the closed-response alternative in the questionnaire were analysed with descriptive statistics, using SPSS version 20. The results were presented as mean (m) to inform the process evaluation framework component mechanism of impact (Moore et al., 2015). The answers from the open questions in the questionnaire and field notes were analysed with content analysis (Elo and Kyngas, 2008). The data were read and coded to form two categories based on similarities and differences in the text, namely: (i) facilitators and challenges in implementing the three-year midwifery curriculum, and (ii) content and structure of the mentorship programme. The emerging findings from the first (i) category informed the component mechanisms of impact and the second (ii) category informed the outcome. Remaining data informed the implementation and context components (Moore et al., 2015).

3.3. Ethical considerations

Approval for the research was obtained from the Director General, Directorate General of Nursing and Midwifery, Bangladesh. Written informed consent was obtained from the midwifery faculty staff members before they participated in the study (National Commission for the Protection of Human Subjects of Biomedical Behavioral Research, 2014).

4. Results

The findings are presented building on the process evaluation framework: implementation, mechanisms of impact, context and outcomes (Moore et al., 2015).

4.1. Implementation

As indicated, the mentorship programme was delivered to the selected mentees. The first visit was a two-day on-site visit prior to the initiation of the online part of the mentorship programme. The second visit was a five-day on-site visit at the end of the programme. The second on-site visit took place after six to eight months after the first visit.

Between visits, the Bangladeshi and the Swedish midwifery faculty staff members met online using an online chat forum that allowed for screen-sharing and chatting. Two Bangladeshi faculty staff members from each institute/college met 25 times in 1 h face-to-face sessions. Headphones and USB network adapters were provided to the Bangladeshi faculty staff members to ensure they could access the Internet and also to ensure good audio quality. The mentorship sessions took place in a silent room at their respective workplaces.

Each online session was prepared following the structure of the midwifery diploma curriculum. The reason for this structure was to orient the midwifery faculty staff members as to the content, sessions and various pedagogical methods and assessment tools. An introductory PowerPoint presentation scheme covering the curricula and syllabus...
while lecture plans and teaching and learning tools were developed and presented. The assessment of the clinical progression from year one to three of the diploma-level programme for the midwifery students was discussed and reflected upon. The PowerPoint presentations were aimed to support critical thinking and decision-making; thus motivating the midwifery faculty staff members to deliver the midwifery curriculum and take on responsibilities for the students' learning. Briefing, communication, debriefing and implementation of theory into practice were meant to enhance individual development. Individual development plans were developed during the second visit based on needs (Table 1).

4.2. Mechanisms of impact

Findings based on survey data from programme implementation, and quantitative and qualitative data strengthened each other and contributed proportionally in this process evaluation framework (Moore et al., 2015). Under this sub-heading, participants' rating of the importance of adherence to the content of the mentorship programme will be presented. Moreover, qualitative data from the open-ended questions in the questionnaire and field notes are presented under the category Facilitators and Challenges in Implementing the Three-Year Midwifery Curriculum.

As shown in Fig. 1, the participants commonly agreed on the importance of teachers' preparation for students' clinical practice including skills labs and clinical teaching. (Fig. 1 here). As shown in Fig. 2, the participants commonly agreed upon the importance of enhancing the students' analytical skills, their implementation skills through experiences, and their ability to find teaching and learning material outside the classroom. Problem-solving strategies, discussions and debates assimilate the experiences gathered outside class into a learning situation within class. This is called flipping the classroom. As such, the midwifery faculty staff members were motivated to use a range of different pedagogical styles to disseminate knowledge about midwifery to the students. (Fig. 2 here).

4.3. Facilitators and challenges in implementing the three-year midwifery curriculum

Close and trustful communication between midwifery faculty staff members and staff at the clinical sites was seen as the main facilitating factor for midwifery students to achieve the learning outcomes. Yet, the main challenge according to the midwifery faculty staff members was communication between the educational institutes/collages and the clinical sites. This was explained as follows: “the educational institutes must have a system in place to inform the superintendent, nursing supervisor and ward in charge at the clinical sites about the midwifery students' rotation plan for clinical placements and learning outcomes of the course”.

Some of the participants expressed the fact that mentorship played a vital role in the delivery of the curriculum at the classroom level as well as in the supervision and assessment of the midwifery students in clinical settings. As articulated by one faculty staff member: "Mentorship is required to improve clinical practice, enhance professionalism, ability to teach skill lab sessions, and increase the ability to deliver evidence-based knowledge both for midwifery faculty staff members and clinical supervisors".

A main challenge in delivering the midwifery curriculum was to apply evidence-based practices as articulated in the curriculum due to the lack of such clinical practice in Bangladesh. For example, the use of graphic recording was seldom used to detect the progress of labour or the heartbeat of the foetus. One midwifery faculty staff member reported that “Partograph is seldom used in clinics, and family planning counselling is not provided by midwives”. To compensate for the lack of common practice of certain evidence-based skills, the midwifery faculty staff members provided skills lab sessions. "I visit my students in clinical placements weekly and have attended deliveries with them. Midwifery-led normal birth must be in focus and if not, we must ensure it is in skills lab simulations".

The midwifery faculty staff members supported each other with ideas for how skills lab sessions could be improved so that they could best deliver the curriculum. They started reflecting on their own teaching situation by asking how the students could be encouraged to use the teaching and learning resources included in the curriculum, and how these resources could be used in a more effective way to enhance student learning. One example was that they sent articles and links to each other in order to inspire each other.

The mentorship sessions motivated the midwifery faculty staff members to ensure that checklists, logbooks and portfolios were in place for each student. "Checklists, logbooks and portfolios are now applied to ensure student performance". Rotation plans (labour ward, neonatal ward, gyn outdoor clinic) were the routes to ensure curriculum implementation at the clinical sites. The midwifery faculty staff members reflected on professionalism, information, communication, etc. They believed students should be encouraged to reflect on these areas as a means to strengthen midwifery evidence-based care.

Fig. 1. Midwifery faculty's adherence to statements of importance on how they produce knowledgeable midwives, understanding the field of midwifery in depth (mean value).
4.4. Context

The understanding of the context influences the intervention, according to Moore et al. (2015). Thus, it may influence the implementation and outcome of the mentorship program. A main facilitator to provide a midwifery-diploma-level program in Bangladesh was that in 2010, the Prime Minister made a call to introduce the new profession according to global standards. Since then a three-year midwifery curriculum has been developed, as has a six-month advanced midwifery education for existing nursing faculty members, which opens up for the opportunity to become a midwifery faculty staff member and to gain a master’s degree in Sexual, Reproductive and Perinatal Health from a Swedish university (Erlandsson et al., 2016).

Governmental steering documents and policies have been developed; for instance, the midwifery act and standard operation procedures for midwifery diploma-level programmes and practice (Bangladesh Nursing Council, & Services, Directorate of Nursing, 2014; Ministry of Health and Family Welfare, 2016). This development comes with incentives. Faculty staff members teaching the midwifery programme received additional incentives compared with nursing faculty staff members who taught only in the nursing education programme. However, the mentorship programme did not bring with it any personal incentives to the Bangladeshi mentees.

As midwifery faculty staff members can also lecture nursing, a barrier might be the workload that comes with teaching both the midwifery diploma-level and nursing programmes. Poor internet connection and inadequate English skills might also serve threats to the delivery of the mentorship programme.

4.5. Outcomes

It was felt by the mentees that the content of the mentorship programme would have been more beneficial if more colleagues had been able to take part in the sessions that were held. A beneficial aspect of the online mentorship was that technology was available for use along with technical support from the Swedish university. Another beneficial aspect was that the latest evidence-based research related to midwifery and its profession was received by the Bangladeshi mentees, provided by the Swedish mentors.

Some of the midwifery faculty staff members described how online mentorship was considered to be a more effective way to deliver the content of the curriculum compared to only on-site coaching. The reason for this was that it saved time, and that there was less interference in their daily working lives. One faculty staff member stated that “Online mentorship is really challenging, but we will overcome it, and an online mentorship programme can improve the competence of midwifery faculty staff members”. However, computers and access to the Internet were prerequisites to its success. One challenge was inadequate and non-availability of electricity and Internet facilities. At the end of the mentorship programme, one mentee expressed her appreciation of being included in the mentorship programme “We need our online mentorship sessions, ma’am.”

The midwifery faculty staff members often came to the next mentorship session and reported that the Power Point presentations used during previous online mentorship sessions added value to their own teaching and correspondence with students and colleagues. In addition, the mentorship sessions motivated them to ensure the progress of midwifery students’ clinical skills through the monitoring of their logbooks and checklists. The midwifery faculty staff members reported on how they had become more responsible and engaged in curricula implementation. “We talked with the government yesterday; we talk with colleges about what subjects have been brought up in the mentorship sessions”. In the mentorship sessions, women’s reproductive health and rights in Bangladesh was repeatedly being brought up for discussion. As such, reflective thinking was a real thread through the implementation of the mentorship programme. “I understand how important evidence-based midwifery is now and I have the ability to reflect on it”.

5. Discussion

This mentorship programme was implemented with minor modifications from one institute/college to another based on needs. It not only triggered the motivation on the part of the Bangladeshi faculty staff members to deliver the national three-year midwifery diploma curriculum in classroom and skills lab teaching, but also generated motivation in providing supportive supervision for midwifery students in clinical settings. The intervention has been judged to be feasible and to enhance the ability to educate midwives so that they acquire the appropriate skills and competences as per ICM global standards (ICM, 2008/2013).

When a midwifery diploma-level programme according to global standards, was introduced in 2010 in Bangladesh, only a few nursing faculty staff members had received midwifery diploma-level education. Given the importance of the role of midwifery faculty staff members in delivery of the national three-year diploma midwifery curriculum in Bangladesh, this process evaluation illustrates that preparation of midwifery faculty staff members is essential when introducing professional midwives. In line with the literature, educators require a broad
range of teaching and learning strategies. Various interventions related to teaching and learning strategies have thus been taken into consideration in building the professional competence of midwifery educators (West et al., 2016; WHO, 2013). As such, the findings from this process evaluation derive from participants’ involvement at each step of the process, while international ‘experts’, Swedish midwifery faculty staff members and technical support staff members, provided contextualised support.

The mentorship programme, using a blended online approach, was shown to be a feasible intervention. Therefore, in line with other studies (Dawson et al., 2016; West et al., 2017), the implementation of such a programme will contribute to minimizing the gaps in the ability of midwifery faculty staff members to deliver a midwifery curriculum with greater confidence and quality. The expectation is that support to midwifery faculty staff members in the delivery of the learning outcomes could be of direct benefit to the midwifery students.

The participants in this study agreed on the importance of teachers preparing the students for clinical placement. Support during clinical placement and communication between the educational institutes/collages and the clinical sites were both deemed important. The faculty staff members support to the midwifery students in their clinical placements is therefore highly relevant for providing quality midwifery education. As such, a direct result of the increase in professional competence of midwifery faculty staff members improves the students’ clinical experience (Dawson et al., 2016). According to the participants in this study and in terms of capacity building of the Bangladesh midwifery faculty staff members, the mentorship programme played a vital role for the ability of the midwifery faculty staff members to deliver the curriculum in the classroom and in clinical placements.

In countries where midwifery as a profession is new, and where mentors with the necessary midwifery qualifications do not exist, mentors from a country where midwifery has a strong tradition can function well, as described in this process evaluation. This is supported by Luyben et al. (2017), where an international clinical mentorship programme for private midwifery education was considered successful. As a response to the Bangladesh government’s commitment to enable midwifery faculty staff members to educate a world-standard midwifery workforce (Dawson et al., 2016; West et al., 2017), one way could be an interculturally blended mentorship programme for the midwifery faculty staff members. Their positive response to the design and the implementation process of this mentorship programme indicate opportunities for future scale-up.

5.1. Limitations

This study reports findings from only 19 midwifery faculty staff members from ten out of 38 public institutes/collages. Further, the process evaluation includes numerous factors that may have influenced the outcomes. Given the fact that Bangladeshi midwifery faculty staff members were already enrolled in the master’s degree programme at a Swedish university, they may not have been representative of all midwifery faculty staff members in the country. As the questionnaire was developed in English, there might also have been a language barrier. The mentorship programme was implemented by experienced international midwifery faculty staff members from a country where midwifery as an independent profession has a long-standing and strong tradition (Byrskog et al., 2015). As such, very different from Bangladesh. Further, the data collector was one out of two mentors, and lectured in the master’s teacher education. Thus, potential dependability (Polit and Beck, 2012) might have existed between mentor and mentee, and this might have influenced the evaluation of the mentorship programme. Keeping these limitations in mind, the findings can still serve as a valuable contribution for future planning, expansion and implementation in similar contexts.

6. Conclusion and clinical implication

A blended mentorship programme, with mentorship sessions on line and on site, was a feasible and acceptable way to support midwifery faculty staff members in their understanding of the full scope of midwifery practice and their delivery of the midwifery diploma curriculum in Bangladesh. It is therefore suggested that a blended mentorship model, after contextualizing, could be replicated in other countries that are moving towards educating a new midwifery workforce according to global standards. A mentorship programme is a possible approach for strengthening a national midwifery programme in countries where midwifery has been recently introduced. It is qualified and experienced midwives, not nurses, who should be teaching midwifery programmes, and the midwifery education needs recognition in Bangladesh.

Conflicts of interest

None.

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Appendix A. Supplementary data

Supplementary data related to this article can be found at http://dx.doi.org/10.1016/j.nepr.2018.02.006.

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