

How can Midwifery Education in Indonesia be Strengthened?

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Abstract

The aim of this study was to explore the experiences of midwives, midwifery lecturers, midwifery students, newly graduated midwives, and obstetricians, regarding what may strengthen midwifery education in Indonesia. This included identifying the barriers and enablers to strengthening midwifery education leading to competent and confident midwifery graduates.

A qualitative descriptive method was used to answer the research question: how can midwifery education be strengthened in Indonesia? Ethical approval was granted from AUTC, New Zealand and HREC, Indonesia. Data were collected from 37 participants: Indonesian midwives, midwifery lecturers, midwifery students, newly graduated midwives, and obstetricians. The participants were recruited from 12 midwifery schools in eight cities situated in six provinces in Indonesia, between August 2016 and January 2017. Thematic analysis of the data obtained from face-to-face in-depth interviews was conducted regarding the views surrounding midwifery education. Bolman and Deal's Four Frames framework was utilised to add depth and a further layer of analysis to the data.

Four key findings were identified: 1) midwifery teaching and learning of theory; 2) midwifery clinical experience; 3) structural and external factors; and 4) the Midwifery Act 2019. The application of the theoretical framework of Bolman and Deal's Four Frames to these findings articulated further the complexity of and tensions in what was already known to strengthen midwifery education in Indonesia, and include setting up a Midwifery Council. These findings are significant in light of the need to provide educated, confident midwives and midwifery services across Indonesia as called for by the United Nations Millennium Summit 2016 and the Sustainable Development Goals 2030.

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Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning."



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Ethics Approval

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Glossary

Amd.Keb:	Ahli Madya Kebidanan/ Expert in Midwifery
APN:	Asuhan Persalinan Normal (training standard of the delivery care)
BAN-PT:	Badan Akreditasi Nasional Perguruan Tinggi (The National Accreditation Body Colleges)
BAPPENAS:	Badan Perencanaan Pembangunan Nasional (National Development Planning Agency)
BKKBN:	Badan Kependudukan dan Keluarga Berencana Nasional (The National Population and Family Planning Board)
BPS:	Biro Pusat Statistik (Bureau of Statistics)
CPD	Continuing Professional Development
DFID:	Department for International Development
DIII:	Diploma of Midwifery
DIV:	Advanced Diploma of Midwifery
EMAS:	Expanding Maternal and Neonatal Survival
HIV/ AIDS:	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HREC:	Health Research Ethics Committee
IBI:	Ikatan Bidan Indonesia (Indonesian Midwives Association)
ICM:	International Confederation of Midwives
Kemendes RI:	Kementerian Kesehatan Republik Indonesia (Ministry of Health Republic of Indonesia)
KKNI:	Kerangka Kualifikasi Nasional Indonesia (Indonesian Qualification Framework)
LAM-PTKes:	Lembaga Akreditasi Mandiri Pendidikan Tinggi Kesehatan Indonesia (the Indonesian Accreditation Agency for Higher Education in Health)
MDGs:	Millennium Development Goals
M.Keb:	Magister Kebidanan/ Master of Midwifery
S.Keb, Bd:	Sarjana Kebidanan/ Bidan (Bachelor of Midwifery/ B.Mid)
SDGs:	Sustainable Development Goals
WHO:	World Health Organization
UN:	United Nations
UNFPA:	United Nations Population Fund
UNICEF:	United Nations Children's Fund

Chapter 1.

Introduction

1.1 The research question and aims of the study

This study explores how midwifery education in Indonesia can be strengthened. Midwifery education has a pivotal role in developing and assisting students to become competent and confident midwives. The International Confederation of Midwives (ICM) (2017a), defines pre-service, pre-registration midwifery education as the “process of preparing midwifery students to meet the educational qualifications and acquire the competencies required for entry to the midwifery profession through midwifery registration/ licensure” (p. 6). The ICM (2017a) defines competence as “the combination of knowledge, psychomotor, communication and decision-making skills that enable an individual to perform a specific task to a defined level of proficiency” (p. 3). Further, the ICM refers to a midwife as

“a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognised in the country where it is located; who has acquired the requisite qualifications to be registered and/ or legally licensed to practise midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery”. (p. 4)

To better understand how midwifery education can be enhanced in Indonesia, a qualitative descriptive investigation was conducted that aimed to answer the following question:

“How can midwifery education in Indonesia be strengthened?”

The Oxford English Dictionary (Oxford University, 2015) provides the following definition of strengthening: “to become stronger, to make something stronger”. Like any system, midwifery education can be improved, and this study seeks to understand the ways to make midwifery education in Indonesia stronger and better.

The aims of the research are to:

1. Explore the experience of midwives, midwifery lecturers, midwifery students, newly graduated midwives, and obstetricians, regarding what can strengthen midwifery education in Indonesia.
2. Identify the barriers and enablers to strengthening Indonesian midwifery education leading to competent and confident midwifery graduates.

The research question and aims of this study have been explored with a focus on education, social science, and health policy, all of which impact on midwifery education in Indonesia.

1.2 Reasons for undertaking the study

Internationally, there is significant concern regarding the quality of midwifery care in many developing countries, in particular, South-East Asia. The majority of maternal and neonatal deaths occur in developing countries, such as Indonesia (World Health Organization [WHO], UNICEF, United Nations Population Fund [UNFPA], & The World Bank, 2012). Midwifery care has been shown to be the most effective and efficient way to decrease maternal and neonatal mortality (Renfrew et al., 2014; Utz & Halim, 2015). It is said that midwifery education is a vital element that contributes to ensuring quality midwifery care (Renfrew et al., 2014; Thompson, Fullerton, & Sawyer, 2011; UNFPA, ICM, & WHO, 2014). The ICM (2010, 2013, 2014) and the WHO (2009, 2011, 2013a, 2016a, 2017b) have all recently published documents outlining the importance of midwifery education. The ICM (2010) pointed out that one of the pillars of midwifery, along with association and regulation, is midwifery education. Sound midwifery education has been associated with competent and skilled midwives which in turn impacts on maternal and neonatal mortality and morbidity rates (Homer et al., 2014; Renfrew et al., 2014; Rokx et al., 2010; ten Hoop-Bender et al., 2014; Van Lerberghe et al., 2014). Evidence has revealed that midwifery with both family planning and interventions for maternal and neonatal health could prevent a total of 83% of all maternal deaths, stillbirths and neonatal deaths (Homer et al., 2014). However, newly graduated midwives in middle-income countries face a myriad of challenges, such as feeling less confident, and they may have fewer opportunities for hands-on clinical practice (UNFPA et al., 2014).

In many countries in South-East Asia, such as Indonesia, there has been significant investment in educating student midwives with the development of midwifery education. Rokx et al. (2010) and Anderson, Meliala, Marzoeki, and Pambudi (2014) researched the quality of midwives and midwifery care in Indonesia and found that many are not practising at the required standard for midwives. Furthermore, Hennessy, Hicks, Hilan, and Kawonal (2006) found that the majority of midwives (60%) provide less than optimal care in Indonesia. The researchers pointed out that it is essential to monitor and optimise the quality of the healthcare in Indonesia by improving midwifery education (Anderson et al., 2014; Hennessy, Hicks, & Koesno, 2006; Rokx et al., 2010). Indonesia has seen a proliferation of midwifery schools. In previous decades, the Indonesian Government took the initiative, building a system of midwifery schools producing graduate midwives to address the high maternal and neonatal mortality rate.

Despite the increased number of schools and graduates, the expected drop in the maternal and neonatal mortality rate has not been seen in Indonesia (Hogan et al., 2010; WHO et al., 2012). Indonesia did not meet the goal of a three-quarters reduction in maternal mortality rates during the Millennium Development Goals (MDGs) period (2000 – 2015) (Biro Pusat Statistik, BKKBN, Kemenkes, & ICF International., 2013; WHO, 2012a). The challenges of midwifery education in Indonesia became more significant in ensuring midwifery services meet the targets of the new Sustainable Development Goals (SDGs) for the period 2016 – 2030 as stated in the United Nations Millenium Summit (United Nations, 2017; WHO, 2015b).

In the Indonesian context, midwifery students in Diploma of Midwifery programmes attend for six semesters, and there is a specific period for clinical placements during this time. Once midwifery students have completed all examinations and requirements during their three-year midwifery programme, they need to sit a national competency test to get a competency certificate. In 2013, this national competency test for graduate midwives was a new concept for midwifery education in Indonesia. At the time of writing this thesis, the national competency test left many questions unanswered when this test was first seen for Diploma of Midwifery programmes. In Indonesia, there are various midwifery programmes, such as Diploma, Advanced

Diploma and Bachelor of Midwifery programmes. A competency certificate is “a must-have document” to apply for registration as a midwife in Indonesia. The national competency test to improve the quality of midwifery education by standardising the competency of newly graduated midwives was developed initially by the Ministry of Research, Technology and Higher Education (Health Professional Education Quality, 2014). Further information regarding a national competency test will be discussed in the overview of midwifery education in Chapter Two. As such, the national competency test is a significant part of midwifery education in Indonesia. However, the quality of midwifery education in Indonesia is questioned, as stated in the quote below:

“Recently, the quality of midwives in Indonesia tends to be lower than some years ago. This should not happen because of the critical role midwives play in reducing the maternal mortality rates in Indonesia. The number of midwives passing the final midwifery competency test was low which shows the decrease in the quality of midwifery education”. (“Kualitas bidan menurun?”, 2014; Widiyani, 2014)

The quote, was published in *Kompas Newspaper* on January 31, 2014, and the *Midwifery Magazine* on March 23, 2014, and reflects the Ministry of Health of the Republic of Indonesia’s discussion of the national competency test held at the end of 2013. At that time, the Ministry of Health did not reveal the exact number of midwives who had passed the national competency test. However, the editor of *Midwifery Magazine* later published the results of the midwifery competency test which showed that of the 3,171 candidates completing the midwives competency test in Java, 40% did not pass (“Kualitas bidan menurun?”, 2014). Two years later, the issue surrounding the quality of midwives in Indonesia was again discussed in *Midwifery Magazine* (“Ketua IBI NTT ragukan kualitas bidan”, 2016). Since 2015, the national competency test for the Diploma of Midwifery programmes has had fluctuating pass rates, as shown in figure 1.1 below. Although the Ministry of Health specified the need for improvement in midwifery education in Indonesia (“Ketua IBI NTT ragukan kualitas bidan”, 2016), it seemed that in the government and public domain, such as in newspapers and magazines, there was doubt about the quality of midwives in Indonesia (“Ketua IBI NTT ragukan kualitas bidan”, 2016). Indeed, Emi Nurjismi, President of the Indonesian Midwives Association, explained that midwives in

Indonesia are the backbone of the successful national health programme (Indonesian Midwives Association, 2015). There was evidence that the quality of midwives was deteriorating. *Kompas Newspaper* (Widiyani, 2014) reported that this deterioration resulted from a lack of supervision of the midwifery programme.

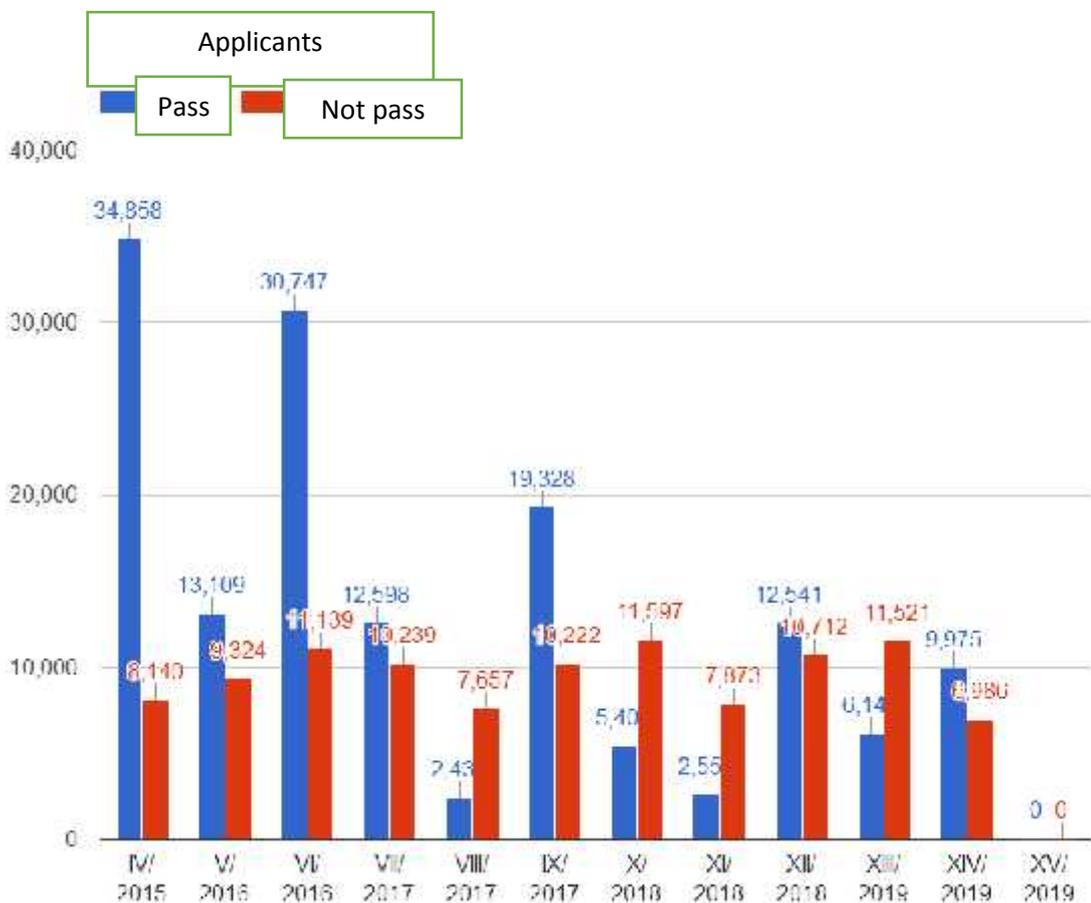


Figure 1.1 Statistics of the national competency test (Ristekdikti, 2019)

High-quality midwifery education is essential in developing competence, and is indispensable in ensuring competent and confident newly graduated midwives who are fit to practice (Ball, 2012; Carolan, 2011, 2013; ICM, 2010; Middleton, 2013; Power, 2016). Furthermore, midwifery education plays a pivotal role in producing qualified graduate midwives who, if well resourced, can potentially make a difference in maternal and neonatal mortality (Brodie, 2013; Thompson et al., 2011). There is recent evidence that having more midwives, and better quality of midwives through the investment in midwifery education, would enhance women's access to midwifery services and quality maternal and neonatal care in lower-middle-income countries (ten Hoop-Bender et al., 2014), of which Indonesia is one. Moreover, quality midwifery care plays a pivotal role in reducing stillbirth and preterm birth, decreases unnecessary

interventions (Hodnett, Gates, Hofmeyr, & Sakala, 2013; Renfrew et al., 2014), and improves maternal and neonatal health (Bogren, Wiseman, & Berg, 2012).

The rationale for doing this research is to provide insight into what can strengthen midwifery education in Indonesia. Effective midwifery education is critical to ensuring competent and confident graduates and is associated with the improvement of maternal and neonatal health. Therefore, quality midwifery education seems crucial to developing excellent newly qualified midwives. Specifically, it is vital for midwives to be competent (defined as the combination of knowledge, psychomotor, communication, and decision-making skills that enable an individual to perform a specific task to a defined level of proficiency) (Fullerton, Ghérissi, Johnson, & Thompson, 2011; ICM, 2017a; McMullan et al., 2003; Milligan, 1998) in order to efficiently and safely offer services to women and family. While the government and the professional organisation in Indonesia have implemented quality assurance processes for the accreditation of midwifery programmes, there have been no studies to evaluate whether such processes have strengthened midwifery education in Indonesia. Therefore, this research seeks to explore the experience of midwives, midwifery lecturers, midwifery students, newly graduated midwives, and obstetricians, and identify what the barriers and enablers are to strengthening midwifery education leading to competent and confident midwifery graduates.

The significance of this study is in enhancing midwifery education in Indonesia which will lead to having well-educated midwives who make a difference to the health and well-being of mothers and babies, and will result in decreased maternal and neonatal mortality as it has in other countries (Renfrew et al., 2014; Utz & Halim, 2015; WHO, 2011). This research can potentially improve care and services for childbearing women through strengthening midwifery education; and enhance regulation and legislation (Day-Stirk & Fauveau, 2012; Horton & Astudillo, 2014; Sakala & Newburn, 2014). It is vital that Indonesia produces research that demonstrates how to strengthen its midwifery education as the quality of graduates is one of the elements which can contribute to improved maternal and neonatal health (Brodie, 2013; Sakala & Newburn, 2014). The findings of this study potentially have a meaningful and unique contribution to make to the development of midwifery education in Indonesia; and

also hold the possibility of reinforcing the significance of midwifery education in other developing countries in South-East Asia where the majority of maternal and neonatal mortality occurs (WHO et al., 2012a, 2012b). The knowledge from this study has implications for and relevance to future midwifery education globally.

1.3 The context of the research setting in Indonesia

The Republic of Indonesia, known as a string of emeralds on the equator, with the capital city Jakarta (Jakarta Special Capital Region), is located in South-East Asia, between the Indian and Pacific Oceans (Central Intelligence Agency, 2015). Geographically, Indonesia is the world's largest archipelago country. It has more than 17,000 islands including Sumatera, Java, Kalimantan, Sulawesi, and Papua. Java is the most populous and most developed of these islands. There are 30 groups of smaller islands, with an area of around 5.1 million square kilometres in total (Maps of World, 2016; United Nations, 2012b). It is a multicultural nation, with a population of approximately 256 million people scattered across 34 provinces; and each province has its local government and capital city. Indonesia, being the fourth-most populous country in the world, after China, India, and the United States of America (Central Intelligence Agency, 2015), form 3.46% of the world population. Administratively, all provinces in Indonesia consist of 514 districts, 98 municipalities, 7,094 sub-districts, 8,412 administrative villages (*kelurahan*) and 74,093 villages (Biro Pusat Statistik et al., 2013; Ministry of Health Republic of Indonesia, 2016). People live in a variety of settings within its borders, stretching from the densely populated urban areas and the glimmer of lights on the island of Java to the sparsely populated rural and remote islands of Papua. Indonesia is a tropical country which straddles the equator. Indonesia contains the most active volcanoes of any country in the world, and more than 80% of the territory is covered with water. Figure 1.2 below gives some geography of the country.



Figure 1.2 Map of the Republic of Indonesia (2019)
Source: <http://www.freeworldmaps.net/asia/Indonesia/>

Indonesia is a multicultural country with more than 350 ethnicities and around 700 local languages (Ananta, Arifin, Hasbullah, Handayani, & Pramono, 2013; Ministry of Tourism Republic of Indonesia, 2016; Pisani, 2014). Bahasa Indonesia is the primary and official language, and Javanese is the most substantial ethnicity (40.1%) (Biro Pusat Statistik et al., 2013; Central Intelligence Agency, 2015; Ministry of Tourism Republic of Indonesia, 2016). Indonesia is also known as the most prominent Muslim population in the world because the majority of the people are Muslims (87.2%). In some regions, many Indonesians are Christian Protestant, Roman Catholic, Hindu, Buddhist, Confucian, and unspecified. Beyond this diversity, Indonesia has a national motto “Bhinneka Tunggal Ika”, which means Unity in Diversity: Indonesians live side by side and are tolerant towards others, adhering to different religions, customs, and traditions.

Similar to other developing countries, health, education, high population and a developing economy are some of the significant issues in Indonesia. The Republic of Indonesia has a centralised government system, where the priority for development has mostly occurred on Java Island and the western part of Indonesia, such as Sumatra. This development has included the growth of midwifery schools, which have

mostly been built on Java Island and Sumatera. Therefore, the research setting of this study is Java and Sumatera, as these areas have the largest number of midwifery schools and high maternal and neonatal mortality rates.

The Indonesian Government has committed to working towards the accomplishment of the MDGs by 2015, followed by the SDGs 2030 established by the United Nations in 2016. This has included various policies, campaigns, and strategies to improve the health of Indonesia's population through the 2010 Health Development Plan Towards Healthy Indonesia (Biro Pusat Statistik et al., 2013). However, Indonesia continues to face hardship in achieving the reduced maternal and neonatal mortality targets as outlined in the MDGs 2015 target (Baird, Ma, & Ruger, 2011; Reinke, Supriyatningsih, & Haier, 2017).

1.4 My journey towards this research

Looking back on my education, I was a second cohort student in an academy midwifery school, under the Ministry of Health, called the Academy of Midwifery. At this academy, students from senior high school went into a direct-entry three-year programme. As midwifery students, we studied full-time. Through clinical placement, I gained valuable experience at the hospital, in private midwifery practice, at the community health centre and in a remote village. The clinical experience as a midwifery student enabled me to learn and develop my skills in becoming a midwife. I felt that I developed confidence and competence from being nurtured by midwives in my clinical placements. Once qualified, I worked in private midwifery practice. In the few months I was working there, I gained much insight into becoming a real midwife. At this place, I met midwifery students who were doing clinical practice, and it was a privilege to guide them. I have reflected that my interest in midwifery education started as I saw many midwifery students face many challenges in gaining knowledge, skills and clinical experience while they were learning at midwifery school. Also, there is no national standard for midwifery education. The midwifery curriculum was implemented differently in each midwifery school.

After several months, I began teaching the Diploma of Midwifery students at Diploma Midwifery school. It was a requirement of the government that every lecturer had to

hold a higher qualification than students they were teaching. Across the country, only one university offers an Advanced Diploma for Midwifery Lecturers. There was great competition to enter this course, and recognising the acceleration of midwifery lecturers who hold the Advanced Diploma of Midwifery, the government opened this course at various locations in different provinces. While studying within this course, I was the second cohort of students in the Advanced Diploma for Midwifery Lecturers and graduated in 2004. My interest in midwifery education began to grow because the midwifery education system was still unclearly written, and nearly all of the key persons in this programme were obstetricians and education lecturers.

Once I graduated with the Advanced Diploma for Midwifery Lecturers, I became a midwifery lecturer at a midwifery school. For several years I worked as a midwifery lecturer and midwife, and gained a lot of experience and insight regarding midwifery schools and midwifery education, mainly because there were numerous policy and programme changes during this period. Once I completed this programme, I was the clinical practice coordinator and, as such, played a significant role in the implementation of the clinical placement and ensuring it ran smoothly. In order to play this role, I met each key person in the maternity settings and visited each of the maternity places where midwifery students were to be placed. I spoke to, and discussed and negotiated with different key persons in maternity settings about the implementation of clinical placement of the Diploma of Midwifery programme. I was aware of the requirements for midwifery students to complete all clinical competencies and what challenges the students faced in trying to reach this requirement. While teaching in the Diploma of Midwifery programme, I was concerned that my experiences had been somewhat different from the Diploma of Midwifery students I was now teaching. There was an alteration in the midwifery curriculum and it was hard to reach the requirements for three-years midwifery programme completion.

Then I studied for a master's degree in midwifery since there was an obligation for the midwifery lecturer to hold a master's degree. At this time, only one university in Indonesia offered a Master of Midwifery programme. Therefore, there was a high level of competition to enter this programme. Nearly all of the potential master's

students were senior midwifery lecturers who were obliged to gain the qualification and were funded by their home midwifery schools and governments (local, provincial, national) to pursue education in different provinces in Indonesia. I knew some of my colleagues were had taken the test to enter this programme more than six times before finally being accepted. The Master of Midwifery programme only opened once per year. If midwifery lecturers have no a master's degree, they would have to become an administrator. My interest in midwifery education became greater because of changeable policy while I was studying in the master's programme which affected all midwifery students.

After graduating, I was appointed to Vice Academic Affairs. In this position, I was involved in building a curriculum based on competencies for midwifery students from the first year until the third year of the midwifery diploma programme. I was involved in rewriting the content of the midwifery curriculum and managing clinical experiences for midwifery students. My role would also allow midwifery students, newly graduated midwives, midwives, and midwifery lecturers to come to me to deal with any issues in the school. My experience in directing the activities in the academic field, finance, students, alumni, and clinical coordinator practice instigated the need to investigate the area of midwifery education in Indonesia. My close involvement with the development of the midwifery programme in my department and then being affected by some policies in midwifery education triggered my keen interest in issues relating to midwifery education, and this interest served as an impetus for this study. During this time, my professional, personal and political convictions were in synchrony, and this was the substantial foundation for my research in this area.

I have chosen a fascinating career path with plenty of challenges as a midwife and midwifery lecturer in Indonesia. I have a broad range of experiences to draw on concerning my study. With a background as an Indonesian certified midwifery lecturer and registered midwife, I have my own experience regarding midwifery education. In exploring the experience of midwives, midwifery lecturers, midwifery students, newly graduated midwives, and obstetricians, through a qualitative descriptive inquiry, I was fully conscious and aware that my previous experience and knowledge differs from others. My unique experience of being a registered midwifery lecturer and registered

midwife in Indonesia and a PhD midwifery student within New Zealand midwifery education - which, it is claimed, offers a world-class service of midwifery education (New Zealand College of Midwives, 2016) - is different from other Indonesian midwifery lecturers and Indonesian midwives.

1.5 Justification of the study

A midwife holds a significant position in partnership with women and the family, which enables them to access maternal health services. Therefore, government programmes in Indonesia have paid attention to the proliferation of midwifery schools producing qualified midwives with the hope of providing midwifery care during pregnancy until postpartum (Achadi et al., 2007; Middleton, 2014; Rokx et al., 2010; Shiffman, 2003). Midwifery care makes a difference in women's health and the well-being of newborns and plays an essential role in creating high-quality maternal and neonatal care (Sandall, Soltani, Gates, Shennan, & Devane, 2016). Furthermore, randomised controlled trials and a meta-analysis revealed that midwifery care reduces genital trauma at birth, cesarean section rates, and maternal and perinatal mortality (Albers, Sedler, Bedrick, Teaf, & Peralta, 2005; Chaillet & Dumont, 2007; ten Hoope-Bender et al., 2014). Additionally, midwifery care is an effective strategy for women with risk factors (Tracy et al., 2013). Women's satisfaction with maternity care is strongly related to an interpersonal connection with their midwife (Green, Spiby, Hucknall, & Richardson Foster, 2012). The midwife is in a unique and privileged position to assist women in staying healthy and making choices throughout the childbearing cycle. Women want midwives to provide midwifery care, to help them stay healthy during pregnancy, ensure a normal and safe childbirth process, manage their labour pain, and maintain continuous support in normal as well as high-risk conditions (Aune, Amundsen, & Skaget Aas, 2014; Hodnett et al., 2013; Klomp, Manniën, de Jonge, Hutton, & Lagro-Janssen, 2014). Ensuring midwifery schools produce well-trained midwives as primary care providers improves quality midwifery care and leads to the higher satisfaction of mothers with antenatal care, the labouring process, and postnatal care (Forster et al., 2016; Phillippi & Barger, 2015). Therefore, this research seeks to enhance midwifery education endeavours in Indonesia, to gain an understanding of the experience of those involved in midwifery education, and to

identify the barriers and enablers to strengthening midwifery education, leading to competent and confident midwifery graduates in Indonesia.

1.6 Choice of methodology and research methods

In the beginning, hermeneutic phenomenology, informed by van Manen, was to be the foundation for conducting the research. Hermeneutic phenomenology is an interpretive research paradigm which questions how things happen and acknowledges that there is more than one way to look at something, more than one way to interpret it, more than one perspective. For van Manen (2014), hermeneutic phenomenology is the process of reflecting the experience of the phenomenon itself. When interpreting data in phenomenology, the researcher must be open to all possible meanings. Through layers of hermeneutic reflection, pre-understandings allow the researcher to understand the experience of the participants in midwifery education.

During data collection, difficulties with hermeneutic phenomenology became evident due to the nature of a cross-language research project. Participants were interviewed in Bahasa Indonesia and the transcripts translated into English. During the process of data collection, nearly all of the participants in Indonesia were confused when the researcher asked about their experiences. For example, the following question was put to newly graduated midwives: "Please tell me about your experience while you were studying in midwifery school, as a newly graduated midwife, after your graduation?". Several times, the participants responded with: "Experience? What do you mean by experience? Which experience? Experience with who and where? How to explain my experience?". A Western perspective regarding 'experience' is interpreted differently from an Eastern viewpoint. The issue was encountered again during the process of translating data from Indonesian into English. Thus the need for a methodology that is more interpretive was identified. The decision was made to use a more appropriate qualitative approach.

This study then turned to utilising a qualitative descriptive design. Qualitative descriptive research allows the researcher to focus on the various aspects of an experience. Sandelowski (2000, 2010) explained that qualitative descriptive research provides an understanding of a comprehensive summary of the complex world of the

experiences of those who live it. Therefore, this methodology was chosen as being appropriate to answering the research question. A theoretical framework proposed by Bolman and Deal called a Four Frames approach (1997, 2003, 2008, 2017) was applied to guide the approach to data analysis as a means of exploring and articulating the complexity of midwifery education in Indonesia.

1.7 Presentation of the thesis

This thesis is comprised of nine chapters.

Chapter 1 has addressed the research question and aims, and described the reason for undertaking this study. In this chapter, background information and study context – being in Indonesia – is outlined as well as the researcher’s journey towards this study. The justification of the study has been described and the choice of methodology introduced.

Chapter 2 explores the development of midwifery education in Indonesia. This chapter describes the problem of maternal and neonatal mortality rates related to midwifery education issues. The development of midwifery education in Indonesia from the 1800s to the present day is explored.

Chapter 3 contextualises the study by reviewing the literature regarding midwifery education in developing countries. The literature highlights the central place of midwifery education. Research papers that were included in the review examine how midwifery can be strengthened in developing countries.

Chapter 4 explores the methodology used in this study. Central to this research are the philosophical ideas of qualitative descriptive research. This chapter illuminates the research question upon which this study is centred and identifies the choice of qualitative descriptive research as a methodology. The explanation starts with the rationale for choosing a qualitative descriptive approach in shifting away from hermeneutic phenomenology. Data were analysed by thematic analysis and are presented in the findings chapters. A theoretical framework, Bolman and Deal’s Four Frames, was applied to add depth and a further layer of analysis to the participants’ experiences in midwifery education.

Chapter 5 illuminates the details of the methods used. This chapter explores the process of the research conducted in Indonesia. The process of preparation before fieldwork in Indonesia, ethical considerations, and the recruitment of participants are presented. The method also outlines the interviewing process and includes the processes of transcribing and translation, analysis, and rigour.

Chapters 6 to 8 reveal the research findings. Face-to-face in-depth interview data from 37 individual interviews with Indonesian midwives, midwifery lecturers, midwifery students, newly graduated midwives, and obstetricians from 12 midwifery schools in eight cities situated in six provinces were thematically analysed. Themes emerging from the data are explored in these three chapters.

Chapter 9 presents the analysis using Bolman and Deal's Four Frames framework.

Chapter 10 presents the discussion and conclusion, along with the contributions to knowledge, and recommendations for midwifery education in Indonesia and further studies. It is the final chapter and includes a consideration of the relationship between the results of this research and other studies, and the limitations of the study.

1.8 Summary of Chapter 1

In this chapter, the research question has been presented, as well as the reasons for conducting the research. The rationale for conducting the study along with background information about the research setting and the researcher's journey towards this study have been described. The qualitative descriptive methodology, which accommodates insight into the experiences of those involved in midwifery education and identifies the enablers and barriers to strengthening midwifery education, leading to competent and confident midwifery graduates, has been introduced. In the next chapter, an overview of midwifery education in Indonesia, as related to this study, will be explored.

Chapter 2.

Overview of Midwifery Education in Indonesia

2.1 Introduction

This chapter explores an overview of midwifery education in Indonesia. Indonesia has a unique history regarding the role of midwives and direct-entry midwifery programmes provided by various types of schools (universities, polytechnics, institutes of health science, and academies). This chapter begins with an analysis of the high maternal and neonatal mortality rates in Indonesia and government responses to these. It also provides a brief overview of the health system hierarchy, which impacts midwifery education. The existence of the Midwifery Association and new accreditation agency are further articulated in this chapter. The definition of midwife and midwifery education in the Indonesian context and the historical development of midwifery education in Indonesia are also explored in this chapter. The various stages of midwifery education in Indonesia from the 1800s to the present are described. It is essential to acknowledge the development of midwifery education in Indonesia and an overview of the current midwifery education issues. The midwifery curricula and differences across different types of midwifery education also discussed in this chapter. The national competency test and the requirements to become a registered midwife are also examined.

2.2 Maternal and neonatal mortality rates in Indonesia

The maternal and neonatal mortality rates are significant indicators in measuring the health status of a country. Reducing maternal and neonatal mortality rates has become a challenge for global public health. The maternal and neonatal mortality worldwide generally comes from developing countries, of which Indonesia is one (Hogan et al., 2010; WHO et al., 2012a, 2012b). According to the WHO et al. (2012a, 2012b), the world's highest maternal and neonatal mortality rates are found in Asian countries and Sub-Saharan Africa, with one-third being found in South-East Asia. Furthermore, according to Save the Children (2013), based on data compiled from

Healthy Newborn Network and UNICEF Global Databases, nearly two-thirds of all newborn deaths (2 million out of 3 million each year) and 59% of maternal deaths occur in just 10 countries, of which is Indonesia is one (see Figure 2.1 below).



Figure 2.1 Neonatal mortality rates around the world (Save the Children, 2013)

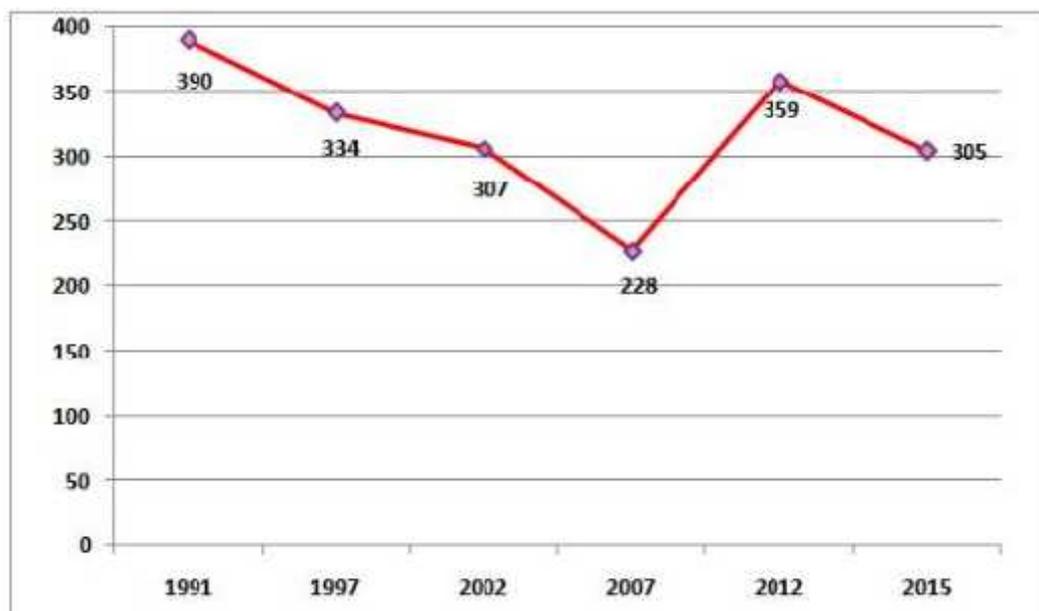


Figure 2.2 Fluctuation of maternal mortality rates in Indonesia (Ministry of Health Republic of Indonesia, 2016).

With 305 deaths per 100,000 births, the maternal mortality rate in Indonesia in 2015 was ranked high in South-East Asia, compared with Malaysia at 170/100,000 births and Brunei Darussalam at 40/100,000 births (Biro Pusat Statistik et al., 2013; Ministry of Health Republic of Indonesia, 2016; WHO, 2012b). Even though the maternal mortality rate decreased from 390 in 1991 to 359 in 2012, maternal mortality rates in Indonesia ranged from 239 to 305/100,000 live births in 2015 (see Figure 2.2) (Biro Pusat Statistik et al., 2013; Ministry of Health Republic of Indonesia, 2016). This number may not reveal the actual deaths, as they are more likely to be under-reported than overreported (Biro Pusat Statistik et al., 2013; Ministry of Health Republic of Indonesia, 2016). According to UNICEF, the WHO, The World Bank, and United Nations (2013), every three minutes, a child aged under five died or around 150,000 children per year in Indonesia. Data from Biro Pusat Statistik et al. (2013) revealed much progress in reducing neonatal, infant, and under-five mortality rates in Indonesia nevertheless, the reduction has been slowing over the past 5 to 10 years.

In the Indonesian setting, the cause of maternal mortality is predominantly due to postpartum haemorrhage, followed by indirect causes, such as heart disease, severe anaemia, malaria, HIV/ AIDS and hepatitis, followed by hypertensive disorders, other direct causes and sepsis (Adisasmita et al., 2015; WHO, 2012a). Postpartum haemorrhage and hypertensive disorders can cause emergency cases, and midwives need to be able to respond effectively to emergencies, but also must have the back up of the hospital or higher maternity settings when needed (Adisasmita et al., 2015; Keputusan Menteri Kesehatan Republik Indonesia, 2010; Mahmood et al., 2018). Causes of maternal mortality in Indonesia are in accordance with the cause of maternal death globally (Naghavi et al., 2015) and include socio-economic status (poverty), access to care, including transportation and geographic difficulties, combined with referral patterns (Adisasmita et al., 2015; Mahmood et al., 2018) (see Figure 2.3).

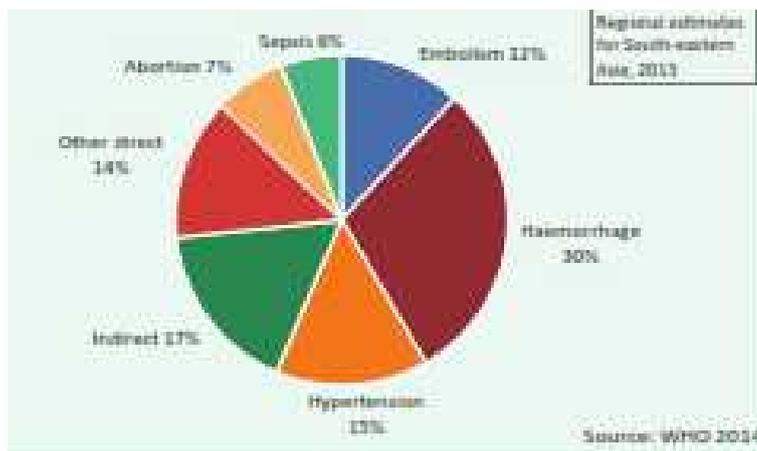


Figure 2.3 Cause of maternal deaths in Indonesia (WHO, 2012a)

2.3 Indonesia's response to high maternal and neonatal morbidity and mortality rates

By implementing many maternal and neonatal health programmes, Indonesia has made intensive efforts to address the high maternal and neonatal mortality rate. In 1988, the Indonesian Government focused on maternal health by establishing Safe Motherhood with a target to reduce the maternal mortality rate to 340 per 100,000 births by 1993. Following this, in 1989, the village midwife programme (Bidan Desa) commenced whereby some nurses were educated to be midwives. Increasing the number of trained midwives attending childbirth in villages aimed to ensure that every woman and family have access to a health worker, especially within pregnancy and until the postpartum period (Koblinsky, 2003; Koblinsky, Campbell, & Heichelheim, 1999; Niehof, 2014; Scott, Chowdhury, Pambudi, Qomariyah, & Ronsmans, 2013; Shankar et al., 2008). In 1996, Gerakan Sayang Ibu or the Mother Friendly Movement started through the empowerment of women, caregivers, and communities to help decrease maternal and neonatal mortality rates. The Indonesian Government established many programmes and made many approaches, such as the participation of husbands, empowering the community, and empowering women through birth preparedness and complication readiness, and a free-of-charge of health service for low-income families across the country. The Alert Husband programme (Suami Siaga), Making Pregnancy Safer, The Village Campaign (Desa Siaga), Healthy Indonesia (Indonesia Sehat), and Insurance Support for Maternal Health Services (Jamkesmas) have been implemented, and aim to reduce maternal-neonatal mortality rates (Kemenkes R. I., Bappenas, DFID, & The World Bank, 2010).

A new health programme, called EMAS (Expanding Maternal and Neonatal Survival), implemented by the Indonesian Government in 2012, focused on improving maternal health care. The programme aimed at ensuring that every woman has access to quality maternal healthcare, including delivery assistance by skilled health personnel in healthcare facilities. The agenda consisted of improving the quality of obstetric and neonatal emergency care; strengthening the referral system in health centres and the hospitals; and improving the quality of maternal healthcare. The Indonesian Government continued the approach with the policy of the Special Allocation Fund for Health Sector. The programme includes the construction of the Village Health Post, health centres, and an official residence for the village midwife. Following this, the Healthy Indonesia programme (Nusantara Sehat) started in 2015. This programme takes a team-based approach, deploying five to nine health workers (doctors, dentists, nurses, midwives, public health staff, and others) to remote and isolated areas (D'Ambruso, 2012; Menteri Kesehatan Republik Indonesia, 2015; Ministry of Health Republic of Indonesia, 2016; UNICEF & WHO, 2015; WHO, 2015a, 2016b).

2.4 The health system hierarchy in Indonesia

Based on new regulations, the health facility can be run by the government, local government, or the community (Menteri Kesehatan Republik Indonesia, 2014; Presiden Republik Indonesia, 2009) and includes public and private hospitals. Public hospitals are controlled by the Ministry of Health, the provincial government, district government, army/ police, other ministries and non-profit private organisations. Private hospitals are managed by state-owned enterprises and private entities (individuals, companies and other private sectors). In addition to the type of service, hospitals are also grouped by facilities and services into Class A, Class B, Class C, and Class D (Ministry of Health Republic of Indonesia, 2016). An overview of the health system hierarchy can be seen in Figure 2.4.

The hierarchy of the health system now has the midwife as the centrepiece of the maternal and neonatal system in Indonesia.

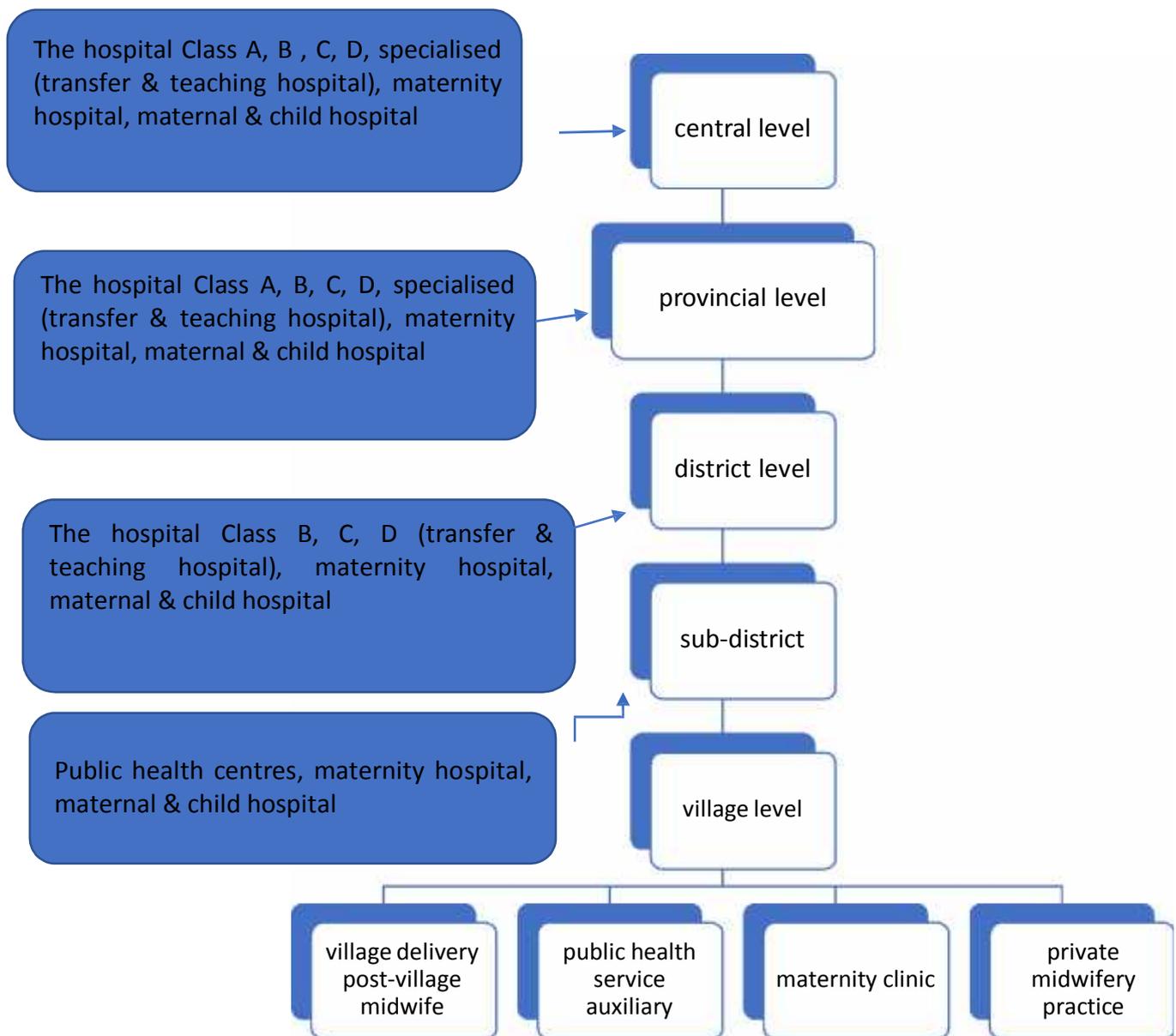


Figure 2.4 Hierarchy of the health system in Indonesia (Ministry of Health Republic of Indonesia, 2016)

2.5 Midwifery education and maternal and neonatal mortality rates in Indonesia

Deploying midwives in rural and remote communities in Indonesia managed to increase the proportion of births attended by skilled midwives from 20% in 1991 to approximately 85% in 2012 (Badriah, Abe, Baequni, & Hagihara, 2014; Kementerian Kesehatan Republik Indonesia, 2014). The Ministry of Health's desire to position one midwife in each village in Indonesia followed the establishment of the village midwives training programme (D'Ambruso et al., 2009; Koblinsky, 2003; Rambu Ngana, Myers, & Belton, 2012; Titaley, Dibley, & Roberts, 2011). The proliferation of midwifery schools in the history of the Indonesian maternal and neonatal health programmes aimed broadly to designate put midwives as the primary provider for maternal and

neonatal health and was focused at the community level. Following this plan, the government began improving midwifery education by opening midwifery schools and placing the newly graduated midwives in service in the villages. Thus, in the 1990s, more than 95% of midwives were deployed throughout the country with a view to reducing maternal and neonatal mortality rates (Ensor, Quayyum, Nadjib, & Suchaya, 2008; Kanchanachitra et al., 2011; Kemenkes R.I. et al., 2010; Makowiecka, Achadi, Izati, & Ronsmans, 2008; Shankar et al., 2008). By 2012, the number of midwives had risen to over 135,000 across the country (Middleton, 2014). Further, in Indonesia, 68.6% of maternity services at childbirth are provided by midwives, followed by doctors (18.5%), non-health workers (11.8%), and maternity-nurses (0.3 %), with 88.55% of deliveries overall being assisted by skilled attendants (Kementerian Kesehatan Republik Indonesia, 2014; Ministry of Health Republic of Indonesia, 2016).

Historically, the Government of Indonesia learned from other countries such as Sweden, England, Wales, China, USA, and Malaysia that successfully battled the high maternal mortality rate by developing skilled midwives for birth attendance (De Brouwere, Tonglet, & van Lerberghe, 1998; Graham, Bell, & Bullough, 2001; Högberg, 2004; Koblinsky, 2003; Koblinsky et al., 1999; Loudon, 1992; van Lerberghe & De Brouwere, 2001). Homer et al., (2014) provided compelling evidence that midwifery with both family planning and interventions for maternal and neonatal health could avert a total of 83% of all maternal deaths, stillbirths, and neonatal deaths. In 78 countries classified according to the Human Development Index (HDI), around 30% of maternal deaths could be averted by midwifery, with an additional 30% averted with the addition of specialist medical care (Homer et al., 2014). Consequently, the continuous strategy to support midwives in offering midwifery care from the government and the private sector to provide a supportive environment is essential (Graham et al., 2001; Rajkotia et al., 2016).

Despite the efforts outlined above, there is an uncoordinated system which is not producing the expected outcomes. Indonesia did not meet the MDGs 2015 target regarding maternal and under-five mortality rate (Kementerian Kesehatan Republik Indonesia, 2014; Shankar et al., 2008; van Lerberghe et al., 2014). The MDGs target was 125 deaths or fewer per 100,000 live births (see Figure 2.5) and 28 deaths or

fewer per 1000 live births for under-five mortality rate (UNICEF & WHO, 2015; WHO, 2012a) (see Figure 2.6). Midwifery education issues, which became a cause of national debate and disagreement in Indonesia, will be discussed later in this chapter.

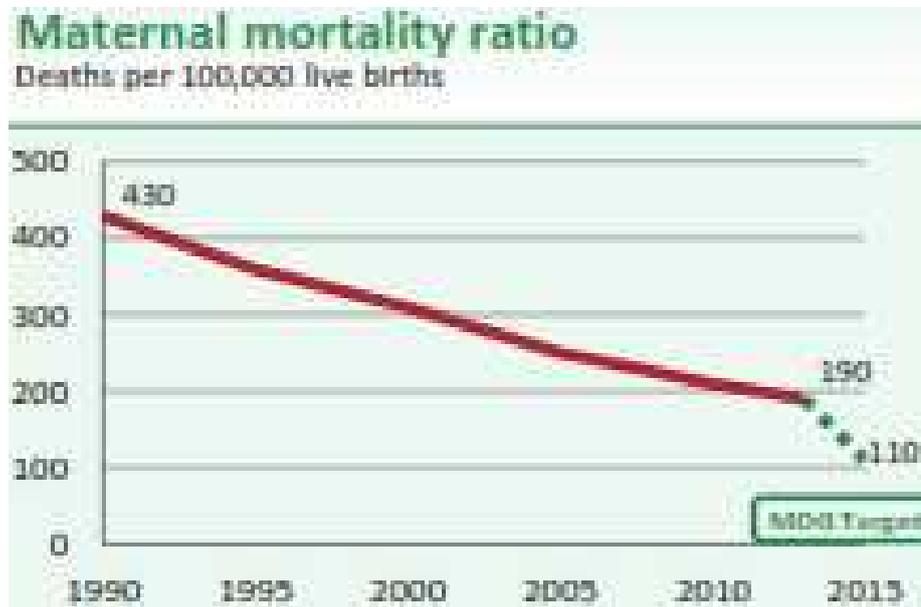


Figure 2.5 Maternal mortality rates in Indonesia (UNICEF & WHO, 2015)

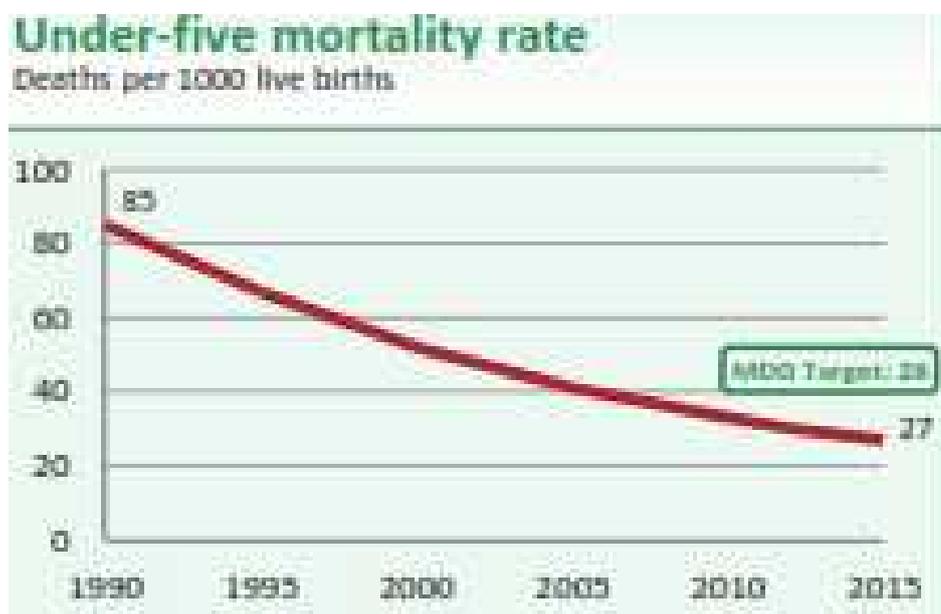


Figure 2.6 Under-five mortality rates in Indonesia (UNICEF & WHO, 2015)

The United Nations established the MDGs in 2000 as a global agreement for international targets to be achieved by 2015. The countries of the world committed to specific targets through 2015 to improve their results in the eight MDG categories: (1) eradicate extreme poverty and hunger; (2) achieve universal primary education; (3)

promote gender equality and empower women; (4) reduce child mortality; (5) improve maternal health; (6) combat HIV/ AIDS, malaria and other diseases; (7) ensure environmental sustainability; (8) develop a global partnership for development. Primarily for MDG4 and MDG5, Indonesia has made significant progress. However, Indonesia is off track on reducing the maternal-child mortality rate to the target set by the MDGs by 2015 (UNICEF & WHO, 2015; WHO, 2015b).

Post MDGs agenda (2000 – 2015), the United Nations set a new development agenda called “Transforming our world: 2030 agenda for sustainable development (2016 – 2030)” or the SDGs. The 17 goals of the new development agenda committed to the following action: (1) end poverty; (2) end hunger; (3) good health and well-being; (4) quality education; (5) gender equality; (6) clean water and sanitation; (7) affordable and clean energy; (8) decent work and economic growth; (9) industry, innovation, and infrastructure; (10) reduced inequalities; (11) sustainable cities and communities; (12) responsible consumption and production; (13) climate action; (14) life below water; (15) life on land; (16) peace, justice and strong institutions; (17) partnerships for the goals. Two out of 17 goals have been explicitly devoted to health and quality education. Specifically, for the health goal, there are 13 targets, including reducing the global maternal mortality rate to less than 70 per 100,000 live births by 2030; reducing neonatal mortality to less 12 per 1000 live births; and reducing child mortality to less 25 per 1000 live births. The SDGs expanded the focus on education, not only to address primary education and literacy, but also access to quality tertiary education and vocational training, and teacher supply. The reason for these objectives is that education is strongly linked to health and other determinants of health (UNICEF & WHO, 2015; United Nations, 2017; WHO, 2015b). Indonesia, together with all countries, has significant work ahead to achieve the SDGs targets proposed by 2030.

2.6 Midwifery Association and accreditation agency in Indonesia

The Midwifery Association or the Indonesian Midwives Association became a member of the ICM in 1956. Indonesia has no Midwifery Council that regulates midwifery education, but it has a Midwifery Association, scattered across 34 provinces, which has a regulatory function. The vision is to educate professional midwives in accord with global standards. The Indonesian Midwives Association was established on June 24,

1951, and as of 2018 has more than 215,000 members across the country. The Midwifery Association has identified that one of the keys to strengthening midwifery education is to have a specific regulatory body for midwives. The political statement voiced by the Midwifery Association to the government impacted on midwifery education and midwifery practice. As such, the Midwifery Association advocated for the government developing the midwifery education system to higher education (moving from diploma to bachelor's level) to adequately prepare midwives to work in maternity services. The government acknowledged the need to review midwifery education. In 2006, in the development of the Bachelor of Midwifery, the Midwifery Association and the government took advice from other countries where Bachelor of Midwifery programmes existed. International midwifery experts from New Zealand, supported the establishment of the Bachelor of Midwifery in Indonesia. The result of this project was that the first Bachelor of Midwifery programme commenced at Airlangga University in 2008 (Indonesian Midwives Association, 2015; Universitas Airlangga, 2016a). However, the Indonesian Midwives Association has no regulatory powers, but has responsibility for midwives' issues and advocated for them with the government (Indonesian Midwives Association, 2015; Middleton, 2014).

On October 28, 2008, the Indonesian Midwifery Education Association was formed to improve the quality of midwifery education within Indonesia. Based on their data, 312 out of 733 midwifery schools joined the association (Asosiasi Pendidikan Kebidanan Indonesia, 2015; Health Professional Education Quality Direktorat Jendral Pendidikan Tinggi, 2012). For the rest, the reason for not joining is unknown; perhaps it is due to there being no obligation to enrol. The Indonesian Midwives Education Association has made an effort to establish a policy regarding quality assurance for the development of midwifery education in Indonesia (Asosiasi Pendidikan Kebidanan Indonesia, 2015).

In March 2015, professional organisations, including those from medicine, midwifery, dentistry, nursing, and pharmacy, formed the Indonesian Accreditation Agency for Higher Education in Health, which regulates the high demands of accreditation, especially for health institutions (Perkumpulan LAM-PTKes, 2015). This agency aims to ensure health organisations in Indonesia, including midwifery schools, meet standards for accreditation to ensure competent graduates work in midwifery services (LAM-

PTKes, 2015). Prior to 2015, the National Accreditation Body Colleges/ Badan Akreditasi Nasional Perguruan Tinggi (BAN-PT), which was formed by the Ministry of Education and Culture, aimed to accredit colleges and universities (Badan Akreditasi Nasional Perguruan Tinggi, 2014). The development of the independent accreditation agency was then commenced, and the Indonesian Accreditation Agency for Higher Education in Health/Lembaga Akreditasi Mandiri Pendidikan Tinggi Kesehatan Indonesia (LAMP-PTKes) was formed under the annual supervision of the National Board for Higher Education/BAN-PT. Later, the Ministry of Research, Technology and Higher Education announced the legalisation of a legal entity, the Indonesian Accreditation Agency for Higher Education in Health, which detailed all of the accreditation of health schools (Kementerian Riset, Teknologi, dan Pendidikan Tinggi Republik Indonesia, 2016).

The new accreditation agency (LAMP-PTKes) has developed a specific accreditation assessment tool, based on the ICM Global Standards, for midwifery education to meet the standards for desired performance (ICM, 2013; LAM-PTKes, 2015). Using the ICM standard as a framework, the tool was outlined with the following domains: (1) vision, mission, goal and subject, and assessment strategies; (2) structure, leadership, management, quality assurance; (3) students and graduates; (4) human resources; (5) curriculum, learning process, and academic atmosphere; (6) finance, resources, and information system; and (7) research, community services, and memorandum of understanding. Each domain covers the minimum requirements needed to achieve quality in a midwifery school, and specific criteria assessment which midwifery school must meet. To evaluate these criteria, the tool has quality grade descriptors which are:

1. score 4 (excellent),
2. score 3 (very good),
3. score 2 (fair),
4. score 1 (poor), and
5. score 0 (very poor).

This board is composed of 15 members, seven from the association, seven from education providers and/or the education association, and one member outside from these two associations. It is stated in the guideline of accreditation that an

accreditation assessment takes around six to nine months (see Figure 2.7, below) (LAM-PTKes, 2015).

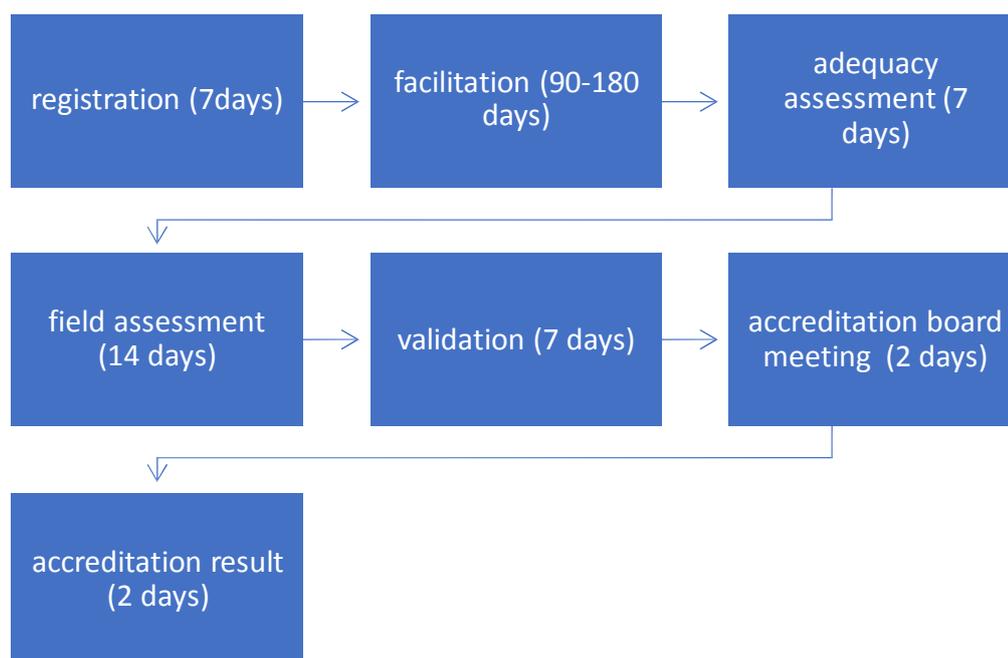


Figure 2.7 Accreditation process for midwifery education (LAM-PTKes, 2015).

The outcome of the accreditation process can be (LAM-PTKes, 2015):

1. A, with a score of 361 – 400,
2. B, with a score of 301 – 360,
3. C, with a score of 200 – 300, or,
4. Not accredited, with a score of less than 200.

In time, 204 out of 733 midwifery schools were accredited by the new accreditation agency and this accreditation must be renewed every five years (see Table 2.1).

Table 2.1 Accredited midwifery programmes

Category accreditation	Number of midwifery school
A	3
B	113
C	88
Total	204

Source: LAM-PTKes (2019)

2.7 Defining midwife and midwifery education

The meaning of the English word midwife is “with a woman”, “wise woman”, “the sage-femme” and is immersed with individual women’s experience of birth (Kitzinger, 1988; Varney, 1997). The word ‘midwife’ comprises “mid” which meant “with” and “wif” or “wife” or “woman” and was most widely understood as “to be with a woman during childbirth” (Ament, 2007; Fraser, Cooper, & Myles, 2009; MacDonald, Johnson, & Warwick, 2017; UNFPA et al., 2014; Varney, 1997). Similarly, the Indonesian word for midwife is “*bidan*” (Indonesian Midwives Association, 2007), which means ‘wise woman’; in other words, a woman who has the skill to care for women in childbirth.

Indonesia adopted the description of a midwife from the ICM, which states that a midwife is typically a woman who has finished a midwifery educational course, has fulfilled the indispensable qualifications to be registered or, with authorisation is qualified to perform midwifery care as a midwife, and is legalised in the country where the midwife is located. Midwives are professionals who are responsible and accountable for enhancing midwifery care and conduct supervision during pregnancy, labour, and postpartum. They have autonomy during the childbirth and facilitate care to newborns and infants (Indonesian Midwives Association, 2007; ICM, 2012; Keputusan Menteri Kesehatan Republik Indonesia, 2010).

Government documents have clearly stated that the philosophy behind the midwifery practice model in Indonesia is that midwives work in partnership with women and provide professional, comprehensive midwifery care. The partnership model means that the midwife and the woman are viewed as equal decision-makers regarding choices in health care, that midwives provide continuity of care, and midwifery care is evidence-based (Keputusan Menteri Kesehatan Republik Indonesia, 2010; Menteri Kesehatan Republik Indonesia, 2007, 2017). The scope of practice of the midwife states that a midwife has to be responsible and accountable as a partner of women to offer support, care, and counselling during pregnancy, the delivery process, and the post-partum period. A midwife takes responsibility for conducting the labour process, including care for the newborn and infant. A midwife in Indonesia may practise in any midwifery service, including the home, community, hospital, clinic, or other health units. Midwifery care includes prevention, detection of abnormal conditions, and

emergency cases. A midwife also provides health counselling and education for the woman, the family, and the community. Midwifery care further includes antenatal education, parenthood, women's health, sexual health or reproductive health and childcare (Keputusan Menteri Kesehatan Republik Indonesia, 2010; Menteri Kesehatan Republik Indonesia, 2007, 2017).

Since 1996, midwifery education in Indonesia has had a 'direct-entry pathway'. A direct-entry midwifery programme recognises midwifery as a separate profession from nursing, and it is the educational pathway which brings students to train to be midwives. It means that registration as a nurse is not required to study midwifery. For developing countries, such as Indonesia, a direct-entry midwifery programme recognises the value of the professional midwife in regards to reducing maternal and neonatal mortality rates (UNFPA et al., 2014).

Midwifery education in Indonesia is delivered in various ways with providers delivering different midwifery qualifications (This is set out in Table 2.2.). Prior to the Midwifery Act 2019 being ratified, all pathways of midwifery programmes leading to registration as a midwife had the same scope of practice and same place of work. The nature of the responsibilities of graduates from each midwifery programme are stated in many government documents. Diploma graduates can work as a midwife in private midwifery practice and in public health centres. Advanced diploma and bachelor's graduates are professional midwives and can be employed as a midwife, manager, or educator. They can either work as a general midwife or become a tutor. The graduates of master's and doctoral programmes can work as a midwife, manager, educator, researcher and consultant in midwifery education, as well as in healthcare universally (Indonesian Midwives Association, 2016; Keputusan Menteri Kesehatan Republik Indonesia, 2010; Menteri Kesehatan Republik Indonesia, 2011, 2017). Further information on ensuring competency is discussed later in this chapter.

Table 2.2 The direct entry of midwifery school in Indonesia

Category of midwifery school	Description
Vocational programme:	
1. Diploma of Midwifery (DIII)	Three years midwifery programme after secondary education
2. Advanced Diploma of Midwifery (DIV)	Four years midwifery programme after secondary education or one-year midwifery programme after graduating from a diploma of midwifery programme
Academic programme:	
3. Bachelor of Midwifery (B.Mid)	Five years midwifery programme after secondary education (four years academic midwifery programme, one-year professional) or two and half years midwifery programme after completing a diploma of midwifery programme
Professional midwifery programme	One and half to two years midwifery programme after advanced diploma of midwifery programme or diploma of midwifery

Based on Indonesian Government regulations for Kerangka Kualifikasi Nasional Indonesia (KKNI) (Indonesian Qualification Framework/IQF), higher education is divided into academic, vocational, and professional education, which can be run by public and private organisations (Presiden Republik Indonesia, 2012a, 2012b) (see Figure 2.8, Table 2.3, and Table 2.4).

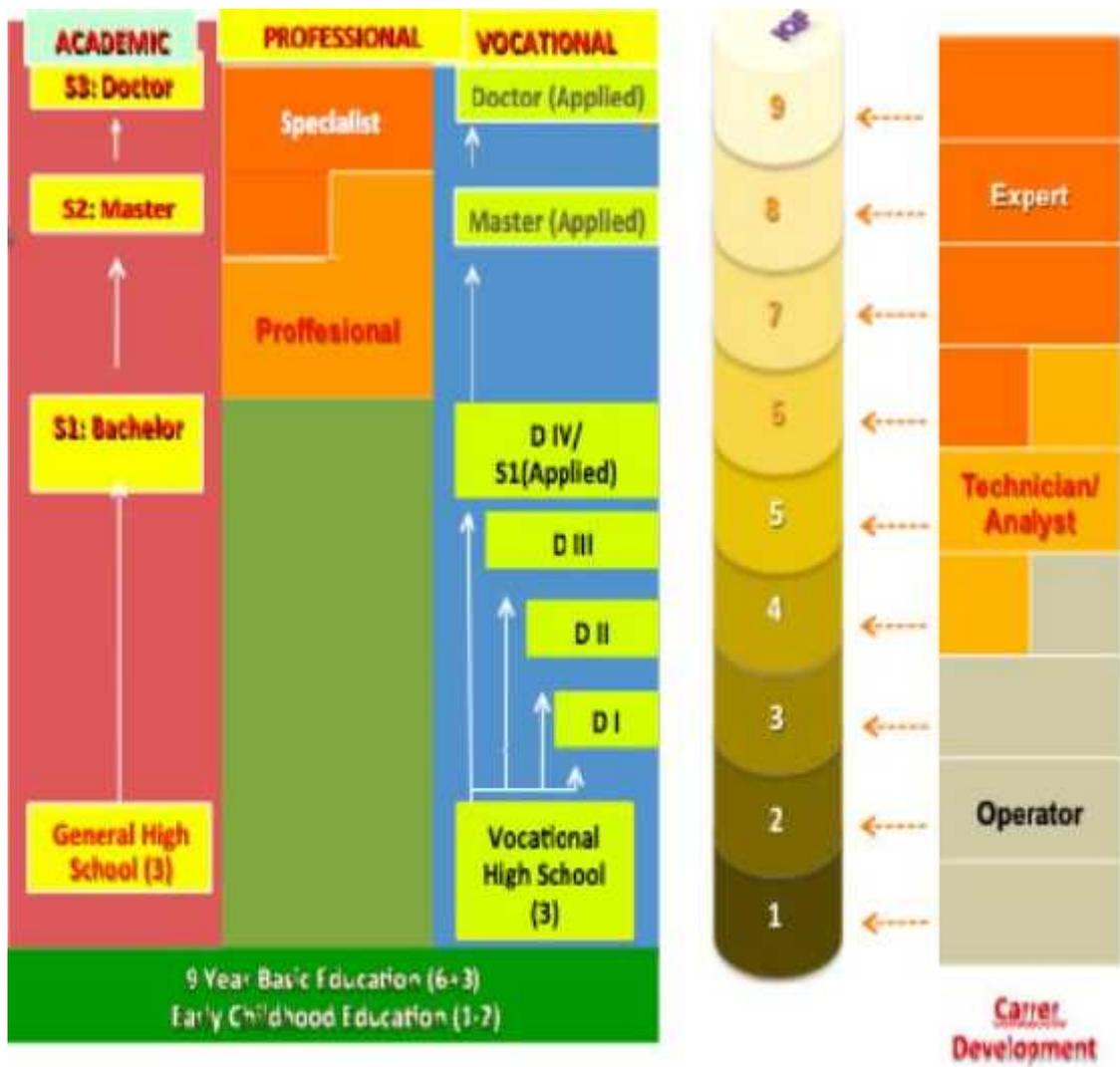


Figure 2.8 Type and level of education based on the Indonesian Qualification Framework (Director of Quality Assurance Ministry of Research, Technology, and Higher Education Indonesia, 2018; Kementerian Riset, Teknologi, dan Pendidikan Tinggi Republik Indonesia, 2018)

Table 2.3 Type and level of education

Who owns midwifery schools	Type of education	Educational level	Graduates' qualification
Public and private organisations	Vocational	Diploma of Midwifery (DIII)	Amd.Keb (Ahli Madya Kebidanan)/ Expert in Midwifery
		Advanced Diploma of Midwifery (DIV)	SST (Sarjana Sains Terapan)/ Bachelor of Applied Science in Midwifery
		Master of Applied Science Doctor of Applied Science	
	Profession	Bidan (Unlicensed Midwife)	Bd.(Bidan)/ Unlicensed Midwife
		Bachelor + Profession	S.Keb, Bd (Sarjana Kebidanan/ Bidan)/ Bachelor of Midwifery
		Advanced Diploma of Midwifery + Profession	SST, Bd (Sarjana Sains Terapan)/ Bachelor of Applied Science in Midwifery
Public organisations	Academic	Bachelor of Midwifery	S.Keb (Sarjana Kebidanan)/ Bachelor of Midwifery
		Master of Midwifery	M.Keb (Magister Kebidanan)/ Master of Midwifery
		Doctor of Midwifery	

Table 2.4 Comparison of public and private midwifery schools

Who own midwifery school	Who runs the midwifery school	Funds	Ministry services	Same qualification from midwifery programmes?
Public midwifery school- government	Civil servants	- Government budget (For example salary of an employee is covered by the government budget)	- Under the Ministry of Health - Under the Ministry of Research, Technology and Higher Education	Yes
Private midwifery school – private organisations	-education providers who hold legal right to run midwifery programmes -societies based on religion foundation such as Muhammadiyah, Nahdlatul Ulama, Christianity	Private organisations raise funds from their dependents, such as the tuition fees from their students. Each private midwifery school covers themselves for all midwifery expenses at the school, including the salary of employees, teaching and learning processes, and clinical placements.	Under the Ministry of Research, Technology and Higher Education	Yes

2.8 The development of midwifery education in Indonesia

The historical development of midwifery education in Indonesia is outlined below:

1. Prior to the 1800s, the traditional birth attendant or *dukun* was a specialised person who accompanied women in childbirth (Hesselink, 2011; Hildebrand, 2012; Nourse, 2013; Stein, 2007). Hesselink (2011) pointed out that the traditional birth attendant

was also tasked with providing contraception, assisting with fertility, and inducing abortion.

2. In the early 19th century (1809), the Dutch governor had an idea regarding the importance of training Indonesian women as midwives to replace *dukun* (Hesselink, 2011).
3. In 1817, European midwives were obliged by the Dutch government to train Indonesian and European women as midwives. At this time, Indonesia was colonised by and under the control of The Netherlands. There was no freedom for Indonesians. Only Indonesian males from noble and royal families had an opportunity to pursue an education; therefore, it was difficult to find suitably qualified Indonesian females. Little is known about the recruitment method. Female students from the lower classes hoped to earn a better status once they had graduated from midwifery school (Hesselink, 2011).
4. In June 1850, the Dutch head of the medical service, Dr Williem Bosch, proposed to establish a midwifery school with hopes of reducing the high risks for women in childbirth and the high maternal and neonatal mortality rate in Java, which was associated with the use of the traditional birth attendant. The Dutch government said it would permit this school if the costs were kept to a minimum after Dr Bosch supplied the requested information, including a budget for the building and the clinic (Hesselink, 2011; Indonesian Midwives Association, 2015; Wiknjastro, 1979).
5. In October 1851, a midwifery school opened in Jakarta with 20 Indonesian female students. The midwifery curriculum consisted of technical subjects: describing the human skeleton in general and the pelvis in particular; the principles of human psychology; the various dimensions of the female pelvis; the theory of pregnancy and the ovum; the natural and unnatural positions of the fetus and various practical rules. The programme was intended to take one and a half years, but in practice, took two and a half to three years because the students had to learn to read and write and do arithmetic first. Along with theory, the students had practical lessons. Practical experience was gained by assisting in childbirth under supervision. It is not clear how the certified midwives were addressed (Hesselink, 2011; Indonesian Midwives Association, 2015; Wiknjastro, 1979).
6. On September 2, 1875, the midwifery school for Indonesian women closed for

reorganisation because of the lack of trust among the population. The majority of Indonesian women at the time preferred to be helped by Western-trained midwives and dukun. The Indonesian midwives did not succeed in winning the trust of Indonesian women. The midwifery school had produced about 100 graduates who worked in 21 regions where they knew the language and customs (Hesselink, 2011).

7. In 1893, the midwifery school for Indonesian women was reopened and remained open until 1915. The programme consisted of one year of midwifery training under the leadership of the Dutch colonial government (Hesselink, 2011; Indonesian Midwives Association, 2015).
8. In 1911, the nursing school began to admit students from the primary level into a four-year nursing programme. The school only accepted male students (Hesselink, 2011).
9. In 1914, the nursing school accepted female students from the primary level into a two-year midwifery programme (Hesselink, 2011).
10. In the 1950s, the midwifery school admitted students from junior high school onto a three-year programme. Indonesia had gained independence on August 17, 1945. The Midwifery Association had argued that, at a minimum, potential midwifery students should be from senior high school (Indonesian Midwives Association, 2015).
11. In 1952, the midwifery school changed its policy. A community midwifery education programme opened in the same year. This programme happened because of the recognition of the need for more Indonesian midwives, which led to the training of midwives who were then placed in villages (Wiknjosastro, 1979).
12. In 1974, the Ministry of Health opened a nursing school admitting students from junior high school onto a three-year programme. At that time, the Department of Health provided a curriculum for the nurse-midwife for assisting normal births. The hours in the curriculum covered practical work as well as study time. Midwives concentrated primarily on maternal and neonatal health care, including family planning (Wiknjosastro, 1979).
13. From 1975 to 1984, the midwifery school was closed (Indonesian Midwives Association, 2015).

14. In the 1990s, some nurses were educated to be midwives, as part of the response to the international safe motherhood conference in Nairobi 1987 (Indonesian Midwives Association, 2015; Koblinsky, 2003; Shankar et al., 2008; Shiffman, 2003). The government established a midwifery training programme for graduates of the junior high school nursing programme which led to a health certificate for conducting midwifery care in maternity service. This programme was then substituted by a three-year direct-entry midwifery diploma programme for graduates of the senior high school (Hennessy, Hicks, & Koesno, 2006; Indonesian Midwives Association, 2015). The government provided a programme which encouraged potential midwives to study in midwifery school. In return, newly graduated midwives were positioned in the villages or rural areas (called village midwives or *bidan desa*) for a minimum of two years, which could be extended (Koblinsky, 2003; Shankar et al., 2008; Shiffman, 2003).
15. In 1996, the Diploma of Midwifery education programme for three years from senior high school finally started. The midwifery programme became a direct-entry programme, that is, the course was offered to female students without a nursing background. The Midwifery Association thought that the minimum entry requirement for becoming a midwife should be the completion of senior high school, not junior high school. They re-opened the midwifery school because of international recognition, strong demand from stakeholders, and the strong emphasis of government policy on placing midwives in rural areas after completion of the village midwife programme. The primary focus of the community midwife programme was on having a sufficient partnership with women and families in order to increase professional delivery care and reduce the imbalance in previous service provision, which would contribute to reducing the maternal and neonatal mortality rate (Indonesian Midwives Association, 2015; Koblinsky, 2003; Middleton, 2014; Shankar et al., 2008). However, in this programme, only 10 of 30 topics in the midwifery curriculum emphasise clinical competency (The US National Academy of Sciences & The Indonesian Academy of Sciences, 2013).
16. Since 2000, the Advanced Diploma of Midwifery for midwifery lecturers opened, because there was an increased need for midwifery lecturers to teach midwifery students in Diploma of Midwifery programmes. The concerns of the one-year advanced diploma programme for midwifery lecturers was

preparing midwifery lecturers to deal with the increased number of midwifery schools and the shortage of midwifery lecturers. In 2003, the National Education Law 20 was released, which established the National Education System in 2005-2006. The Ministry of Education and Culture and the Ministry of Health launched a regulation regarding the delegation of responsibility for midwifery diploma programmes from the Ministry of Health to the Ministry of Education and Culture. The number of midwifery schools increased from 50 to 750 from 2006 to 2011. With some amendments of the regulation by the Ministry of Education and Culture, the teaching and learning processes at midwifery schools is the responsibility of the Ministry of Education and Culture, but the scope of practice of midwife remains the responsibility of the Ministry of Health. However, the Ministry of Health still holds responsibility for some midwifery schools and open Advanced Diploma of Midwifery programmes, which has resulted in different perceptions in the two ministries about what constitutes a certified midwife (Indonesian Midwives Association, 2015; Middleton, 2014; The US National Academy of Sciences & the Indonesian Academy of Sciences, 2013).

Then, the regulation was changed (the National Law about Teacher and Lecture 14/ 2005) to stipulate that midwifery lecturers must hold a master's degree following the opening of a master of midwifery programme in some universities (Indonesian Midwives Association, 2015; Presiden Republik Indonesia, 2005b). Some of the requirements to be met in order to be able to apply for a master of midwifery programme are teaching experience and holding an advanced diploma or bachelor's degree. There were concerns from the Indonesian Government regarding the minimum educational background of a lecturer, as lecturers held a strategic position in ensuring the quality of education (Presiden Republik Indonesia, 2005b). Along with the regulation of midwifery education, the Bachelor of Midwifery programme commenced in 2008. The implementation of the Bachelor of Midwifery programme was seen as a key strategy for the development of national standards for midwifery education that meet the needs of midwives. At the present time, Indonesia offers a Diploma, Advanced Diploma, Bachelor's degree, and a Master's degree in midwifery (Indonesian Midwives Association, 2015).

17. In 2018, the professional midwifery programme commenced in some midwifery schools. This programme is intended to define the standards for qualified midwifery graduates. Also, the programme entails a one-half year to two years of study in midwifery school, which begins at the end of the Advanced Diploma of Midwifery programme or Diploma of Midwifery programme. The professional midwifery programme is a new concept for midwifery education in Indonesia (Indonesian Midwives Association, 2019; Kementerian Sekretariat Negara Republik Indonesia, 2019).

2.9 Current midwifery education issues

The Indonesian Government and private organisations, such as education foundations, Muhammadiyah societies, and Nahdlatul Ulama societies, have made a significant investment in educating student midwives since the direct entry midwifery programme was instigated in 1996. As a result, the number of midwives who graduate each year doubled from 8,264 in 2006 to 17,828 in 2010. In 2015, 151 diploma midwifery programmes produced around 34,401 new midwives (Ministry of Health Republic of Indonesia, 2016). There are currently 733 midwifery schools of which 328 are situated in Java, and these are run by universities, institutes of health science, polytechnics of health science, and academies (Health Professional Education Quality Direktorat Jendral Pendidikan Tinggi, 2012). In Indonesia, private education organisations operate under the Ministry of Research, Technology and Higher Education. It is complicated as there are two ministries which run midwifery schools: the Ministry of Health and the Ministry of Research, Technology and Higher Education. The Ministry of Health runs vocational education courses with diploma and advanced diploma qualifications in midwifery. The Ministry of Research, Technology and Higher Education also offers vocational education and academic education with advanced diploma, bachelor's, and master's qualifications in midwifery. Private organisations offer a similar range of qualifications (see Tables 2.5 and 2.6, below).

Table 2.5 Number of midwifery schools in Indonesia

Category of midwifery school	Number of schools
Vocational programme:	
- Diploma of Midwifery (DIII)	682
- Advanced Diploma of Midwifery (DIV)	38
Academic programme:	
- Bachelor of Midwifery	3
Professional of Midwifery	32

(Indonesian Midwives Association, 2019; LAM-PTKes, 2019).

Table 2.6 Number of postgraduate midwifery programme in Indonesia

Category of midwifery school	Number of schools
- Master of Midwifery (two years midwifery programme with matriculation programme after graduating from an Advanced Diploma of Midwifery or two years midwifery programme after completing Bachelor of Midwifery programme)	7
- Doctor of Midwifery (three years midwifery programme after finishing a Master of Midwifery programme)	0

(Indonesian Midwives Association, 2019; LAM-PTKes, 2019)

Before the ratification of the Midwifery Act 2019, midwives from all pathways/ programmes in Indonesia could choose how they worked. The government policy stated that a village midwife automatically became a government employee. Also, a midwife has licence to open a private midwifery practice at home and create a dual practice of a midwife at the village if she held a diploma. Both conditions attract many potential midwifery students to enter midwifery school resulting in a significant growth of midwifery schools because it is relatively easy to get a high income job as a midwife. In 1994, the government policy about midwives changed due to many factors and a village midwife now works under a national or local government

contract, and does not automatically become a government employee (Presiden Republik Indonesia, 1994). The regulation later changed again regarding the conditions of a contract midwife in a village (Menteri Kesehatan Republik Indonesia, 2016), which in turn affected the conditions of contract midwives and led to the national debate and disagreements due to the number of vacant of midwife positions (Ikatan Bidan Indonesia, 2016a; Middleton, 2014).

Furthermore, the proliferation of midwifery schools created by the government aimed to produce skilled graduate midwives who were intended to provide an excellent service and meet the complex needs of women and families at all stages of the health system in Indonesia (Anderson et al., 2014; Middleton, 2014). However, Anderson et al. (2014) and Middleton (2014) argued that the proliferation of midwifery schools in Indonesia could lead to difficulties in assessing the quality of education, and may create competitiveness between midwifery schools and an unsupportive environment for new midwives. Even though the Ministry of National Education reported a large number of midwifery schools, the performance of the newly graduated midwives has been questioned (Kemenkes Republik Indonesia et al., 2010; Middleton, 2014; The US National Academy of Sciences & the Indonesian Academy of Sciences, 2013). Midwifery schools being run by both the Ministry of Health and the Ministry of Research, Technology, and Higher Education has resulted in divergent views on midwifery education.

Over time, several government policies have been written, and national seminars and conferences held, to develop a national midwifery education framework, bringing together the government chairperson, midwives, midwifery lecturers, and others from throughout Indonesia. The different competencies, including graduate profiles, of the diploma, advanced diploma, bachelor, master, and doctor of midwifery programmes have become a national debate. Within the context of midwifery education, the new accreditation agency and the government articulated different views about the level of midwifery education (see Table 2.7). Due to divergent views on midwifery education, it was becoming clear that the national framework of midwifery education was required. The national framework of midwifery education may provides evidence of how graduate midwives were prepared for maternity services in Indonesia.

Table 2.7 Education level

Education level	Based on Indonesian Qualification Framework (Presiden Republik Indonesia, 2012a)	Based on the Indonesian Accreditation Agency for Higher Education in Health (LAM-PTKes, 2015)
Diploma programme	Level 5	Level 5
Advanced diploma	Level 6	Level 5
Bachelor		Level 6
Profession	Level 7	Level 7
Specialist	Level 8 or 9	Level 7
Master	Level 8	Level 8
Doctorate	Level 9	Level 9

Also, Rokx et al. (2010) and Anderson et al. (2014) pointed out that, despite all these midwifery schools, the standard of education was limited in some places, without a transparent accreditation process. They suggested that the capacity of midwifery teaching, the infrastructure, curriculum, and the lack of a regulatory body for midwives is alarming. As a consequence, according to Anderson et al. (2014) and Middleton (2014), the low-level quality of midwives in Indonesia needs urgent attention by the improvement of midwifery education, certification, and accreditation. The proliferation of midwifery schools in Indonesia has created a situation that makes it difficult to ensure accountability, quality assurance processes, graduate support once midwives leave their school, and supervision (Health Professional Education Quality, 2014; Middleton, 2014). Furthermore, at present, midwifery students in Indonesia may graduate with limited knowledge and skill, so the newly graduated midwives do not always provide quality midwifery care (Health Professional Education Quality, 2014; Middleton, 2014; Yanti, Claramita, Emilia, & Hakimi, 2015).

Therefore, Middleton (2014) and Rokx et al. (2010) suggested the evaluation and development of midwifery education in Indonesia should be undertaken to inform the schools' performance following the required ICM competencies of a midwife. Amidst the growth in the number of midwifery schools, certain elements have been identified that need to be strengthened to ensure that sufficient numbers of quality midwives are produced. Issues noted that particularly need strengthening

are the midwifery curriculum, competency criteria, and clinical standards (Anderson et al., 2014; Hennessy, Hicks, & Koesno, 2006; Middleton, 2014; Rokx et al., 2010). Prior to 2013, there was no national standard for the midwifery diploma curriculum (Kemenkes R. I. et al., 2010). Strengthening midwifery education is the first critical step, along with legislation and accreditation in an agenda for midwifery education globally (Bharj et al., 2016).

Within Indonesia, Java is the island that has the highest number of midwifery schools with the diploma, advanced diploma, bachelor's, and master's qualifications in midwifery available, followed by Sumatera and Sulawesi Island. Educational models in Western countries such as The Netherlands, the United Kingdom, and New Zealand have influenced the development of midwifery education in Indonesia (De Vries, 2001; Gilkison, Pairman, McAra-Couper, Kensington, & James, 2015; Health Professional Education Quality, 2012; Mivšek, Baškova, & Wilhelmova, 2016). Examples of aspects which have been drawn from international programmes are: the direct-entry programme; a competency-based curriculum; having qualified midwifery lecturers; having qualified clinical mentors; components of the practice:theory ratio (60:40); and the achievement of a minimum standard for clinical competencies, such as conducting 50 births (Badan Pengembangan Pemberdayaan Sumber Daya Manusia Kesehatan, 2011; Direktorat Jenderal Pendidikan Tinggi Kementerian Pendidikan dan Kebudayaan, 2011).

2.10 Midwifery curricula in Indonesia

The Indonesian midwifery curriculum emphasises that the body of knowledge of midwifery is unique and focuses on the normal and physiologic life cycle of a woman. The curriculum contains human ecology, social and behavioural sciences, and reproductive and developmental biology (see Appendix A) (Ikatan Bidan Indonesia & Asosiasi Institusi Pendidikan Kebidanan Indonesia, 2010). It also has practical lessons, where a mannequin, as well as a simulated patient, are used to practise midwifery skills. The Ministry of Health, the Republic of Indonesia, published the core curriculum for the Diploma of Midwifery programme in 2011, called a core competency-based curriculum. The core competency-based curriculum was a revision of the previous curriculum (curriculum 2002) because of the development of the need

for midwives with knowledge in science and health technology. The curriculum of 2011 is one strategy that was developed by the government to enhance midwifery educational quality to create newly qualified midwives to reach specific outcomes or competencies that deliver the maximum health outcomes of the mother, baby, and family. The development of the core curriculum began with an agreement between midwifery education providers, the Midwifery Association, and stakeholders. The primary purpose of this new curriculum is to create competency standards for newly graduated midwives to ensure a high quality of midwifery education in response to the demand for competent midwives. The government has implemented this reform in midwifery diploma education in Indonesia, and each midwifery educational provider is required to institute the curriculum. In other words, midwifery educational providers need to integrate all subjects into classes and practice to achieve the standard competencies of qualified midwives.

Nationally, the curriculum structure in Diploma of Midwifery programme in Indonesia follows the guidelines from the Ministry of Health. The curriculum structure of the Diploma of Midwifery programme has a balance of 60% clinical practice (57 credits) and 40% (39 credits) theory to produce a level of competence that graduates meet as part of the three-year direct-entry according to ICM (2017) standards and national guidelines. Competent graduates can be developed through innovative educational methods such as problem-based learning, project-based learning, and mentoring approaches. The fragmented midwifery care learning model is implemented during the clinical placement phase of the Diploma of Midwifery programme. Beginning in semester three, midwifery students undergo a clinical phase, which typically uses the fragmented care learning model to achieve specific clinical competencies (Kementerian Kesehatan Republik Indonesia, 2011). When the Diploma of Midwifery programme commenced under the Ministry of Health in 1996, the health centres (the hospital) and midwifery school were united under one ministry (The Ministry of Health). Since 2012, midwifery education has been regulated under the Ministry of Education and Culture rather than the Ministry of Health. As a consequence, there has been a proliferation of public and private midwifery schools, which are no longer united with the health centres. The type of hospital and service has a significant impact on midwifery education and the clinical placement of midwifery students.

In Indonesia, midwifery students are placed in clinical placements where they are allocated to a clinical setting, such as a hospital, maternity clinic, public health centre, private midwifery practice, or rural area, to achieve a specific number of clinical competencies. Clinical placement organised by midwifery schools and midwifery student is part of the midwifery unit roster. As such, memoranda of understanding with terms and conditions applied and mapping clinical practice between midwifery schools and clinical settings were required. Different kinds of clinical settings, therefore, have their administrative requirements prior to clinical placement. Clinical placement of the midwifery students to midwifery setting depends on each midwifery school and midwifery programme, and how each midwifery programme is organised into different kinds of midwifery settings. Essentially these differences are related to different types of midwifery programmes which influence where the students are placed. These differences included the midwifery programme using an integrated per week model of clinical placement or being reliant on the fragmented care learning model. In order to understand how the implementation of clinical experience for midwifery students, clinical meetings with key people and mentor midwives occur. Prior to the commencement of the clinical placement, an entry test is sometimes required. No national guidelines exist for clinical practice or for the criteria to become a mentor midwife. This is left to each midwifery programme and agreements with clinical settings.

Additionally, a number of midwifery student cohorts and owners of midwifery schools (private or public) were strongly influencing the midwifery schools to pay for clinical practice. Generally, each midwifery school identifies the enrolment fee, the tuition fee, and building services fee. The cost of midwifery education is listed in Table 2.8 below, based on information gathered from some midwifery schools' websites to provide a picture of the financial management of the schools. For the reason of confidentiality, the names of the two midwifery schools are not given and only a brief description of the cost is provided. Therefore, further investigation is needed regarding the cost of midwifery education as none of the midwifery schools transparently or briefly explained how the midwifery schools pay for clinical placements.

Table 2.8 Example of cost of midwifery education programme

Name of midwifery school	Type	Type of midwifery programme	Cost
School A	Public	Bachelor	Tuition fee: 7,500,000 = NZD 805.25 Education development: 15,000,000 = NZD 1610.49 Matriculation: 6,000,000 = NZD 644.20 Entry test fee: not mentioned
School B	Private organisation	Diploma of Midwifery	Tuition fee: 3,000,000 = NZD 322.10 Education development: 6,600,000 = NZD 708.62 Tuition fee for 1 credit: 345,000 = NZD 37.04 Medical kit: 475,000 = NZD 51 Book: 750,000 = NZD 80.52 Uniform: 1,500,000 = NZD 161.05 Entry test fee: 200,000 = NZD 21.47
		Professional midwifery programme	Tuition fee: 3,000,000 = NZD 322.10 Education development: 7,000,000 = NZD 751.56 Medical kit: 475,000 = NZD 51 Book: 750,000 = NZD 80.52 Uniform: 1,500,000 = NZD 161.05 Entry test fee: 200,000 = NZD 21.47
		Advanced Diploma for Midwifery educator	Tuition fee: 3,250,000 = NZD 348.94 Education development: 6,250,000 = NZD 671.04 Tuition fee for 1 credit: 345,000 = NZD 37.04 Book: 350,000 = NZD 37.58 Uniform: 1,200,000 = NZD 128.84 Entry test fee: 200,000 = NZD 21.47

In Indonesia, the Ministry of Health has described the standard competencies specific to midwives (Keputusan Menteri Kesehatan Republik Indonesia, 2007). There are nine standards of midwives' competencies including: professional knowledge, skills, professional behaviour and attitude, counselling, ethics, high quality of midwifery care

from the planning of pregnancy, contraceptive advice, sexual health, and comprehensive care of children to the age of five. The nine standards, stated in government policies, provide the foundation for the scope of midwifery practice of midwives at maternity services. To attain these competencies, potential midwives need to have assessed real patients (women) in the full range of clinical areas.

2.11 Differences between midwifery programmes

The curriculum of each of the diploma, advanced diploma and bachelor's programmes have some significant differences regarding the subjects taught, the clinical and skill requirements, and the entry criteria (see Appendix A). For example, Diploma of midwifery students are required to complete a list of specific clinical competencies by the end of midwifery education which includes: conducting 50 births, doing antenatal care which includes 100 laboratory tests, and giving 50 immunisations. The specific number of clinical competencies during the three-year programme was a national agreement (see Appendix A). Advanced diploma and bachelor's programme vary depending on their midwifery school policy as there are no academic documents published about these programmes. The differences in the specific number of clinical competencies arise from a different types of midwifery programmes. Additionally, professional midwifery programmes have not published a curriculum. It is recognised that professional midwifery programmes are still working on this (Indonesian Midwives Association, 2019).

Along with skills, the curriculum structures of the Advanced Diploma of Midwifery and the Bachelor of Midwifery also specify the theory, practice, and clinical experience that must be provided. It is reported that the Advanced Diploma of Midwifery curriculum has 58 credits for theory (1 credit = one contact hour/week), 38 credits for simulated practice (1 credit = 2 contact hours/week), and 53 credits for clinical practice (1 credit = 4 contact hours/week) (Fakultas Kedokteran Universitas Padjadjaran, 2015). In comparison, the Bachelor of Midwifery curriculum has 146 credits for theory and simulated practice and 36 credits for clinical practice (see Appendix A), while professional midwifery programmes are still developing their curriculum (Indonesian Midwives Association, 2019; Midwifery Undergraduate Degree Programme Fakultas Kedokteran Universitas Brawijaya, 2016). The Advanced Diploma and Bachelor of

Midwifery programmes decide upon the assessment criteria and evaluation methods for their curriculum.

All midwifery programmes start with introductory subjects such as humanities, Bahasa Indonesia, English, civil education, religion and concept of midwifery that provide a broad overview of midwifery in Indonesia and the profession internationally. Midwifery students learn about subjects ranging from midwifery care during preconception, and normal childbearing, to maternal and neonatal pathology care. Communication skills, family planning, reproductive health, and infant and childcare are also taught. The advanced diploma and bachelor's curricula incorporate: management, leadership and entrepreneurship; community care and enhancing the midwife as a midwifery educator and community midwife; the methodology to increase the midwifery student's understanding of the scope of practice of a midwife; and being a researcher. In the bachelor's programme, bioscience consists of biomolecular and basic biochemical science, anatomy, physiology, microbiology, parasitology, and pharmacology, which are designed to tailor the understanding of the science of practice. However, there was no agreement on the differences between the competencies for the Diploma of Midwifery, Advanced Diploma of Midwifery and Bachelor of Midwifery programmes. The midwifery component, including the skills required, such as minimum requirements for the number of births, is left to each midwifery school.

Furthermore, the admission criteria for the different midwifery programmes are similar. For example, entry to the four-year Advanced Diploma of Midwifery programme requires women who have an interest in becoming a midwife to have a minimum height of 155 centimetres and to have graduated from senior high school with science. There are no formal documents that explain the rationale for the height restriction. Based on my experience, it was associated with the height of the bed in the maternity unit and it was deemed to be essential that a midwife can reach the bed with a normal gesture. Potential students sit an academic test, a health test, and a psychology test. Personal interviews are also conducted (Fakultas Kedokteran Universitas Padjadjaran, 2015). Candidates for the five-year Bachelor of Midwifery programme have similar admission criteria to the Advanced Diploma of

Midwifery and the Diploma of Midwifery (Universitas Airlangga, 2017). The admissions process is part of university activities and needs approval by faculty and university. In this way, all midwifery programmes (diploma, advanced diploma and bachelor's) are also obliged to meet minimum requirements such as passing a written test, a health test, and an interview.

2.12 The national midwifery competency test and requirements to become a registered midwife

After successful completion of a midwifery programme, graduates have to register as midwives by passing a national competency test set by the Ministry of Research, Technology, and Higher Education and complete a number of other requirements before they can be certified to practise as a midwife (Indonesian Midwives Association, 2016; Menteri Kesehatan Republik Indonesia, 2011, 2017). Prior to the ratification of the Midwifery Act 2019, the national competency test was designed to evaluate the fresh graduates of midwifery schools as the number of fresh midwives increased from around 50,000 in 2006 to about 200,000 in 2012. Based on some midwifery reports that showed that many new midwives had inadequate knowledge, skills and clinical experience, and indicated that their competency levels as substandard. The rapid growth of midwifery schools not being followed by a proper credentialing process was identified as a problem (Anderson et al., 2014; Middleton, 2014; Rokx et al., 2010; The US National Academy of Sciences & the Indonesian Academy of Sciences, 2013). Therefore, in 2011, with World Bank support, the Ministry of Health collaborated with the Ministry of Education and Culture to embark on a process of regulatory reform which involved the standardisation of education. In 2011, under a Ministerial Decree, the Indonesian Health Profession Board was established to implement the reforms. The Indonesian Health Profession Board's tasks were to assist the Ministries of Health and Education in formulating policies and strategies to improve the quality of health services provided by health care providers. There are three divisions under the chairman of this board which are a division of registration, a division of competency testing, and a division of professional development (Middleton, 2014; The US National Academy of Sciences & the Indonesian Academy of Sciences, 2013).

Based on National Law 12/2012 on Higher Education (Presiden Republik Indonesia, 2012b), it is stated that the competency certificate is needed to assure the quality of midwifery education. Therefore, the national competency test is held, with the aim of improving the quality of midwifery education. In 2014, the Indonesian Government had produced umbrella policies to manage the national competency test for new graduates midwives (Dewan Perwakilan Rakyat Republik Indonesia & Presiden Republik Indonesia, 2003; Menteri Pendidikan Nasional, 2008; Pemerintah Republik Indonesia, 2014; Presiden Republik Indonesia, 2005a). The national committee for the implementation of the national competency test was composed of some midwifery lecturers selected by the Ministry of Research, Technology, and Higher Education. The blueprint of the national competency test included all areas of midwifery competencies: women's health (teenagers, pre-conception, antenatal care, labour care, postpartum care, menopause, care for newborn, baby and child under five); midwifery scope of practice (physiology, detecting obstetric complications, referral mechanisms, emergency care); management of midwifery care (assessment, diagnosis, planning, implementation, evaluation); subject of midwifery care (individual, family, community); and setting of midwifery practice (communities, health clinic, hospital). There are 180 multiple choice midwifery cases, and fresh graduates will choose A, B, C, D, or E and fill in the answer sheet with a response for each case. As a result, the competency certificate states whether the graduate is competent or not competent (Kementerian Riset, Teknologi dan Pendidikan Tinggi, 2019a; Ristekdikti, 2019). Also, in 2019, this board released a guideline about preparation for fresh graduates who will take the national competency test. This included a list of preparation guides for the national competency test including registration, general information about the competency test, example material, references used for the competency test, exercises, and discussion. Fresh graduates receive a competency certificate which is then utilised to apply to be a registered midwife (Kementerian Riset, Teknologi dan Pendidikan Tinggi, 2019a).

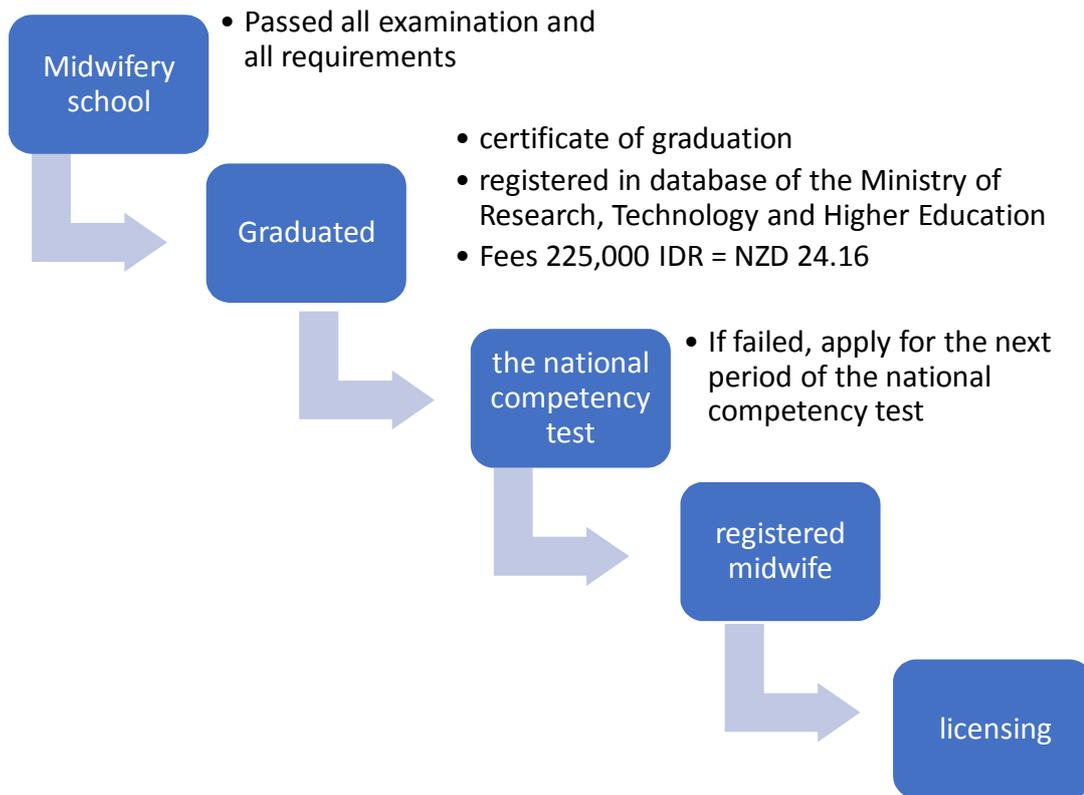


Figure 2.9 Scheme of the national competency test and registered midwife, adapted from Kementerian Riset, Teknologi dan Pendidikan Tinggi (2019a), Middleton (2014), Ristekdikti (2019)

The registration certificate of the midwife will be released by the Indonesian Health Profession Board which includes a member appointed by the Indonesian Midwives Association (Majelis Tenaga Kesehatan Indonesia, 2015; Menteri Kesehatan Republik Indonesia, 2011). The Ministry of Health of the Republic of Indonesia determines the standards of midwifery competence required for an Indonesian midwife to work within the scope of midwifery practice, including fulfilment of individual elements and minimum standards that are expected to be present to be a midwife (see Table 2.9, below) (Keputusan Menteri Kesehatan Republik Indonesia, 2007). Furthermore, the Ministry of Health states that the graduate midwives' profile in Indonesia has to show that a graduate is a qualified midwifery care provider, decision-maker, communicator, community leader, and manager (Kementerian Kesehatan Republik Indonesia, 2011).

Table 2.9 The requirement to become a registered midwife in Indonesia

An obligation to become a certified midwife (new):

1. Midwifery degree-minimum diploma of midwifery programme
2. Competency certificate
3. A certificate of physical and mental health
4. Statutory declaration
5. Will adhere to professional ethics
6. Statement letter has the private midwifery place
7. A cover letter from the head of healthcare
8. Recommendation letter from the public health official
9. Recommendation letter from the Midwifery Association
10. The newest formal picture

The requirement for recertification as a registered midwife:

1. Copy of the ID of the member of the association
 2. The previous certificate of registered midwife
 3. Competency certificate of a midwife
 4. The newest formal picture
 5. Fulfil their midwifery care activities, continuing education, compulsory training, community services, professional development and scientific activities
 6. Fees as a member
 7. Administration fees for fulfilling re-registration and recommendation letter
-

Source: Indonesian Midwives Association (2016), Menteri Kesehatan Republik Indonesia (2011, 2017)

Furthermore, newly graduated midwives have to provide further documents as administrative prerequisites to apply for a job as a midwife. Some hospitals have published their requirements on their website (RS Universitas Andalas, 2017; Rumah Sakit Umum Daerah Dr Tjitrowardojo, 2017; Rumah Sakit Umum Dr Soedono, Madiun, 2017) including requiring newly graduated midwives to attend mandatory APN (Asuhan Persalinan Normal) training:

1. Have a degree (minimum diploma of midwifery). A cover letter cannot be used to apply for a job.
2. Have the Indonesian midwife registration/certificate.
3. Have as a minimum the certificate of training, such as APN training.
4. Commonly graduated from midwifery school with minimum B accreditation for private organisations.

Nationally, the Midwifery Association has implemented the training standard of delivery care called APN to increase the midwifery skills of midwives. This training is part of the government programme to improve the skills of midwives since all

deliveries have to be accompanied by skilled birth attendants. Based on evaluations, there was lack basic competency core skills among midwives since there was no continuing professional development (CPD) training once the midwives graduate from diploma programme (Hennessy, Hicks, Hilan, & Kawonal, 2006; Hennessy, Hicks, & Koesno, 2006; Kemenkes R. I. et al., 2010).

The APN course is ten days of training divided into four days theory and six days in the field to obtain a minimum of three supervised standard care births. Based on records, only 14% of the total number of midwives in Indonesia have attended the training, even though it is an obligation for all midwives (Kemenkes R. I. et al., 2010). Later, the midwifery regulation was altered and stated that the personal specifications require a new midwife to hold the certificate of APN to apply for a midwife position. Furthermore, other training such as Management of Lactation, Contraceptive Update, Midwives' Updates, or a relevant certificate of training in obstetric-gynaecology is preferable when applying for a job as a midwife (RS Universitas Andalas, 2017; Rumah Sakit Umum Daerah Dr Tjitrowardojo, 2017; Rumah Sakit Umum Dr Soedono, Madiun, 2017).

2.13 Summary of Chapter 2

In this chapter, an overview of midwifery education has been explored. The critical position of the midwife and midwifery education in Indonesia was examined by explaining the contextual background of the midwife in the effort to reduce maternal and neonatal mortality rates. This chapter has examined the efforts of the Indonesian Government to combat maternal and neonatal mortality rates. Significant policies and strategies have been implemented across the decades to reduce the high maternal and neonatal mortality rates in Indonesia. The existence of the midwife and midwifery education, as well as the development of midwifery education from the time of Dutch colonisation to the present day has been explored. This exploration was needed to elucidate the past, present and future of midwifery education in Indonesia. The background information regarding midwifery education in Indonesia provides an essential ingredient for understanding this inquiry into strengthening midwifery education in Indonesia. The exploration of the Midwifery Association and the accreditation agency, the number of midwifery schools, midwifery curricula, as well as

the national competency test and the requirements of becoming a midwife has revealed many factors influencing the evolution of midwifery education in Indonesia. In the following chapter, the literature review discusses the strengthening and enhancement of midwifery education in developing countries.

Chapter 3.

Literature Review

3.1 Introduction

In this chapter, the pertinent literature is reviewed to identify what research has been done in the area of midwifery education in developing countries. The literature is synthesised, scrutinised, and organised by theme to provide a rationale for the research problem being studied. Literature providing both context and scope of the material that needs to be considered for strengthening midwifery education in developing countries is presented, and gaps in the literature are identified.

3.2 Background to a global picture of midwifery education in developing countries

The ICM (2014) and WHO (2009) outlined the international standards for midwifery education, which include criteria for midwifery faculty, admission, midwifery students, midwifery curriculum, resources, and facilities. These competencies and standards have remained the benchmark against which the majority of studies reviewed have been measured. The competencies and global standards set out by the ICM have been re-evaluated independently since the development in 2002, which revised in 2010, 2013 and updated in 2018.

In 2013, at the 66th World Health Assembly (WHA), member states passed Resolution 66.23 called “Transforming health workforce education in support of universal health coverage”. This resolution noted that the health workforce education challenge is global, and observed the need for intersectoral collaboration between the Ministry of Health, the Ministry of Education, public and private institutions and health professional organisations in strengthening the health workforce education system to produce competent health workforces that support universal health coverage (World Health Assembly, 2013).

Prior to this, the WHO (2013a) published education guidelines called “Transforming and scaling up health professionals education and training”. These guidelines set out five domains and recommendations on the best way to reach the objective of producing graduates quickly to respond to the health requirements of the people in the country, including: 1) education and training institutions; 2) accreditation, regulation; 3) financing and sustainability; 4) monitoring and evaluating; and 5) governance and planning (WHO, 2013a). The WHO (2013b) has also developed standards for midwifery educators’ competency with the work involving 70 experts in Geneva in 2012 and a global Delphi survey. Well-qualified midwifery educators are defined by WHO as having core competencies including education, qualification, clinical midwifery experiences, and educational training. These ICM and WHO documents underpin midwifery education globally and the research regarding strengthening midwifery education, especially in developing countries.

The Lancet’s series about midwifery provided compelling evidence that educated, licenced and regulated midwives from high-quality midwifery education programmes play a pivotal role in countries burdened with high maternal mortality rates (Homer et al., 2014; Renfrew et al., 2014; ten Hoope-Bender et al., 2014; Van Lerberghe et al., 2014). Further, the UNFPA et al.’s (2014) *State of The World’s Midwifery* report detailed the condition of midwifery in 73 of the 75 developing countries with high maternal and neonatal mortality rates. The report stated that a midwife is a critical element in reducing maternal and neonatal death. The *State of The World’s Midwifery* report (UNFPA et al., 2014) gathered data through a questionnaire administered to a workshop of experts, and incorporated secondary data, concluding that developing countries contribute to 96% of global maternal mortality, 91% of global stillbirths and 93% of global neonatal mortality. This report found that despite progress in midwifery education across these countries, many elements were identified as still lacking such as infrastructure, qualification of teachers, clinical practice, and regular update and review of the midwifery curriculum. Also lacking was training for teachers and a lack of accreditation of midwifery programmes (UNFPA et al., 2014).

Some barriers identified by the ICM, WHO, and The White Ribbon Alliance (2016) were that there were unequal power relations within the health system which impacted the capability of midwives to offer quality midwifery care. The ICM et al. (2016) also found that there was a lack of adequate midwifery education, including access to higher education and professional development, and a lack of accreditation and regulation. From this report, it was proposed that midwifery programmes be taught by experienced midwifery educators and with standardised midwifery curricula. It is reported that midwives, who are trained, skilled and standardised to global standards, can offer 87% of the primary care required by women and newborns (UNFPA et al., 2014). Furthermore, Homer, et al., (2014) argued that midwifery with both family planning and interventions for maternal and neonatal health could avert a total of 83% of all maternal deaths, stillbirths, and neonatal deaths.

Moreover, the key areas to target to reach the SDG 2030 have been stated, in “Global strategic directions for strengthening nursing and midwifery 2016-2020”, as including education, continuing professional development, partnership, and political will (WHO, 2016a). The literature shows that a commitment to enhanced midwifery education remains on the global agenda to ensure the competence of new midwives and the sustainability of midwifery services for ensuring optimal maternal and neonatal health outcomes. There is an international commitment that improved midwifery education in developing countries is required to produce qualified new midwives, who can offer quality midwifery care (Castro Lopes et al., 2016; UNFPA, 2017; UNFPA et al., 2014a; WHO, 2016a). A case study of Bangladesh reported by UNFPA et al. (2014a) asserted that 500 trained, skilled, and set-up midwives across the country decreased maternal mortality by up to 80% and scaled-down neonatal mortality by 75%.

Midwifery education has been determined to be a crucial element contributing to the maternal and neonatal mortality morbidity rates in developing countries. A Cochrane systematic review (Munabi-Babigumira, Glenton, Lewin, Fretheim, & Nabudere, 2015) has stated that the quality of education is one factor, alongside government policy, social-cultural environment, human resources, financing, and health systems, that

influences midwives to deliver high-quality midwifery care, and ensures the optimum outcomes of maternal and neonatal health in developing countries.

3.3 The literature review process

Relevant papers were chosen by applying inclusion and exclusion criteria to ensure the significance of their contribution to the research topic on pre-service midwifery education (Randolph, 2009) (see Table 3.1, below). Appropriate articles were identified from the following electronic databases: Science Direct, Pubmed, OVID, CINAHL, Medline, Scopus, and Google Scholar. Studies on experiences in midwifery school or relevant participants (nurses considered as midwives) and written in English were included; as were studies published between 2008 and 2018. Also included were studies which investigated midwifery education to upskill birth attendants. In countries with high maternal and neonatal mortality rates, programmes have been established to scale up the numbers of skilled birth attendants such as midwives (UNFPA et al.,2014). The review was limited to developing countries as per the setting for this current study. A descriptive narrative approach was selected for this review as it allows the literature in a specific area to be summarised and synthesised, and gaps within the current knowledge to be identified (Cronin, Ryan, & Coughlan, 2008).

Table 3.1 Inclusion and exclusion criteria

	Date of publication	Country	Language	Participants	Study design
Included	2008-2018	Developing countries as defined by the United Nations	English	Midwives, midwifery students or key person in midwifery school/ maternity services/ association/ government	Qualitative and quantitative studies
Excluded	Before 2008	Developed countries as defined by United Nations	Other than English	Doctors, nurses, traditional birth attendants	Opinion/ discussion papers, theoretical papers, conference papers

Appropriate studies concerning evaluation and improvement of pre-service midwifery education in developing countries were sought by applying the Boolean items OR and AND (Cronin et al., 2008). Keywords and relevant phrases containing combinations of words were used, including midwifery education, midwifery school, midwifery, the importance of midwifery education, strengthening/enhancing/improving midwifery education, developing country. Countries were included if they met the United Nations (2012) developing countries classification. Papers were excluded if they involved nurses, traditional birth attendants or nursing education, unless they were about upskilling these health workers to become midwives. Moreover, opinion and philosophical/ theoretical articles were eliminated from the literature review process.

The sections of the research papers which reported the findings were reviewed to identify successful elements of strengthening midwifery education in developing countries. The review of this literature provides an understanding of key aspects of approaches that may have been seen to be effective in strengthening midwifery education in developing countries. Relevant articles were documented in an Endnote library.

The initial search resulted in 921 papers. The titles and abstracts were read and reviewed to identify the relevant papers. After reviewing the abstracts, 772 possible relevant papers remained. More detailed investigation for possible inclusion was applied as per the research question to identify the key factors concerning the evaluation or improvement of midwifery education in developing countries. This led to a further, 401 papers being removed. Further, the application of exclusion criteria and removal of duplicates resulted in further papers being discarded, leaving 41 relevant papers. The literature review process can be seen in the chart below. The quality of the relevant papers was further assessed by a critical appraisal of the research (Heyvaert, Hannes, Maes, & Onghena, 2013; Kuper, Lingard, & Levinson, 2008). Initially, six key questions were utilised to review the papers systematically. According to Kuper et al. (2008), a thorough assessment can be done using interpretive action and reflective thought rather than a scoring system. The six key questions used to review the research focused on: the appropriate sample as per the research question; appropriate data collection; proper data analysis; transferability; and ethical issues, including reflexivity for qualitative research (see Tables 3.2 and 3.3). All relevant papers were assessed according to the critical areas identified by Heyvaert et al. (2013) and Kuper et al. (2008)

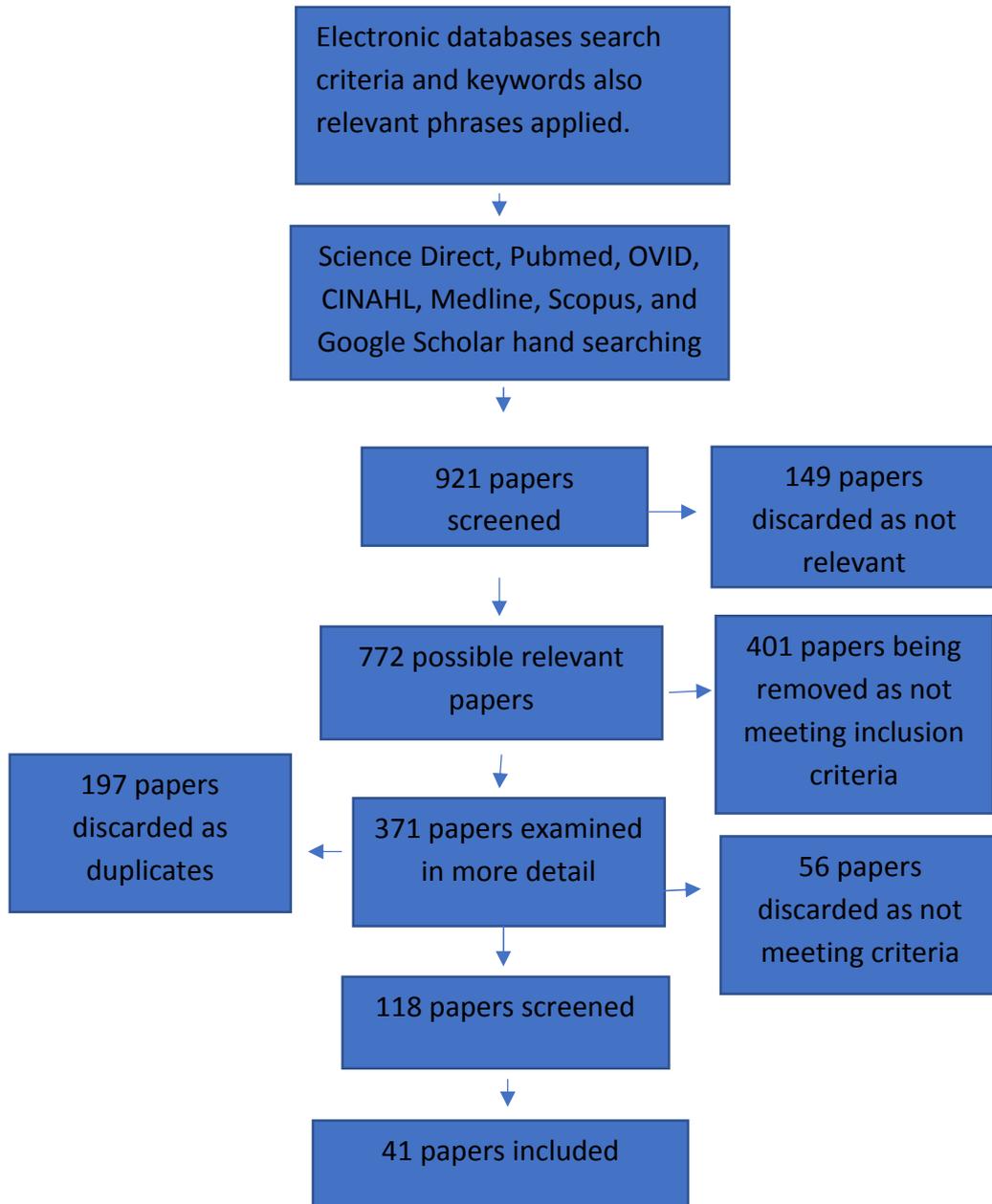


Figure 3.1 Overview of the literature review process

Table 3.2 Key questions to ask when reading qualitative research studies

Number	Questions
1.	Was the sample used in the study appropriate to its research question?
2.	Were the data collected appropriately?
3.	Were the data analysed appropriately?
4.	Can I transfer the results of this study to own setting?
5.	Does the study adequately address potential ethical issues, including reflexivity?
6.	Overall: is what the researchers did clear?

Source: Kuper et al. (2008).

Table 3.3 Generic critical appraisal criteria

Number	Criteria
1.	Articulating the theoretical framework of the study
2.	Presenting the research aims and questions
3.	Employing an appropriate design
4.	Employing appropriate sampling and data collection methods
5.	Implementing appropriate data analysis methods
6.	Presenting the interpretation, conclusions, inferences, and implications of the study
7.	Putting the context of the research
8.	Explaining the impact of the researchers
9.	Being transparent in the reporting of the study

Source: Heyvaert et al. (2013)

3.4 Description of the reviewed papers

Papers identified in this literature review are listed in Table 3.4. Often, the studies did not mention the differences between nurses and midwives. In some countries, the pathway to midwifery is through nursing, and midwifery students have to become a registered nurse first before becoming a registered midwife. As long as the pathway leads to registration as a midwife, the research papers were included

Table 3.4 The reviewed papers

No	Papers	Objective of study	Country	Methodology	Participants	Results
1.	Smith, Currie, Azfar, and Javed Rahmanzai (2008) Title: Establishment of an accreditation system for midwifery education in Afghanistan: Maintaining quality during national expansion	To establish a mechanism for ensuring and regulating quality pre-service midwifery education during a period of intense expansion (between 2003 and 2007) in Afghanistan	Afghanistan	Case study – standards-based management and recognition	21 midwifery schools	All midwifery schools were authorised to reach accreditation. Most schools were accredited. One school was closed because of the inability to achieve the national standards.
2.	Akiode, Fetters, Daroda, Okeke, and Oji (2010) Title: An evaluation of a national intervention to improve the postabortion care content of midwifery education in Nigeria	To examine the impact of a national intervention conducted between 2003 and 2006 to improve the post-abortion care (PAC) content of midwifery education in Nigeria	Nigeria	Mixed methods	Six midwifery schools for evaluation, 169 midwifery educators from 70 midwifery schools, 149 graduate midwives	All schools had training on PAC and manual vacuum aspiration. Schools had at least two instructors who had received training; had post-abortion teaching aids, educational materials and manual vacuum aspirators. Midwifery educators had more knowledge and skills regarding PAC and manual vacuum aspiration. However, graduates were better prepared because most were working at facilities with functioning manual vacuum aspiration equipment.

3.	Binfa, Pantoja, Gonzalez, Ransjö-Arvidson, and Robertson (2011) Title: Chilean midwives and midwifery students' views of women's midlife health-care needs	To determine Chilean midwives' views with regards to Chilean women's health-care needs in midlife and to explore Chilean midwifery students' perspectives on the clinical care offered to women in midlife from November 2008 to April 2009 in Santiago, Chile	Chile	Qualitative study	22 midwives, 13 midwifery students	Midwives reported that they had poor performance in assessing psychosocial and women's social health care, such as sexuality problems, abuse, and violence. Midwifery students had difficulties dealing with women's social health care, including counselling. Midwifery students also questioned the midwives disrespectful attitude to women, including towards minority and immigrant women. Midwives and students mentioned the need for social and communication skills to better interact with psychosocial aspects affecting women's lives.
4.	Fullerton, Johnson, Thompson, and Vivio (2011) Title: Quality considerations in pre-service midwifery education: Exemplars from Africa	To stimulate discussion about issues that must be carefully considered in the context of midwifery educational programming and the expansion of the midwifery workforce	Ethiopia, Ghana, Malawi	Mixed qualitative and quantitative, in the context of the outcomes of a USAID project	Country-level participants, midwives, students, representative of the donor, collaborating and implementing	Compared routes to midwifery, student admission, midwifery curriculum, teaching/ learning strategies, accreditation, assessment. Found big differences, inconsistencies in pathways, nurses or direct entry, length of programmes. Recommended selection

				agencies		pathway using international recommendations.
5.	Gross, McCarthy, and Kelley (2011) Title: Strengthening nursing and midwifery regulations and standards in Africa	Describes the initiative (the African Health Profession Regulatory Collaborative for Nurses and Midwives), presents the approach and results, and discusses vital strengths that have emerged during the first year of implementation	East, Central, and Southern	Collaborative regulatory improvement	14 country teams	First regional conference held in Kenya to discuss professional regulatory issues. Ten countries submitted a one-year grant proposal for regulation improvement projects. Technical assistance included the review of national scopes of practice for midwives and nurses.
6.	Mansoor, Hill, and Barss (2012) Title: Midwifery training in post-conflict Afghanistan: Tensions between educational standards and rural community needs	To compare the performance of students selected for midwifery education by three methods: community mobilisation in rural Afghanistan, a regional examination by the Institute of Health Sciences and the National University Entrance Examination.	Afghanistan	Retrospective survey	178 midwifery graduates, 31 final-year students, key informant	96% of graduates from communities were employed, although their academic performance was lower within education. There was no difference in pass rates and the acquisition of practical skills.
7.	Bogren et al. (2012) Title: Midwifery education, regulation and association in six	To describe the situation of midwifery education, regulation and association in six South Asian countries	Afghanistan , Bangladesh, Bhutan,	Descriptive	One teacher, one decision-maker, and one representative	Variations exist in the level of midwifery education, midwifery curriculum, qualifications of teachers, midwifery regulation,

	South Asian countries – A descriptive report		India, Nepal, Pakistan		for midwifery association	the and	and midwifery association. This study also reported midwifery challenges and recommendations.
8.	Shaban, Barclay, Lock, and Homer (2012) Title: Barriers to developing midwifery as a primary health-care strategy: A Jordanian study	To identify the current barriers to developing midwifery as a primary health-care strategy in Jordan and exploring the strategies to overcome these barriers	Jordan	Exploratory design using an action research approach	52 midwifery providers, 12 midwifery educators		Barriers identified: professional recognition, societal recognition and image, stress and workload, medical domination of services, the importance of midwifery education. Strategies suggested: including role models and skilled midwifery leaders, national consumer network, midwifery assistant and clear job description, strong, effective regulation, education re-development.
9.	Turkmani et al. (2013) Title: ‘Midwives are the backbone of our health system’: Lessons from Afghanistan to guide expansion of midwifery in challenging settings	At the request of the Ministry of Public Health an evaluation to improve the pre-service midwifery education programme through the identification of its strengths and weaknesses	Afghanistan	Mixed methods	138 midwifery graduates, 20 key informants, 24 focus group discussions with women		Midwifery graduates reported overall satisfaction with the quality of their education. Midwives and stakeholders perceived that women were more likely to use midwifery services in villages where midwives set up. Strengths of the midwifery education

						programme, included evidence-based content, standardised materials, clinical training and a supportive learning environment. Weaknesses of the programme were identified.
10.	Sangestani and Khatiban (2013) Title: Comparison of problem-based learning and lecture-based learning in midwifery	To compare the effect of problem-based learning (PBL) and lecture-based learning on the satisfaction and learning progress of undergraduate midwifery students.	Iran	Quasi-experimental study	56 midwifery students	PBL significantly improved the application of theory lesson in clinical practice, increased learning motivation, educational activity. There was more satisfaction with the PBL method, and PBL was considered a more suitable and better method.
11.	Sharma, Johansson, Prakasamma, Mavalankar, and Christensson (2013) Title: Midwifery scope practice among staff nurses: A grounded theory study in Gujarat, India	Explores and describes the midwifery scope of practice among staff nurses in Gujarat, India	India	Grounded theory approach	28 service providers from maternity facilities.	Midwifery falls under the nursing profession. Right to practice is unclear as is midwifery regulation and licensing.
12.	McCarthy et al. (2013) Title: Nursing and	To describe the perspectives	East, Central, and	Survey	Nine chief nursing officers,	The majority reported task shifting. Stakeholders reported

	midwifery regulatory engagement of Southern Africa (13 countries)	reform in east, central, and southern Africa: A survey of key stakeholders	stakeholders in advancing critical regulatory and educational reform		10 association presidents, eight academicians	different roles and levels of involvement concerning midwifery regulation. The challenge most impacting midwifery regulatory reform was the absence of capacity and resources required to implement change.	
13.	Bogren, van Teijlingen, and Berg (2013)	Title: Where midwives are not yet recognised: A feasibility study of professional midwives in Nepal.	Explores the feasibility of establishing a professional midwifery cadre in Nepal that meets the global standards of competencies and to define a strategy to reach this	Nepal	Mixed-methods	21 key persons from the Government of Nepal, professional organisations, NGO, UN agencies	There were variations of cadres offering midwifery care, education level and regulation. A professional association for staff providing midwifery care and assessments of academic institutions. Some strategies proposed include: legislation and regulation; training and education; deployment and utilisation; and professional associations.
14.	Zainullah et al. (2014)	Title: Establishing midwifery in low-resource settings: Guidance from a mixed-methods evaluation of the Afghanistan	Analyse the costs and graduate performance outcomes of the two types of pre-service midwifery programmes in Afghanistan that were either established or strengthened between	Afghanistan	A mixed-methods	138 midwifery graduates for skill assessment, 20 key informant interviews, 24 focus group	Community midwifery education graduates achieved an overall mean competency score on the clinical competency assessment compared for Institutes of Health Sciences. The average cost of the

	midwifery programme	education	2002 and 2010 to guide future programme implementation and share lessons learned			discussions with women, clinical practices documentation	midwifery programme \$298,939 or \$ 10,784 per graduate.
15.	Speakman, Sondorp, Atta, and Howard (2014) Title: Development of the Community Midwifery Education initiative and its influence on women's health and empowerment in Afghanistan: A case study	Shafi, Shafi, and Atta	Analyse the community midwifery education development and implementation to help determine successes and challenges	Afghanistan	Case study	Eight key informants	The community midwifery education programme has contributed to consistently positive indicators, including up to a 1273/100,000 reduction in maternal mortality ratios, up to a 28% increase in skilled deliveries and a six-fold increase in qualified midwives since 2002. This programme gained the support of international donors, the Afghan Government and civil society.
16.	Yigzaw et al. (2015) Title: How well does pre-service education prepare midwives for practice: Competence assessment of midwifery students at the point of graduation in Ethiopia.		To evaluate the quality of midwifery education by assessing the competence of graduating midwifery students	Ethiopia	Cross-sectional study	484 midwifery graduates from 25 public institutions	Basic midwifery education programmes reported including type, qualification, curriculum and entry requirement. Most students rated the learning environment negatively. Only 32% of all students attended 20 or more births, 31.6% of students had overall performance that equal national

						passing standards of 60%, significant factors of achievement of competencies.
17.	Sharma et al. (2015) Title: Do the pre-service education programmes for midwives in India prepare confident 'registered midwives'? A survey from India.	To assess the confidence of final-year students from pre-service education programme (diploma and bachelor's) in selected midwifery skills from the list of midwifery competencies of the ICM.	India	A cross-sectional survey	633 final-year students from 25 nursing institutions considered as midwives	25-40% of students scored above the 75th percentile; 38-50% below the 50th percentile of confidence. Majority of students had not attended the required number of births.
18.	Bogren, Wigert, Edgren, and Berg (2015) Title: Towards a midwifery profession in Bangladesh—a systems approach for a complex world	To explore how actors connect to promote Bangladesh's midwifery profession	Bangladesh	Explorative study	16 informants from different organisations	Some elements described: having a common goal, contributing with different competencies, moving forward through collaboration, challenges to collaboration, creating communication channels for visibility, challenges to communication and being dependent on financial and technical support.
19.	Abou-Malham, Hatem, and Leduc (2015) Title: Analyzing barriers and facilitators to the	To understand the implementation process by identifying the characteristics of this	Morocco	Case study	17 midwives, 29 midwifery educators, 15 midwifery	Facilitators to implementing the action plan: social-cultural system, educational system (training for midwifery

	implementation of an action plan to strengthen the midwifery professional role: A Moroccan case study.	intervention and the dimensions of the three systems which could act as barriers to / facilitators of the implementation process			students	teachers). Barriers: social-cultural system; educational system (dominant technocratic approach, human resources, lack of educational support for teachers, lack of information, lack of collaboration across educational institutes).
20.	Yanti et al. (2015) Title: Students' understanding of "Women-Centred Care Philosophy" in midwifery care through Continuity of Care (CoC) learning model: A quasi-experimental study	To determine any differences in students' understanding of midwifery care philosophy between students who underwent the CoC learning model and those who underwent the fragmented care learning model	Indonesia	Quasi-experimental design	54 final-year midwifery students using a CoC learning model and 52 students from the other school using a fragmented learning model as the control group	There was no significant difference in students understanding of midwifery care philosophy between the two groups before the study. There is a significant difference between the two groups after clinical training.
21.	Moyer et al. (2016) Title: Exposure to disrespectful patient care during training: Data from midwifery students at 15 midwifery	To determine what midwifery students were witnessing, perceiving and learning with regards to respectful care during labour and childbirth	Ghana	Cross-sectional survey	853 final-year midwifery students	Three-quarters of respondents said that maltreatment of labouring women is an issue in Ghana and women are treated more respectfully in private facilities than in public facilities.

	schools in Ghana.					Majority of students saw maltreatment during clinical practice.
22.	Moore et al. (2016) Title: Education, employment and practice: Midwifery graduates in Papua New Guinea.	To explore the education, employment, and practices of newly graduated midwives who studied midwifery in 2012 and 2013 as part of the initiative commenced in 2012 funded by the Australian Government in Papua New Guinea	Papua New Guinea	Mixed methods descriptive study	181 midwifery students and 138 midwifery graduates from four midwifery schools	Almost all respondents were working as midwives. 88% satisfaction with preparation for practice, which includes a clinical component and ability to work in rural areas. Impact of the midwifery education on practice noted.
23.	Dawson et al. (2016) Title: Midwifery capacity building in Papua New Guinea: Key achievements and ways forward	An evaluation of the Maternal Child Health Initiative (MCHI) (2012-2013) to determine critical factors contributing to maternal health workforce strengthening	Papua New Guinea	Descriptive mixed methods	43 stakeholders, 55 course coordinators, 73 educators, 106 midwifery students, 10 faculty members, 29 site reports, eight meetings	Reported the contribution of the MCHI to midwifery clinical teaching and practice and obstetric care
24.	Yigzaw et al. (2016) Title: Using task analysis to generate evidence for	To identify the needs for strengthening the midwifery workforce in	Ethiopia	Cross-sectional study	138 skilled midwives	Analysis of tasks performed. There were gaps in the midwifery programme and the

	strengthening midwifery education, practice, and regulation in Ethiopia	Ethiopia				need for training and exam blueprint for midwifery licensing exam.
25.	Homer, Turkmani, and Rumsey (2017) Title: The state of midwifery in small island Pacific nations	To explore the current situation of the education, regulation and association of midwives in 12 small island nations of the South Pacific and determine the gaps in these areas	PNG, Fiji, Solomon Islands, Vanuatu, Samoa, Kiribati, Tonga, Cook Islands, Tuvalu, Nauru, Niue, Tokelau	Descriptive study	Key country representatives	Midwives needed to be registered nurses and variations of midwifery education programmes, regulation, licensing and midwifery association.
26.	Nyoni and Botma (2017) Title: Aligning summative clinical examination with competence-based curriculum: Midwifery educators experiences in Lesotho	Describes the lived experiences of midwifery educators who developed OSCE	Lesotho	Qualitative study	21 respondents including the heads of institutions, head of the midwifery department, midwifery educators, clinical	Development of the OSCE process in line with the competency-based curriculum resulted in awareness, empowerment and leadership.

					instructors	
27.	Kibwana et al. (2017) Title: Trainers' perception of the learning environment and student competency: A qualitative investigation of midwifery and anaesthesia training programs in Ethiopia.	Explores the perceptions of trainers towards the adequacy of student's learning experience and implications for achieving mastery of core competencies	Ethiopia	Grounded theory	78 informants from midwifery programmes and 18 from anaesthesia programmes	Five themes emerged associated with the quality of training and competency of graduates.
28.	Vuso and James (2017) Title: Effects of limited midwifery clinical education and practice standardisation of student preparedness.	Explores the perceptions of midwifery educators regarding the effects of limited standardisation of midwifery clinical education and practice on clinical preparedness of midwifery students	Eastern Cape in South Africa	Qualitative, explorative, descriptive and contextual research approach	17 midwifery educators from five campuses of the nursing college	Inconsistencies in clinical teaching and practice between midwifery educators and clinical midwives; a professional compromise between educators when evaluating students; midwifery educators having different approaches to evaluation of students
29.	West, Dawson, and Homer (2017) Title: Building midwifery educator capacity using international partnerships: Findings	To determine how one capacity-building approach in Papua New Guinea used international partnerships to improve teaching and learning	Papua New Guinea	Qualitative exploratory case study design	26 midwifery educators	Seven themes emerged which provide insights into the factors that enable and constrain midwifery educator capacity building.

from a qualitative study

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| 30. | Taghizadeh, Khoshnam Rad, and Montazeri (2017)
Title: Basic educational needs of midwifery students for taking the role of assistance in disaster situations: A cross-sectional study in Iran | To investigate the midwifery students' basic educational needs for taking the role of assistant in disaster situations | Iran | Cross-sectional study | 231 final-year midwifery students | 86.8% of students felt not prepared for disaster conditions. Statistically significant between age, educational course, work experience in disaster conditions and educational needs. |
| 31. | Nyoni and Botma (2018)
Title: Sustaining a newly implemented competence-based midwifery programme in Lesotho: Emerging issues | Reports on issues that challenge the sustainability of a newly implemented competency-based curriculum in Lesotho | Lesotho | A qualitative descriptive study with document analysis | 12 administrators, five educators, four clinical educators from five midwifery institutions, five focus group discussions consisting of eight midwifery students per midwifery school | Four themes emerged: accountability within and for the programme, management of the programme, educators' capacity to implement the CBC and students' response to the CBC. |

32.	Phafoli et al. (2018) Title: Student and preceptor perceptions of primary health care clinical placements during pre-service education: Qualitative results from a quasi-experimental study	To describe the effect of primary health care (PHC) placements on students and preceptors	Lesotho	Qualitative methods	69 focus group discussions with 12 second-year nursing students, 12 third-year nursing student (had completed a midwifery course), 24 midwifery students, nine nurse-midwifery educators, 12 preceptors	Four themes emerged: the contribution of PHC clinical placements on confidence and competence of students and preceptors; contribution of PHC clinical placements on relevant skill acquisition; effect of PHC clinical placements on deployment decisions; logistics and recommendations for clinical placements.
33.	Isbir and Ozan (2018) Title: Nursing and midwifery students' experiences with the course of infertility and assisted reproductive techniques: A focus group study from Turkey	To evaluate nursing and midwifery students' experiences with the course on infertility and assisted reproductive techniques	Turkey	Qualitative descriptive	75 nursing and midwifery students	Themes: action, learner-centred, interaction, nursing competencies.
34.	Baloyi and Mtshali (2018b) Title: Developing clinical	Understanding the action/interaction strategies adopted to develop clinical	South Africa	Grounded theory	16 focus group discussions with final-year	Process and competency oriented curriculum, preparation paradigm-shifting of students in

	reasoning skills in an undergraduate midwifery program: A grounded theory inquiry	reasoning skills in an undergraduate midwifery programme that uses a problem-based and competency-oriented approach			midwifery nursing students, academics	12	learning, developing clinical reasoning skills, students paradigm shifts and midwifery educators' roles. Problem-based learning and competency-based curriculum enabled collaborative work among students to develop clinical reasoning skills.
35.	Baloyi and Mtshali (2018a) Title: Clinical reasoning skills in undergraduate midwifery education: A concept analysis	Explain of the concept of clinical reasoning through the identification of its key antecedents and attributes concerning midwifery education and practice	South Africa	Grounded theory	16 focus group discussions with final year midwifery students, midwifery lecturers	12	Antecedents and attributes of clinical reasoning skills presented. The results included inadequate preparation of midwifery graduates, unmanageable high maternal and child mortality rates, a paradigm shift to decentralise midwifery practice, diverse and complex nature of maternity health-care, expanding roles of midwives in the 21st century, sustaining human capital in maternity services, process and product-oriented curriculum, student-centred teaching and learning process, learning environments, purpose-oriented assessments.

36.	Lakhani et al. (2018) Title: Experiences of the graduates of the first baccalaureate midwifery programme in Pakistan: A descriptive exploratory study	To explore the experiences of the first graduates of a Bachelor of Science in Midwifery programme to deepen understanding of their views of the programme's strengths and difficulties, and to obtain their suggestions for change	Pakistan	Qualitative descriptive	21 midwifery graduates	Competence acquisition, attitude transformation, strengths and limitations of the programme. The results discussed theoretical and clinical learning, personal and professional development, an image of a midwife, diverse clinical settings, the content of curriculum, academic environment, and evaluation.
37.	Erlandsson, Doraiswamy, Wallin, and Bogren (2018) Title: Capacity building of midwifery faculty to implement a 3-years midwifery diploma curriculum in Bangladesh: A process evaluation of a mentorship programme.	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 colleges in Bangladesh	Bangladesh	Qualitative and quantitative	19 midwifery faculty member at 10 colleges	Implementation of a mentorship programme between staff members online, the importance of teachers' preparation before clinical practice includes skill labs and clinical teaching, facilitators and challenges in implementing the diploma midwifery curriculum, development of midwifery curriculum, online mentorship programme considered more effective than on-site teaching.
38.	Aein (2018) Title: Midwifery	Explore perceptions and experiences of midwifery	Iran	Qualitative study	30 fourth-year midwifery	Problem-solving based on interprofessional learning is a

	students' experiences of problem-solving based interprofessional learning: A qualitative study	students from interprofessional learning with nursing students			bachelor's students	challenging approach to learning. The participants challenged in a simulated clinical setting demonstrated professional knowledge.
39.	Bogren, Sathyanarayanan, and Erlandsson (2018) Title: Development of a context specific accreditation assessment tool for affirming quality midwifery education in Bangladesh	Explore and describe important 'must-haves' for inclusion in a context-specific accreditation assessment tool	Bangladesh	Questionnaire study	123 nursing educators teaching the midwifery diploma programme	Important components included in accreditation tools are organisation and administration, midwifery faculty, student body, curriculum content, resources, facilities and services, and assessment strategies.
40.	Willott, Sakashita, Gendenjamts, and Yoshino (2018) Title: Distance learning for maternal and child health nurses and midwives in Mongolia: A qualitative evaluation	Provide an analysis of the successes and failures of the programme, in order to improve future versions of this and similar programmes in Mongolia and elsewhere	Mongolia	Qualitative descriptive	22 participants comprising of head nurses and midwives at national and provincial hospitals, nursing and midwifery faculty from all national	Changes made as a result of the programme: clinical and teaching practice as a result of the distance education programme. Clinical competencies have been enhanced. Barriers to change: the structure of the Mongolian health system, under the supervision of an obstetrician when delivering a

<p>41. Muraraneza and Mtshali (2018) Title: Conceptualization of competency-based curricula in pre-service nursing and midwifery education: A grounded theory approach.</p>	<p>Explores the meaning of competency-based curriculum in pre-service nursing and midwifery education in Rwanda</p>	<p>Rwanda</p>	<p>Grounded theory approach</p>	<p>universities</p>	<p>baby; technical and equipment.</p>
		<p>17</p>	<p>staff members: four administrators and leaders; seven academic management and teaching positions; six educators</p>	<p>Competency-based curriculum was conceptualised as transformative, a tool in primary health care philosophy; technology and a modular system.</p>	

3.5 The literature results

The literature findings were synthesised and organised to discuss the patterns across the studies which illuminated the complexities of midwifery education in developing countries. The analysis revealed key themes from the literature about enhancing midwifery education in developing countries. Themes include: the place of accreditation and midwifery regulation in midwifery education in providing a government policy environment; improving the midwifery curriculum to develop the knowledge and skills of midwifery graduates; adequate clinical practice; and resources to build the competency of midwifery students; and the capacity of midwifery lecturers and mentors (who work in clinical settings with students) (see Figure 3.1). Under the four headings of accreditation and midwifery regulation, midwifery curriculum, clinical practice and resources, and midwifery lecturer and mentor, all of the included papers are discussed below.

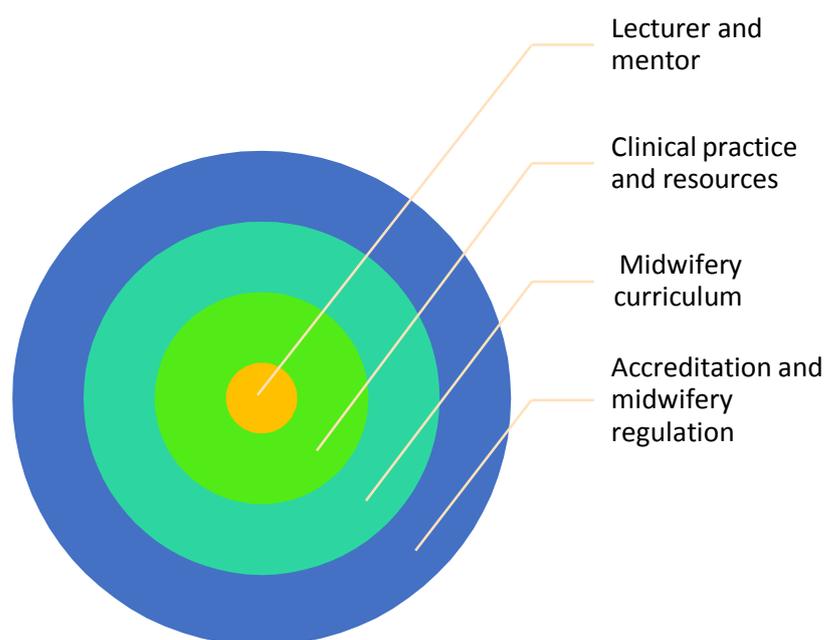


Figure 3.2 Themes of literature review

The first theme reported in this literature review was the importance of accreditation and midwifery regulation in relation to midwifery education.

3.5.1 The place of accreditation and midwifery regulation in midwifery education

Many studies have claimed that midwifery regulation enables a midwife to provide midwifery care as a practising midwife, ensures the development of midwifery education, legislation, and continuing professional development (Bogren et al., 2013; Bogren et al., 2012; Dawson et al., 2016; Gross et al., 2011; Homer et al., 2017; McCarthy et al., 2013). Studies in Bangladesh, Afghanistan, Pacific nations and East, Central and Southern Africa noted that accreditation should be in place to address the quality of midwifery education (Bogren, et al., 2018; Homer et al., 2017; McCarthy et al., 2013; Smith et al., 2008). Studies in Pacific nations and India reported that a lack of accreditation system would be a challenge to fulfilling the quality of midwifery education (Homer et al., 2017; Sharma et al., 2015; Sharma et al., 2013). A study in Afghanistan reported that the Ministry of Public Health updated the accreditation of midwifery education (Speakman et al., 2014; Zainullah et al., 2014) in regard to improving the quality of midwifery education. The experience of the design and implementation of a structured system for accrediting midwifery education programmes in Afghanistan reported that one school closed before the implementation of the programme and reopened two years later; and another school was ordered to close (Smith et al., 2008). This study stressed the vital aspect of the accreditation system to ensure the quality of midwifery education.

Papers on research conducted across South Asia, the Pacific, Jordan and Africa described how the invisibility of midwifery regulation contributed to the unclear scope of practice of the midwife and national recognition, which reflects on midwifery education (Bogren et al., 2013; Bogren et al., 2012; Gross et al., 2011; Homer et al., 2017; Shaban et al., 2012; Sharma et al., 2013). National standards for midwifery education did not exist in India because midwifery is unregulated; therefore, a lack of formal job descriptions at workplaces resulted in self-identity as a nurse rather than a midwife (Sharma et al., 2015; Sharma et al., 2013). In Jordan, midwifery has lower entry criteria compared with nursing and other health professions, so its status in the community is low (Shaban et al., 2012). Blurring of professional roles and belittling by peers, as reported in Jordan and Afghanistan, resulted in midwives having to take non-midwifery duties, including housekeeping tasks and even working as a cleaner in the hospital (Shaban et al., 2012). Medical domination in the health system has also made

midwifery's autonomy difficult in some countries (Shaban et al., 2012; Sharma et al., 2013; Turkmani et al., 2013). Lack of midwifery regulation in India resulted in the difficulties in nurse-midwives to practice as practising midwives. The role of midwives in the workforce, and midwifery education, are seen as subordinate to nursing in India (Sharma et al., 2015; Sharma et al., 2013).

A study in East, Central, and Southern Africa found that midwifery regulation, such as registration, licensing, and pre-service accreditation were established in most of these countries (McCarthy et al., 2013). Nevertheless, in some African countries, the scope of midwifery practice, licencing, CPD, and accreditation systems is still to be developed (McCarthy et al., 2013). With the unavailability of midwifery regulation in some countries across the Pacific to provide the foundation for a scope of practice of midwives, the improvement of midwifery education and midwifery care are all affected and struggle to continue to exist (Homer et al., 2017). Midwifery regulation was acknowledged as having a significant impact on pre-service midwifery education, and it was stressed that some countries reported providing advice to the government in this issue (Homer et al., 2017; McCarthy et al., 2013).

Accreditation and midwifery regulation were evaluated in some countries as beneficial for the credentialing process and clear definitions of the right to practise of midwives in working in the maternity settings. It was found that midwifery regulation would support the strategic plans of governments to produce graduated midwives who would address the maternal and neonatal mortality rates at national levels (Homer et al., 2017; Sharma et al., 2015; Sharma et al., 2013; Smith et al., 2008).

Papers included in this theme represent an understanding that accreditation and midwifery regulation affect the development of midwifery education. The literature highlights accreditation and regulation as a critical factor that has the potential to influence a midwife to practise based on the scope of midwifery practice, national recognition, and professionalism. In summary, papers reviewed under this theme emphasise the significance of an enabling policy environment with political commitment. Having midwifery regulation has been reported to strengthen the status of the midwifery profession. It was acknowledged that accreditation and regulation

were essential to the settlements of the midwifery education led to the improvement of midwifery education.

The second theme identified in the literature review is the importance of the midwifery curriculum to ensure that midwifery graduates develop the required knowledge and skills.

3.5.2 Midwifery curriculum to develop the knowledge and skills of midwifery graduates

It is clear from some of the research reviewed that the development of the midwifery curriculum in countries like Bangladesh, Papua New Guinea, Ghana and Malawi succeeded only because there was a broad coalition of national authorities, professional associations, communities, development partners, health services, and educational institutions (Bogren et al., 2015; Dawson et al., 2016; Fullerton, Johnson, et al., 2011).

Most of the papers highlighted strategies to evaluate the quality of midwifery education. The midwifery curriculum is seen as a strategy for the improvement of midwifery education (Dawson et al., 2016; Muraraneza & Mtshali, 2018; Nyonu & Botma, 2018). Some research studies claimed that the midwifery curriculum would improve the quality of midwifery education (Bogren et al., 2012; Fullerton, Johnson, et al., 2011; Muraraneza & Mtshali, 2018; Turkmani et al., 2013). Fullerton, Johnson, et al. (2011) discussed how a midwifery curriculum which follows ICM international standards and the standardisation of the midwifery curriculum was vital and plays an essential part in determining how a midwifery school develops the knowledge and skills of midwifery students. According to Baloyi and Mtshali (2018a, 2018b), midwifery curricula facilitated the effective teaching and learning process in the classroom, laboratory, and clinical sites. These studies claimed that the midwifery curriculum plays a critical role in facilitating the development of clinical reasoning skills and decision-making. Clinical reasoning and critical thinking skills are built by problem posing, deconstructing a situation, gathering information to generate a midwifery diagnosis, priority, and reflection.

One study in Rwanda (Muraraneza & Mtshali, 2018) revealed that the midwifery curriculum could be seen as transformative if different teaching methods were used, turning midwifery students into competent graduates who are fit to practise and able to deal with dynamic maternity settings. In this context, it can be seen as transformative that midwifery students could learn from memorisation, analysing, and the synthesis of knowledge for decision-making. In comparison, Dawson et al. (2016) and Nyoni and Botma (2018) revealed that the improvement of the quality of the midwifery curricula in Papua New Guinea and Lesotho came about through using new teaching strategies such as simulation activities. However, some countries in South Asia, Africa and the Pacific highlighted that they had an inadequate midwifery curriculum and did not meet the international standard (Bogren et al., 2013; Bogren et al., 2012; Fullerton, Johnson, et al., 2011; Homer et al., 2017).

Besides theory, the midwifery curriculum has to include clinical practice, both laboratory skills and clinical placements, to narrow the gap between midwifery education and clinical practice in maternity services. It was identified that exposure to clinical experience contributed to student learning (Fullerton, Johnson, et al., 2011; Moores et al., 2016; Phafoli et al., 2018). One study in Papua New Guinea asked midwifery graduates to report on how well the midwifery curriculum had prepared them for clinical practice (Moores et al., 2016). The graduates suggested a further 6-12 months was needed to complete all requirements, including appropriate clinical experience (Moores et al., 2016). In Pakistan, most of the midwifery students thought that achieving 40 deliveries was a big challenge; however, the students reported they were satisfied with their clinical learning (Lakhani et al., 2018). It was suggested by Lakhani et al. (2018) that the midwifery curriculum should be a better balance between theory and clinical hours because students found the theory period very short in comparison to the time for clinical experience. However, the authors did not describe the midwifery curriculum length and content (Lakhani et al., 2018). Another study reported that experts developed the midwifery curriculum in Ethiopia with minimum input from midwifery lecturers, so therefore it was not linked to expected outcomes for midwifery clinical practice. Even though theory and practice hours were proportionate based on the national ministries, midwifery schools were not accountable for meeting the standards (Fullerton, Johnson, et al., 2011).

Interestingly, an Indonesian study described the benefits of the continuity of care experiences learning model. A quasi-experimental study of continuity of care experiences at midwifery schools was conducted in two midwifery schools in Central Java, Indonesia (Yanti et al., 2015). The continuity of care experiences learning model was shown to offer a unique learning opportunity for midwifery students to understand the philosophy of midwifery, such as women-centred care. The authors believed that continuity of care experiences would strengthen the midwifery curriculum in Indonesia (Yanti et al., 2015).

A number of the articles reviewed revealed at length the issue of midwifery graduates doubting their midwifery skills and knowledge when working with women in clinical settings, and this was linked to how prepared they felt by their midwifery education (Baloyi & Mtshali, 2018a; Binfa et al., 2011; Dawson et al., 2016; Moores et al., 2016; Yanti et al., 2015; Yigzaw et al., 2016).

3.5.2.1 Responding to the country context regarding midwifery programmes and curriculum

Some studies have identified weakness in the quality of midwifery education in countries such as Pakistan and Afghanistan, in Pacific nations, and across Africa. To evaluate midwifery education programmes, Turkmani et al. (2013) drew from in-depth interviews and focus group discussions in Afghanistan, while Fullerton, Johnson, et al. (2011) conducted individual interviews, focus group discussions and site visits in Africa. Both studies suggested some areas be strengthened including pathways of midwifery education, the entry levels of education for midwifery students, educational resources, professionalism, the mentor-student ratio, congruence standards, competency assessment, recognition as formal civil service employee, and strategies to ensure a comprehensive midwifery curriculum. In terms of pathways of midwifery education, this review identified a variety of midwifery programmes were available and may be appropriate, including direct-entry, required nursing background and midwifery programmes available as diploma, bachelor's and certificate qualifications (Fullerton, Johnson, et al., 2011; Homer et al., 2017; Lakhani et al., 2018; Mansoor et al., 2012; Speakman et al., 2014)

A study in Nigeria (Akiode et al., 2010) described how the midwife's scope of practice includes additional skills such as post-abortion care and manual vacuum aspiration to address the common causes of maternal mortality rates in the country. In another study in Ethiopia, Yigzaw et al. (2016) found that the content of the midwifery curriculum firmly focused on obstetric complications, gynaecology, public health, professional tasks, and prevention of mother-to-child transmission of HIV (PMTCT). These papers argued for the need for a review of the national midwifery curriculum to overcome the incongruence of the curriculum with the cause of the maternal mortality and morbidity rates in the countries. Some Pacific nations reported that their midwifery curriculum did not cover the core competencies required in their country context (Homer et al., 2017). Other studies in Turkey, Pakistan, Iran, and Chile also suggested subjects changes to the midwifery curriculum, including infertility, women's health care, leadership, management, English language development and disaster management. None of these papers stated the language of midwifery programmes. However, English language development in Pakistan, for example, raised a particular challenge and was identified as students' weakest area as it was seen as crucial that midwifery students could study in English. The focus of the content in these midwifery programmes was for the midwifery students to gain appropriate knowledge and skills to become competent graduates in the country's context (Binfa et al., 2011; Isbir & Ozan, 2018; Lakhani et al., 2018; Taghizadeh et al., 2017). A study in Papua New Guinea reported that leadership skills were required when graduates returned to communities in a rural area (Moore et al., 2016). Kibwana et al. (2017), and Mansoor et al. (2012) argued that the midwifery curriculum should prepare graduates for the needs of the community that they serve. These studies asserted that although global standards have been published to improve midwifery education, each country has different needs and expectations for strengthening midwifery education and midwifery curricula to produce qualified midwives.

3.5.2.2. Competency assessment in midwifery curriculum development of knowledge, skills, and critical thinking

Within the literature on midwifery education, some studies in South Africa, Lesotho, Pakistan, and Turkey have described ways to facilitate the teaching-learning process and the quality of assessment. Authors suggested active learning such as problem-

based learning and assessment by Objective Structured Clinical Examination (OSCE) which they claimed have a significant influence on student learning in midwifery programmes (Aein, 2018; Baloyi & Mtshali, 2018a; Fullerton, Johnson, et al., 2011; Isbir & Ozan, 2018; Kibwana et al., 2017; Lakhani et al., 2018; Nyoni & Botma, 2017).

Aein (2018) and Isbir and Ozan (2018) described active learning as student-centred learning and suggested that learning to be competent is facilitated when the learning process is student-led rather than teacher-led. Studies in Iran, Pakistan, and Mongolia found that the motivation of midwifery students increased when utilising various strategies, and they thought they were more satisfied and challenged with problem-based learning than didactic teaching such as lecturing (Aein, 2018; Lakhani et al., 2018; Sangestani & Khatiban, 2013; Willott et al., 2018). Some studies highlighted the role of problem-based learning as a significant learning tool that improved midwifery students' communication skills, critical thinking, access to new information, motivation, discovery of leadership, and ability to analyse (Aein, 2018; Baloyi & Mtshali, 2018a, 2018b; Isbir & Ozan, 2018; Lakhani et al., 2018; Willott et al., 2018).

Studies included under this theme found that the midwifery curriculum being reviewed primarily by midwifery lecturers was one of the keys to improving midwifery education. As highlighted by the literature, the midwifery curriculum was conceptualised and designed to prepare the midwifery student to become a qualified midwife who reflects the needs of the community.

In summary, studies included under the midwifery curriculum theme found that reviewing and updating the midwifery curriculum was essential. Being able to apply the midwifery curriculum in line with the requirements of the country was revealed to improve graduate midwives and led to an improvement in midwifery education.

In the next theme, literature on adequate clinical practice and the resources required to build the competency of midwifery students is discussed.

3.5.3 Adequate clinical practice and resources to build the competency of midwifery students

Efforts to produce skilled new midwives in developing countries face various challenges, especially for clinical practice. There was much discussion within the literature in regard to the place of clinical practice supported by adequate resources in developing competence and confidence of midwifery students (Bogren, et al., 2018; Bogren et al., 2013; Erlandsson et al., 2018; Fullerton, Johnson, et al., 2011; Kibwana et al., 2017; Lakhani et al., 2018; Moores et al., 2016; Vuso & James, 2017). Nevertheless, the foremost challenge, revealed by Turkmani et al. (2013), who has researched in Afghanistan, and Vuso and James (2017), who have researched in South Africa, was that there was incongruence between the standards of care taught in midwifery school and the actual care observed in clinical sites. One example was the difference between infection prevention practices in theory and in clinical sites (Turkmani et al., 2013).

Yigzaw et al. (2016) identified the gaps in midwifery education for Ethiopia. In Ethiopia, the role of the midwife includes: detecting reproductive organ cancers and tumours; performing manual vacuum aspiration; assisting with operations; identifying pelvic muscle injuries, diagnosis and management of ectopic pregnancy; diagnosis and management of abortion; induction and augmentation; identifying counselling needs; and preventing infertility. This study is critical because it found that there were significant gaps in the content of midwifery education in the areas of obstetric complications, gynaecology, public health, professional duties, and PMTCT of HIV. The majority of respondents did not learn several tasks that are within expected midwifery practice in midwifery education. Participants in this study mentioned that, at their school, they were not trained in detecting reproductive organ cancers and tumours, performing manual vacuum aspiration, identifying injuries of pelvic muscles, the surveillance of maternal and newborn health conditions, training and supervising community health workers, and preparing and assisting with operations. This study also revealed the significant gaps in the ability of the existing midwifery workforce to identify and manage obstetric complications, reproductive organ cancers, and infertility (Yigzaw et al., 2016).

One study in Lesotho reported that midwifery students received minimal exposure to public health care settings. During two to four weeks of clinical experience in public health care settings, midwifery students would gain a better understanding of cultural competence, adaptation, comprehensive client management, collaboration with other professions, and specific areas where students' confidence improved such as family planning services, immunisations, consulting and giving health education (Phafoli et al., 2018). Having a minimum of four weeks in public health care for the clinical experience under an adequate mentor was reported to be adequate time to assist midwifery students in gaining relevant midwifery skills. Reportedly, midwifery students who were placed in public health care increased their levels of confidence and competence. Phafoli et al.'s (2018) qualitative cross-sectional study using focus group discussions reported the contribution of primary health care to preparing midwifery graduates to be deployed to real-life settings after graduation. Improved competence was found to be associated with enhanced and sufficient clinical experience which led to improved student outcomes and improved the quality of pre-service midwifery education (Lakhani et al., 2018; Yigzaw et al., 2015).

The majority of the midwifery students in Pakistan reported satisfaction with their clinical experience because they had opportunities for hands-on practice, which built their competence and confidence (Lakhani et al., 2018), while studies in Ethiopia and India revealed most students had less clinical hands-on practice (Sharma et al., 2015; Yigzaw et al., 2015). Yigzaw et al. (2015) found that attending more births during training, perceived availability of laboratory skills training and resources and perceived sufficiency of clinical experience were significantly and positively associated with student performance. Most students in Pakistan thought that conducting 40 deliveries independently was a big challenge (Lakhani et al., 2018), while in Ethiopia it was reported that only 32% of all students had attended 20 or more births (a national standard), and less than 6% had attended 40 or more births (Yigzaw et al., 2015). In India, the majority of students had not attended the required number of births at least 30 births are required for registration as a midwife (Sharma et al., 2015). Further, graduate midwives found that in urban areas they were able to respond quickly, had more opportunities to learn about complex care, gained a better understanding of socio-cultural issues and comprehensive knowledge on managing clients, and

experienced less dependency on doctors (Moores et al., 2016; Phafoli et al., 2018). Therefore, clinical experience at remote or rural areas, if well supported, would improve midwifery skills such as graduate midwives learning how to transfer women to a higher-level facility and how to take care of women requiring emergency care.

Even though midwifery graduates gain experience in rural settings, many midwifery graduates in Papua New Guinea and Afghanistan expressed a lack of confidence and competence in emergency skills (Moores et al., 2016; Zainullah et al., 2014). Some studies revealed that exposure to a full range of clinical experiences offers the chance for graduate midwives to gain skills in: leadership in maternal and newborn care services; delivering respectful maternity care; problem-solving and decision-making skills; understanding the real-life setting; developing critical thinking, communication and counselling skills; independence; professional growth; and providing comprehensive primary health care in rural areas (Moores et al., 2016; Phafoli et al., 2018; Shaban et al., 2012). Moores et al. (2016) and Zainullah et al. (2014), who have researched midwifery graduates in Papua New Guinea and Afghanistan, contended that although midwifery graduates require appropriate clinical experience in order to develop midwifery skills, primarily a higher proportion of time needs to be spent in birthing. Yet, some countries, including Pacific nations, South Africa, Bangladesh, and Ethiopia, reported inadequate clinical sites to achieve the core midwifery competencies and insufficient time for clinical experiences (Erlandsson et al., 2018; Homer et al., 2017; Kibwana et al., 2017; Vuso & James, 2017).

The literature widely acknowledges the critical position of clinical experience in building the competence and confidence of midwifery students. A study in Ghana revealed that nearly half of the midwifery students (49%, n=853) were witnessing disrespectful care in clinical sites (Moyer et al., 2016). This cross-sectional study, with a self-administered computerised and structured questionnaire, argued that midwifery education must be evaluated with role-modelling and positive woman-midwife interactions to provide appropriate clinical experience for midwifery students during their education (Moyer et al., 2016). The reality of limited clinical placement time and experience in clinical sites has been shown to lead to students' lacking competence (Kibwana et al., 2017; Vuso & James, 2017).

Clinical experience, supported by adequate resources, has been discussed as a strategy to significantly develop the knowledge and skills of midwifery students. The literature articulated the view that clinical experience in real-life settings was essential to the learning process of midwifery students. However, successful clinical experience for midwifery students was not solely related to the opportunities for hands-on practice. Instead, appropriate clinical experience includes a full range of clinical settings and good role modelling by a clinical mentor.

In summary, the literature in this theme demonstrated the importance of adequate clinical experience in increasing midwifery students' confidence and competence. Midwifery students' confidence improves the ability to gain relevant midwifery skills and knowledge. Having sufficient clinical practice, when incorporated into adequate clinical environments and with appropriate mentoring, was reported to improve the student outcomes and led to the strengthening of midwifery education.

The final theme identified in the literature review highlights the capacity of midwifery lecturers and mentors.

3.5.4 The capacity of midwifery lecturers and mentors

Several publications mentioned the essential role of human resources - midwifery lecturers and mentors - in midwifery education. Bogren et al. (2012), Dawson et al. (2016), Fullerton, Johnson, et al. (2011), Lakhani et al. (2018), and West et al. (2017) found that in developing countries, midwifery lecturers and midwife mentors (who work in clinical settings with students) are the key people for making changes to midwifery programmes. Abou-Malham et al. (2015), Baloyi and Mtshali (2018a), Bogren et al. (2012), Erlandsson et al. (2018), Fullerton, Johnson, et al. (2011), and Nyoni and Botma (2017, 2018) suggested that midwifery lecturers have significant capacity to support the curriculum and play a pivotal role in midwifery education because they are responsible for midwifery content in the curriculum and the quality of assessment. On the other hand, some studies revealed the lack of capacity of midwifery lecturers and clinical midwives resulted in inadequate midwifery education (Abou-Malham et al., 2015; Bogren et al., 2012; Homer et al., 2017; Turkmani et al., 2013; West et al., 2017).

Turkmani et al. (2013) in Afghanistan, Vuso and James (2017) in South Africa, and Willott et al. (2018) in Mongolia found that, in some instances, midwifery lecturers and midwives were not always implementing the national standards, showed a lack of experience, and a lack of professionalism which potentially resulted in disrespectful behaviour to students. Turkmani et al. (2013) and Willott et al. (2018) found that some lacked skills in the use of audiovisual aids such as overhead projectors and there was poor quality translation of handouts. However, the translation of handouts, for example, was not explained.

The variety of educational backgrounds of the midwifery lecturers and mentors across developing countries was reported. Midwifery teachers in Malawi are appointed directly from teaching colleges and must hold a nursing degree. In Ghana, teachers were selected from among midwifery graduates (Fullerton, Johnson, et al., 2011). Ten Pacific nations, along with Jordan, stated a lack of qualified lecturers and hardship in recruiting sufficient midwifery lecturers because there were no higher degree programmes (Homer et al., 2017; Shaban et al., 2012). In Jordan, nurse educator programmes were often inappropriate for midwives (Shaban et al., 2012). In some African countries, there was a challenge in the number and skill quality of clinical mentors to guide midwifery students in clinical settings (Fullerton, Johnson, et al., 2011). Midwifery lecturers and mentors have a significant impact on the teaching-learning process in the classroom, laboratory, and clinical settings in regard to the opportunities and quality of experience (Fullerton, Johnson, et al., 2011; Kibwana et al., 2017; Shaban et al., 2012; Turkmani et al., 2013; Vuso & James, 2017; West et al., 2017).

Dawson et al. (2016) reported on the evaluation of the first two years of the Maternal and Child Health Initiative (MCHI). The MCHI, which was funded by the Australian Government, which supported by WHO Collaborating Centre at the University of Technology, Sydney, aimed to strengthen midwifery capacity in Papua New Guinea. Through this programme, eight international clinical midwifery facilitators were placed in four midwifery schools across the country to guide midwifery lecturers, and two obstetricians were placed in regional hospitals. Workshops supported by the WHO

team were held and educational resources provided, including a scholarship for midwifery students. Dawson et al. (2016) evaluated the programme through interviews with participants, including teachers and students. They found increased teaching capacity following opportunities to learn many skills using different approaches to teaching and presentation techniques in the classroom as part of the MCHI programme. Dawson et al. (2016) did not state their part in ensuring the success of the project. Nevertheless, the authors of this paper did not declare any conflicts of interest.

In some countries, the scope of midwifery practice includes abortion care. A study in Nigeria (Akiode et al., 2010) discussed educational training, such as post-abortion care and manual vacuum aspiration training. Improvements in midwifery lecturers' knowledge and skills were demonstrated by pre- and post-evaluation of the training, which included: communication techniques; management of patients with abortion; assessment and diagnosis; pain management; use of manual vacuum aspiration; instrument processing; infection prevention; counselling; post-abortion contraception; post-procedure care; screening; and ethical issues (Akiode et al., 2010).

Moreover, to ensure that midwifery lecturers were adequately prepared to deliver the national midwifery curriculum, a mentorship programme delivered by Swedish midwifery staff members was carried out in Bangladesh (Erlandsson et al., 2018). Erlandsson et al. (2018) from a Swedish university, mentored 19 faculty from 10 of the 38 government midwifery schools in Bangladesh using a blended model of face-to-face and online sessions. They found that the participants commonly agreed on the importance of teacher preparation for students' clinical practice. The participants also benefited from the programme because they received the latest evidence-based research in midwifery from the Swedish mentors. However, some Bangladeshi midwifery teachers were enrolled in the master's programme at a Swedish university. Therefore, the results of this study may not be representative of all midwifery teachers in Bangladesh. Moreover, the study questionnaire was developed in English, which may be a limitation. It is argued that the actual results in improving education would be harder to find. Also, the authors of the study established an online mentoring system, so potentially have an interest in its success.

In a Moroccan study, many participants reported their satisfaction and positive experiences through adopting new teaching skills and learning resources following completion of the Advances in Labor and Risk Management (ALARM) project run by Canadian instructors. The participants learned to practise on an anatomic model and gained knowledge in dealing with obstetric emergency cases (Abou-Malham et al., 2015). Abou-Malham et al. (2015) found barriers to implementing the action plan in Morocco, such as the educational system having a dominant technocratic approach to midwifery education, deficient educational support for midwifery teachers, limited technical resources, and inadequate collaboration across the educational institutes. Further, some studies reported the implementation of problem-based learning in the educational institution to enhance student learning because it is seen as an interactive teaching strategy which is different from traditional lectures (Erlandsson et al., 2018; Fullerton, Johnson, et al., 2011; Nyoni & Botma, 2018; West et al., 2017). Abou-Malham et al. (2015), Erlandsson et al. (2018) and West et al. (2017) stressed the significance of workshops, training, and guidance from international advisors as one of the keys to enhancing the capacity of midwifery lecturers who then translate knowledge and skills to midwifery students. Nevertheless, whatever the educational training and workshop held in an educational institution, the motivation of midwifery lecturers to implement teaching strategies to improve the quality of the teaching and learning process at midwifery schools is crucial.

In some countries, such as Papua New Guinea, Bangladesh, Pakistan, and Nepal, the clinical mentors based at the clinical sites, together with the midwifery educators in the midwifery school, make a unique contribution to student learning (Bogren et al., 2013; Dawson et al., 2016; Erlandsson et al., 2018). Where a skilled midwifery mentor is available, midwifery students' confidence is boosted because they facilitate the midwifery students' education by demonstrating skills in practice (Bogren et al., 2013; Erlandsson et al., 2018; Lakhani et al., 2018). On the other hand, some studies in Papua New Guinea, Afghanistan and Jordan found a lack of quality and quantity of midwifery educators and midwifery mentors, which resulted in limited guidance for midwifery students in clinical settings (Dawson et al., 2016; Shaban et al., 2012; Turkmani et al., 2013; West et al., 2017). Midwifery graduates have identified that support and

guidance from clinical mentors is a vital aspect of ensuring what they have done was right (Lakhani et al., 2018; Moores et al., 2016; Vuso & James, 2017). There was a great concern from mentors in Ethiopia and South Africa to ensure hands-on practice for midwifery students, mainly in providing a diversity of experience because of limited clinical experience (Kibwana et al., 2017; Vuso & James, 2017). One study in Lesotho reported that midwives who become mentors admit that guiding midwifery students was valuable to them as midwives because they learn from current literature and evidence-based practice to refresh their midwifery knowledge (Phafoli et al., 2018).

In summary, the quality of midwifery lecturers and mentors has been shown to improve the quality of midwifery education to strengthen midwifery education. All papers reviewed indicate that many aspects, such as educational background, skill, and motivation, are needed to ensure the quality and capacity of midwifery lecturers and mentors.

3.6 Gaps in the literature

This review provided an analysis of the literature on midwifery education in developing countries. Four themes identified in the review revealed the critical factors for improving midwifery education in developing countries. The four themes cannot be separated from another one; each influences the other. The four themes were: the place of accreditation and midwifery regulation provides the foundation for midwifery education because the autonomy of midwives depends on the national recognition from regulation boards as well as the national standards for midwifery education. Further, a midwifery curriculum develops the knowledge and midwifery skills of students, if it is well supported by good attributes of midwifery lecturers and mentors. Nevertheless, if the midwifery curriculum is not supported by adequate clinical practice and learning resources, then it will not produce competent midwives. Sufficient clinical practice and resources build the competency of midwifery students and the capacity of midwifery lecturer and mentor. It is argued that the capacity of the midwifery lecturers and mentors shapes midwifery graduates as midwifery lecturers and mentors are the front lines of midwifery education.

Exploration of relevant studies in developing countries reveals none of the relevant research discusses midwifery education in Indonesia in any depth. The literature review found only one relevant published study from Indonesia (Yanti et al., 2015). Therefore the question arises, how can midwifery education in Indonesia be strengthened?. It is the central research question which this current study intends to address. There is a lack of research in Indonesia which captures the experiences and perspectives of midwifery students, newly graduated midwives, midwifery lecturers, midwives, and obstetricians, on midwifery education in Indonesia. This study aims to examine what may strengthen midwifery education, and endeavours to identify the barriers and enablers to strengthening midwifery education that will lead to competent midwifery graduates. This is of the utmost importance as strengthening midwifery education is needed to improve maternal and neonatal health in Indonesia.

The Indonesian Government has put much effort into addressing the maternal and neonatal mortality rates. One of the strategies is deploying midwives to villages with the aim of providing the women and the family in the community with qualified health workers (D'Ambruoso et al., 2009; Kemenkes R. I. et al., 2010; Middleton, 2014; Ministry of Health Republic of Indonesia, 2016; Shankar et al., 2008). The Indonesian Government has the aim of one midwife in each village across the country to ensure that every woman has access to midwifery care from pregnancy until postpartum. It is expected that maternal and neonatal mortality rates would decrease by ensuring the women and her family have access to a qualified midwife in their community (Ministry of Health Republic of Indonesia, 2016; Niehof, 2014; Scott et al., 2013; Shankar et al., 2008). High-quality midwifery education is recognised as a way to produce skilled new graduate midwives, which will impact on maternal and neonatal mortality and morbidity. This research will play an essential part in helping to understand what is required to strengthen midwifery education and to bring about optimal outcomes for the women and babies of Indonesia.

3.7 Summary of Chapter 3

Considerable attention is being given to midwives on the global agenda as well as in midwifery education. Furthermore, it is vital that midwifery education is strengthened. Midwives, who are the frontline of providing midwifery care in a diversity of settings

(hospitals, clinics, private midwifery practices, villages, and educational systems) must be well educated, knowledgeable and competent in understanding maternal and neonatal health outcomes. This review has revealed the gap in the literature calling for research studies to address midwifery education. The review of related literature confirms the need to conduct further research in Indonesia regarding the experiences of midwifery students, newly graduated midwives, midwives, midwifery lecturers, and obstetricians. In this chapter, the literature associated with the context of midwifery education was reviewed and provided the catalyst for the research question in this study. Midwifery education has a central place in determining maternal and neonatal health outcomes. The research reported in this thesis adds to current literature and provides insights regarding strengthening midwifery education in developing countries based on the experience of newly graduated midwives, midwives, midwifery lecturers, midwifery students, and obstetricians in Indonesia. Chapter 4 describes the methodology, research paradigm, and theoretical framework which guide this study.

Chapter 4.

Research Methodology

4.1 Introduction

This study investigated the experiences of midwives, midwifery lecturers, midwifery students, newly graduated midwives, and obstetricians, regarding what can strengthen midwifery education in Indonesia. The research sought to identify the barriers and enablers to enhancing midwifery education leading to competent and confident midwifery graduates. It was vital to ensure that an appropriate methodology was chosen that would achieve the target of this study, and so a qualitative descriptive approach was employed. This chapter addresses the qualitative descriptive approach within an interpretive paradigm for conducting this research. The chapter begins by describing the choice of an appropriate methodology and research paradigm for this study. The significance and rationale behind the qualitative descriptive methodology and its fit with the study's objective and central research questions are discussed. Following the qualitative descriptive data analysis, Bolman and Deal's Four Frames approach (1997, 2003, 2008, 2017) an organisational theory, which was utilised to further explore the complexity of what could strengthen midwifery education in Indonesia. How the theoretical framework is used to inform the study is described in this chapter. This chapter also provides my reflexivity for this study.

4.2 Choosing an appropriate methodology

In the process of deciding the methodology, consideration was given to alternative methodological approaches available to the researcher. Initially, hermeneutic phenomenology, informed by van Manen, was considered as being appropriate for conducting the research. A hermeneutic phenomenological approach was initially chosen, as it can assist with giving meaning and understanding to those who participate in midwifery education (van Manen, 1990a, 1997a, 1997b, 2003, 2007, 2014, 2015). There was a reason why the initial methodology considered was changed and why it was not fit for this study. The research question for this study, "How can midwifery education in Indonesia be strengthened?" required a qualitative inquiry to

obtain rich, in-depth data of the participants' views and experiences. The qualitative descriptive methodology was considered appropriate for this study as it fits with the purpose of the study and the questions being investigated. The nature of a qualitative descriptive approach provides the detailed views and perspectives of those who involved in midwifery education in Indonesia (Sandelowski, 2000, 2010). Therefore, a qualitative descriptive approach was considered a suitable method to give voice to the participants' experiences.

Hermeneutic phenomenology as explained by van Manen (1990a, 1997a, 1997b) is based on the meaning of the experiences we live as we live them in everyday experience. van Manen stated that the purpose of hermeneutic phenomenology is to bring to light and reflect upon the lived meaning of experience (van Manen, 1990a, 1997a, 1997b). van Manen's approach and his four existentials for reflection (spatiality, corporality, temporality and relationality) (van Manen, 1990a, 1997a, 1997b), was considered could not serve as a guide to answering the research question and aims of my study. Furthermore, the translation process made the interpretive approach very complicated, and I, along with my supervisors, became increasingly anxious about losing the connection to the actual data. The impacts of the translation process meant that the interpretation needed to happen on multiple levels, which frequently gave rise to concerns about the meaning in regard to the original intent of the data. It was felt the qualitative descriptive approach would ensure that the original intent of the participant and data, despite translation, were more accurately represented.

In using hermeneutic phenomenology, I was analysing the data using the hermeneutic circle informed by van Manen. I was sitting with, reflecting on, and working with the translated transcripts in a manner that engaged the researcher in the hermeneutic process. I was very committed to using the hermeneutic process but, despite this, the engagement with the data and the required layers of interpretation (when dealing with multiple languages) meant that description rather than interpretation more accurately connected with and reflected the data. In this research, all data were collected by interviews which focused on the participants' experiences regarding midwifery education in Indonesia. A more descriptive approach assisted in ensuring that every

data point was documented “as it is” while still capturing the uniqueness of the participants. Thus, in working with the data and data analysis, it was clear that the issue of translation and the multiple layers involved in analysis meant that the qualitative descriptive approach was the most suitable fit.

I also explored using interpretive description informed by Thorne (2008) and Thorne, Kirkham, and O'Flynn-Magee (2004). This methodology provides insight into the nature of the experience. However, exploring meanings and explanations of clinical phenomena was not the methodology that best served this research, and hence interpretive description was not utilised. Some qualitative approaches which are familiar within healthcare and nursing, including ethnography, grounded theory, and phenomenology were also considered. Ethnography stresses the significance of human beings' demeanour in the substance of a culture to understand cultural rules and norms. The grounded theory seeks to develop theory and phenomenology aims to study consciousness and investigate the lifeworlds of individuals (Corbin & Strauss, 2008; Willis, Sullivan-Bolyai, Knafl, & Cohen, 2016). This research did not seek to explore cultures, discover a concept or postulate about the essence of the life experience; therefore, none of the above approaches was a suitable fit.

Qualitative descriptive studies, on the other hand, are less interpretive in that they do not require the researcher to move as far from the data (Sandelowski, 2000, 2010). In this study, the researcher was interested in explicating and exploring the participants' experiences. This is the reason why qualitative description is well-suited as a methodology for this study. Qualitative description allowed the researcher to examine the experience of the key informants regarding midwifery education in Indonesia. This methodology emphasises discovery and description extracted from the experience of the participants (Denzin & Lincoln, 2000, 2013; Sandelowski, 2000). Table 4.1 compares qualitative description and hermeneutic phenomenology and illustrates why qualitative description is the more appropriate methodology for this research (Merriam, 2009; Sandelowski, 2000; Willis et al., 2016). However, it can be said that there is no method which is undoubtedly right or wrong. Instead, one is either more or less appropriate relating to the aim of the study (Sandelowski, 2000, 2008, 2010, 2015).

Table 4.1 Comparison of hermeneutic phenomenology and qualitative description research

Aspects of research process	Hermeneutic phenomenology	Qualitative description
Purpose/aims	To bring to light and reflect upon the lived meaning of experience (van Manen, 1997b). "Phenomenology is the study of the lifeworld - the world as we immediately experience it pre-reflectively rather than as we conceptualise, categorise, or reflect on it" (van Manen, 1990b, p. 9).	To describe the range of responses to the life event or health situation.
Example of a research question	What is the essence and meaning of the lived experience...?	How does a parent describe the journey of parenting...?
Preparation for analysis	Van Manen advised the researcher to make explicit assumptions, opinions, and beliefs concerning the research focus. His methodological structure differs from technical procedures of other qualitative research such as coding and methods comprised of step-by-step procedure.	Each transcript is read and summarised. Commonly, the techniques comprise a step-by-step procedure.
Analysis	Uses the hermeneutic circle of reading, writing, rewriting and crafting of stories as a continuous interpretative process.	Data are coded and clustered within and across transcripts looking for themes. Commonly, the thematic analysis consists of six phases.
Findings	Structure of the fundamentals and nuance of the lived experience, including facets of what is highlighted in the lifeworld (corporeal, temporal, spatial, relational).	Significant clusters of rich themes and sub-themes using participants' language.

Source: Braun and Clarke (2006), Braun, Clarke, and Rance (2015), Colorafi and Evans (2016), Kim, Sefcik, and Bradway (2017), Magilvy and Thomas (2009), van Manen (1997b), Willis et al. (2016)

4.3 Research paradigm

A paradigm consists of the following elements: ontology, epistemology, methodology, and methods. Ontology is about the nature of reality and the nature of things. Ontological assumptions are focused on what is. Epistemological assumptions are ways of researching and enquiring into the nature of reality and the nature of things. In turn, these assumptions give rise to the strategy or the process of the research which lies behind the use of particular techniques (methodology) and procedures utilised to collect and analyse the data (methods). Added to ontology and epistemology is axiology, which refers to the values and beliefs that researcher hold (Creswell & Poth, 2018; Cohen, Manion, & Morrison, 2011). A research paradigm can be defined as the beliefs, values, commitments, and assumptions that shape the research project (Creswell & Poth, 2013; Denzin & Lincoln, 2000). Guba (1990) asserted that paradigm is “a basic set of beliefs that guide action, whether of the everyday garden variety or action taken in connection with a disciplined inquiry” (p. 17). The paradigm for this research is an interpretive paradigm. While researchers may use multiple compatible paradigms, this study adopts an interpretive paradigm because it aligns with the methodological approach, design, research methods, and data analysis. Interpretive researchers hold an assumption that multiple realities exist and are context-bounded, and that the researcher and researched are co-constructors of knowledge who bring their own experiences and values in constructing the knowledge (Creswell & Poth, 2018; Guba, 1990; Merriam & Tisdell, 2016). Guba (1990) defined interpretive knowledge as follows:

“interpretive knowledge comprises the reconstruction of intersubjective meanings, the interpretive understanding of the meanings human construct in a given context and how these meanings interrelate to form a whole”. (p. 235)

The research framed within an interpretive paradigm employs an inductive process, with knowledge being generated from the data, and focuses on exploring participants’ subjective meanings and interpretations of their social world to make sense of and report these meanings and interpretations. The interpretive paradigm, as Guba (1990) stated, leads to ‘grounded’ knowledge, not knowledge developed from deductive reasoning but knowledge that is both discovered and justified from field-based research. Thus, the research question is broad (Cohen, Manion, & Morrison, 2011; Creswell & Poth, 2018; Merriam & Tisdell, 2016; Saldana, 2015). An interpretive

paradigm is based on the belief that realities or truth are multiple, composed, holistic, and inseparable between researcher and the participant (Cohen, Manion, & Morrison, 2011; Denzin & Lincoln, 2000, 2013). Thus, the ontological position of interpretivism is relativism, which means that reality is subjective (Guba, 1990). In this study, the researcher had an important role in preparing, collecting, and analysing the data. The semi-structured open-ended questions in face-to-face interviews were analysed with the understanding that knowledge comes from multiple views, which is in line with an interpretive paradigm. Open-ended questions in a semi-structured interview offer more space for developing ideas to allow the researcher to obtain in-depth insights.

Regarding the epistemological position, I recognise each individual with their varied backgrounds and experiences. In this case, I focus on each participant's experiences and views regarding midwifery education in Indonesia. Therefore, the research outcome comes from the interaction between the researcher and the participants as I becomes a meaning-maker to interpret and make meaning.

Interpretive researchers see the social world as “not out there” but believe that human beings socially construct it. The interpretive paradigm accommodates social change over time. It can be said that the absolute truth of a phenomenon can never be fully understood as there are always many possible ideas and explanations (Cohen et al., 2011; Guba, 1990). Thus, understanding how midwifery education can be strengthened in this research is considered as always evolving. An interpretive paradigm sees that knowledge comes from various or many realities rather than one reality (Cohen et al., 2011; Guba, 1990). The qualitative descriptive methodology offers the opportunity to present multiple facets of participants' worlds (Sandelowski, 2000). In this study, I employed multiple perspectives from various participants to capture detailed description and appropriate data. The adoption of this paradigm ensured the comprehensive exploration of data central to the research question. An interpretive paradigm can provide insight into the experiences of participants regarding midwifery education.

4.4 Rationale for choosing a qualitative descriptive approach

Qualitative research seeks to gain insight into how people react within their natural settings (Denzin & Lincoln, 2000, 2013; Sandelowski, 2000). As Denzin and Lincoln (2000) wrote, “qualitative research is a field of inquiry in its own right. It crosscuts disciplines, fields, and subject matters. A complex, interconnected family of terms, concepts, and assumptions surround the term qualitative research” (p. 2). Qualitative research is about understanding the participants’ experiences utilising multiple methods to collect data either through interviews, observations, documents, or focus group discussion (Denzin & Lincoln, 2000; Holloway & Wheeler, 2010; Marshall & Rossman, 2011; Savin-Baden & Major, 2013). There are common characteristics in qualitative research: the data have priority; it is context-bound; the researcher immerses herself in the natural setting; the focus is on participants’ perspectives; the positions of the researcher and participants are equal; it is fundamentally interpretative; and the stance of the researcher as part of the research process is made clear (Holloway & Wheeler, 2010; Marshall & Rossman, 2011). A qualitative methodology provides a framework that is well suited for identifying what can strengthen midwifery education in Indonesia.

Denzin and Lincoln (2000) pointed out that qualitative research involves empirical material, such as interviews to discover and understand knowledge through sharing the personal experience of individuals’ lives. Sandelowski (2000) stated that, in qualitative descriptive studies, the researcher stays closer to the material and the surface of the words and experiences. Qualitative description also facilitates the researcher’s understanding of the nature of reality for the participant. Thus, the qualitative researcher can get closer to the significance of the experience through detailed interviewing (De Vries, Dingwall, & Bourgeault, 2010; Rubin & Rubin, 2005; Silverman, 2013). Sandelowski (2000) further asserted that:

“qualitative descriptive studies offer a comprehensive summary of an event in the everyday terms of those events. Researchers conducting such studies seek descriptive validity, or an accurate accounting of events that most people (including researchers and participants) observing the same event would agree is accurate and interpretive validity or an accurate accounting of the meanings participants attributed to those events that those participants would agree is accurate”. (p. 336)

A qualitative descriptive methodology was chosen to assist this exploration and gain rich description from those who participate in midwifery education. Further, a qualitative descriptive study relies on the participant, rather than the researcher, to define and create the construct; and therefore provides a robust description of the interest in and understanding of the phenomena under review (Sandelowski, 2000, 2010). Using a qualitative descriptive approach gave me the ability to acquire comprehension and understanding of participants' experiences in this study, the experience of the participants (newly graduated midwives, midwifery students, midwifery lecturers, midwives, and obstetricians) who are involved in midwifery education. This study addresses each area of the who, what, and where (Sandelowski, 2010) of the participants' experiences regarding involvement in midwifery education. According to Sandelowski (2010), a qualitative descriptive approach is particularly useful to describe how people feel about an event; however, the researcher still needs to conduct more interpretative work, and this is where a theoretical framework is utilised. Therefore, to support the qualitative descriptive approach to answering the 'how' question, further analysis to explore the data and provide the structure for findings of more depth can be achieved through the use of the theoretical framework.

4.5 Qualitative description in midwifery research

The qualitative descriptive methodology provides the researcher with a way to obtain better understanding of the nature of everyday experiences (Denzin & Lincoln, 2000; Sandelowski, 2000). Qualitative description of the participants' experiences has the potential to add valuable knowledge regarding midwifery. This is illustrated by the following midwifery studies which have used qualitative description methodology.

Cummins, Denney-Wilson, and Homer (2015, 2017) utilised a qualitative descriptive approach to examine new graduates' experiences of working in midwifery continuity of care. Cummins et al. (2015) employed semi-structured interviewing in their qualitative descriptive study conducted in South Australia. In this study, qualitative description methodology was utilised to understand the feelings and experiences of new graduates midwives working in midwifery continuity of care. The voices of the new midwives through continuity of care allowed the researcher to analyse the

themes of how new midwives felt about their transition from student to a midwife.

Other researchers who used qualitative description are Vallely et al. (2013) who explored women's experiences and perspectives of pregnancy and childbirth in rural Papua New Guinea. Focus group discussions and in-depth interviews in the local language were translated into English by the local interpreter. As a cross-language study, the qualitative design was chosen, which enabled an in-depth exploration of how differences in context and process affected the participants' responses. These midwifery studies show the place of qualitative descriptive methodology, primarily when working across multiple languages and layers of interpretation and description.

Furthermore, Duffy's (2009) qualitative descriptive work aimed to uncover preceptors' experiences through reflective practices. Fenwick et al. (2012) also worked with qualitative description to explore the experiences of newly qualified midwives in Australia. Another example of qualitative description being used in midwifery research is the study by McDonald, Sword, Eryuzlu, and Biringer (2014) who explored women's and care providers' experiences of participating in group pregnancy care. Their qualitative descriptive design included focus group discussion and semi-structured interviews. As with the results of other studies, which successfully employed a qualitative descriptive methodology, it was seen to deliver the purpose of the research and to describe the research question under investigation. Given the limited research on the experiences of participants in regard to midwifery education in Indonesia using qualitative descriptive methodology, it was expected to be able to explore and describe the event in this study fully.

Research on midwifery education in Indonesia is still limited; in fact, there was no research about how midwifery education can be strengthened in Indonesia which influenced the decision for a qualitative descriptive methodology to understand the experiences of participants involved in midwifery education in Indonesia. A review of the literature indicated that there was one relevant piece of research about midwifery education from Indonesia (Yanti et al., 2015). This is in line with Sandelowski's (2000)

suggestion that qualitative descriptive provides an accurate summary of the phenomena when there is limited information on a topic.

4.6 Bolman and Deal's Four Frames as a theoretical framework

Anfara Jr and Mertz (2006, 2014) described a theoretical framework which informs research as “any empirical or quasi-empirical theory of social and/or psychological processes, at a variety of levels (e.g., grand, mid-range, and explanatory) that can be applied to the understanding of phenomena” (p. xxvii). As Collins and Stockton (2018) noted, a theoretical framework is at the intersection of 1) existing knowledge and previously formed ideas about complex phenomena, 2) the researcher’s epistemological dispositions, and 3) a lens and a methodically analytic approach. A clarification of terms used in a theoretical framework is essential because even though the use of a theoretical framework in qualitative research has become widespread, most qualitative researchers usually have varied perspectives about the theoretical framework (Anfara Jr & Mertz, 2006, 2014; Collins & Stockton, 2018; Green, 2014; Jackson & Mazzei, 2012; Ravitch & Riggan, 2012). Bolman and Deal’s (1997, 2003, 2008, 2017) Four Frames approach was applied in this study to add another lens to the qualitative descriptive data analysis.

Consolidating major themes of organisational perspectives, Bolman and Deal (1997, 2003, 2008, 2017) developed a theory with four essential elements, which are the structural, human resource, political, and symbolic. Bolman and Deal see four perspectives or frames as providing vantage points that can be used to conceptualise, focus and order the world of organisations. They view the four frames as being complementary rather than in conflict and suggest people across a wide variety of settings would do well to use these frames as a rotating perceptual prism through which to interpret and thus better understand the organisations within which they work (Bolman & Deal, 1997, 2003, 2008, 2017).

A key concept within the Bolman and Deal model is that of reframing, which means examining the same situation from multiple vantage points (Bolman & Deal, 2003). They defined a frame as “coherent set of ideas forming a prism or lens that enables you to see and understand more clearly what goes on from day to day” (Bolman &

Deal, 2008, p. 43). Midwifery education can be seen as an arrangement of organisations which contains many elements, such as the government, the midwifery professional association, the accreditation agency, and educational institutions (private and public organisation) which run midwifery programmes in Indonesia; therefore, an organisation framework is applicable to this research question. Each of the four frames relate to this study in the following ways:

1. The structural frame

The structural component of the framework emphasises the importance of formal organisational structure and the development of policies, rules, systems and hierarchies. Bolman and Deal view this component as a 'factory'. Controlling, planning and rational decision-making constitute the thrust of organisational activity according to this viewpoint (Bolman & Deal, 2008). The structural framework was developed from the work of Frederick W Taylor and other scientific management writers (Fayol, Urwick, Gulick) as well as from the contributions of economists and sociologists such as Max Weber (Bolman & Deal, 1997, 2003, 2008, 2017). The structural frame provides the architecture for pursuing an organisation's strategic goals, which offer a blueprint for the organisation. Bolman and Deal state that if the structure does not line up well with current circumstances, redesign and reorganisation of the form of an organisation is often required. Bolman & Deal (2017) commented on the structural frame:

"The assumptions of the structural frame are reflected in current approaches to organisational design or social architecture. The central belief of the structural frame reflects confidence in rationality and faith that a suitable array of roles and responsibilities will minimise distracting personal static and maximise people's performance on the job. Properly designed, these formal arrangements support and accommodate both collective goals and individual differences" (p. 47-48).

2. The human resource frame

The human relations component of the framework was developed with its focus on interpersonal relationships and views the organisation as an extended family, as stated by Bolman & Deal (2017): "our most important asset is our people" (p. 113). The human resource perspective sees individuals with needs, feelings, prejudices, skills, and limitations. The human resource approach builds from several human resource theorists who focus on people and organisations. This framework was built on the

ideas of Mary Parker Follett, Elton Mayo, Abraham Maslow, Douglas McGregor and Chris Argyris (Bolman & Deal, 1997, 2003, 2008, 2017). The human relations framework concentrates on the fit between human and organisational needs.

The human resource frame highlights the relationship between people and organisations. At this point, an individual's competencies or social skills are a critical element in the effectiveness of relationships at organisations. Bolman & Deal (2017) stated the following about the human resource frame:

“One side sees individuals as objects or tools, important not so much in themselves as in what they can do for the organisation. The opposing camp holds that the needs of individuals and organisations can be aligned, engaging people's talent and energy while profiting the enterprise. This debate has intensified with globalisation and the growth in size and power of modern institutions. Can people find freedom and dignity in a world dominated by economic fluctuations and a push for cost reduction and short-term results? Answers are not easy. They require a sensitive understanding of people and their symbiotic relationship with organisations”. (p. 117)

3. The political frame

The third component of the framework is political. The political component explores how organisations make decisions, set goals, structures, and policies, and allocate resources through an ongoing process of bargaining and negotiation among various interest groups found both within and outside the organisation (Bolman & Deal, 2008). Bolman and Deal view the organisation as a 'jungle' which sees organisations as roiling arenas, hosting ongoing contests arising from individual and group interests. Fundamental ideas about this approach are concerned with organisational conflict, coalition and power, and are rooted in the work of political scientists. Traditional views see organisations as created and controlled by legitimate authorities who set goals, design structure and ensure pursuit of the right objectives.

The assumptions of the political frame explain that organisations are inevitably political. The political view suggests that exercising power is a natural part of ongoing contests. Bolman & Deal (2008) stressed that “there is no guarantee that those who gain power will use it wisely or justly” (p. 210). This is a critical point of the political frame: how people in an organisation use their power and influence decisions.

4. The symbolic frame

The fourth component of the framework provided in the Bolman and Deal typology is the symbolic framework. Meaning, belief, and faith are its central concerns. The symbolic lens, drawing on social and cultural anthropology, treats organisations as ‘temples, theatres, and carnivals’. It abandons the assumptions of rationality prominent in other frames and depicts organisations as cultures, propelled by rituals, ceremonies, stories, heroes, and myths rather than rules, policies, and managerial authority. The organisation is also theatre: actors play their roles in the drama while audiences form impressions from what they see on the stage. Issues arise when actors do not play their parts appropriately, symbols lose their meaning, or ceremonies and rituals lose their potency. From a symbolic perspective, organisations are judged as much on appearance as outcomes. This perspective emphasises the symbolic value of events found in organisations.

The symbolic frame highlights the meaning and belief as well as the assumptions of the culture of the organisation. Defined as ‘the way we do things around here’ (p. 278), Bolman and Deal (2008) point out that culture anchors an organisation’s identity and sense of itself. The core and values of people involved in midwifery education are an essential consideration in working within a complex system.

Bolman and Deal’s agenda, in effect, is to expand the conceptual repertoire that people use in thinking about organisation - related problems, issues, ideas, and plans of action. The four frames approach as a theoretical framework fits with this study as it is not so much a matter of finding correct answers to midwifery education problems but instead of being able to look at situations from multiple points, which in turn leads to responses that are richer in complexity in terms of enhancing midwifery education in Indonesia. This multi-perspective approach adds value to this research by providing a framework to explain how midwifery education can be strengthened in Indonesia. As a theoretical framework, this model is thought-provoking and attempts to show the complicated relationship among all of the factors (structural, human resource, political, symbolic) that impact on midwifery education.

Bolman and Deal's framework was selected because it resonates with the conception of midwifery education as a process and a system (ICM, 2017b). Considering a complex system in midwifery education (Johnson, Fogarty, Fullerton, Bluestone, & Drake, 2013; Keshavarz, Nutbeam, Rowling, & Khavarpour, 2010; Nyoni, Botma, 2019; UNFPA, UNICEF, WHO & ICM, 2019), using the Four Frames approach as a lens will provide a more complete picture and achieve the aims of the research which are to explore the experience of midwives, midwifery lecturers, midwifery students, newly graduated midwives, and obstetricians, regarding what can strengthen midwifery education in Indonesia. Also, the barriers and enablers to strengthening Indonesian midwifery education, leading to competent and confident midwifery graduates, could also be explored.

4.7 Reflexivity

In this type of qualitative research, the researcher is a valuable tool during the investigation process (Miles, Huberman, & Saldaña, 2014). When conducting qualitative descriptive research, researcher reflexivity is significant and an essential requirement for validating the quality of the research (Braun & Clarke, 2013; Dowling, 2006; Holloway & Wheeler, 2010; Merriam, 2009). Therefore, it is impossible to put aside the researcher's views when exploring the experiences of the participants. Reflexivity is a core concept in qualitative research and acknowledges the researcher's power and biases throughout the research process. Reflexivity is the stage of reflecting critically on the self as a researcher and the human as an instrument (Denzin & Lincoln, 2000). A researcher needs to clarify her personal views and insights that influence, describe, and explore the experiences of the participants. This section presents a brief explanation of my assumptions as they related to this study. The intention is to provide transparency and give context as to how I have explored the study based on personal understanding and experiences. A researcher's reflexivity can also be seen to maintain the credibility and trustworthiness of the study by identifying and acknowledging her biases and pre-assumptions to ensure the findings are credible (Creswell & Miller, 2000; Willis et al., 2016).

I had established extensive relationships with the broad stakeholders in Indonesia, and my professionalism and integrity have been built. As an insider (being an Indonesian

midwife and midwifery lecturer), I may find it easier to understand what the participants are possibly going through because of familiarity with the culture and the language. Throughout the data collection, I was mindful of my position as a novice researcher and acknowledged the possibility of power imbalance, especially when interviewing the midwifery lecturer, midwives, and obstetricians. Also, it is essential to recognise that having experience of the process at midwifery school and local midwifery association allowed me to understand the issues of the participants' world better. As a midwifery lecturer, I had worked with many challenges and significant elements within the context of midwifery schools, including obstetricians and midwives in clinical practice. I have been involved in the selection of potential midwifery students and offered support in the learning process towards accreditation in midwifery schools. The accreditation process is about fulfilling the accreditation agency's administrative requirements, with which the midwifery educational providers comply.

I have a deep commitment to improving myself as a lifelong learner by continuing higher education. My deep involvement in midwifery schools and understanding of the current situation of midwifery education in Indonesia made me realise that many elements need to be improved. During interviews I did not discuss any thoughts on midwifery education in Indonesia to avoid influencing the participants' views on the topic. As a product of the evolution of midwifery education in my country, I was mindful that my personal and past experiences would shape the way I explored the data and generated findings. Over six years, I had learned to manoeuvre through the administrative domains of midwifery education from the Diploma of Midwifery programme through to the Master of Midwifery programme.

Additionally, throughout the data collection in Indonesia, I regularly met via Zoom with both supervisors in New Zealand to reflect in practice. These regular meetings allowed me to establish the clarity, sensitivity and comprehensibility of interviewing participants during data collection. It also taught me to use field notes during and immediately after each interview. The supervisors' roles and feedback were significant in maintaining rigour within the research process. Also, my academic activities and

preliminary findings presented at international midwifery conferences revealed feedback which added to the research rigour.

Based on my experience, I firmly adhere to the belief that every individual is essential and has a voice and personal story which shapes the understanding of experience. I have shifted from being an insider Indonesian midwifery lecturer and midwife and now have an outsider positioning as a researcher of midwifery education in Indonesia.

4.8 Summary of Chapter 4

This chapter has justified the use of the qualitative descriptive methodology to explore the research about midwifery education in Indonesia. This chapter has discussed the choice of an appropriate methodology and the rationale and explanation for the use of qualitative description to examine the participants' experiences of midwifery education in Indonesia. This chapter also included a critique of Bolman and Deal's Four Frames approach, which was applied to the qualitative data analysis. My reflexivity was also examined. The following chapter on research methods details the application of the qualitative descriptive methodology.

Chapter 5.

Research Methods

5.1 Introduction

This chapter illustrates the methods utilised to explore the research question and achieve the research aims. The qualitative descriptive methodology, as presented in the previous chapter, assisted the researcher to examine the phenomena in this study. This chapter begins by explaining the settings of the study and discussing the preparation process for undertaking data collection. Ethical considerations are described, followed by the method of participant selection. Next, the transcribing and translation process and data collection, as well as strategies to analyse the data, are addressed. Finally, the procedures used to ensure rigour are discussed.

5.2 Research settings

As this study aimed to answer the question “How can midwifery education in Indonesia be strengthened?”, participants involved in all aspects of midwifery education and from a broad range of midwifery schools were required. Java and Sumatera were selected as the study locations. These two locations were selected as they are areas with high maternal and neonatal mortality rates. Secondly, these locations have a broad range of educational institutions running midwifery schools, including universities, institutes of health science, polytechnics of health science and academies under the Ministry of Research, Technology and Higher Education and the Ministry of Health. Private organisations, such as Muhammadiyah societies, and a range of academic qualifications (diploma, advanced diploma, bachelor’s, and master’s of midwifery programmes). For confidentiality, the status of certification of each midwifery school and a full description of the research settings were not included, and only a succinct summary taken from the website is provided (see Table 5.1 for more explanation). I respect the research sites and protected them from adverse conditions as a result of participating in the study by utilising an ethical framework and timing during the research process (Creswell & Creswell, 2018; Cresswill & Poth, 2018; Iltis, 2006; Richards, 2015). I gave in-depth consideration to finding appropriate settings to

generate suitable data for the study and to protecting people's identities. The sites selected for this research were multi-school and accredited by one or both accreditation agencies in Java and Sumatera, Indonesia.

Table 5.1 List of research settings of this study

Setting	Description
Padang	1. Midwifery Programme, Padang Polytechnic Health Ministry under the Ministry of Health (Poltekkes Kemenkes Padang, 2016)
	2. Midwifery Department, Faculty of Medicine, Andalas University under the Ministry of Research, Technology and Higher Education (Universitas Andalas, 2016)
Jakarta	3. Midwives from the Indonesian Midwifery Association & Midwives from the Indonesian Midwifery Education Association (Asosiasi Pendidikan Kebidanan Indonesia, 2015; Indonesian Midwives Association, 2015)
	4. Jakarta Polytechnic Health Ministry 3 under the Ministry of Health, Jakarta Special Capital Region (Politeknik Kesehatan Jakarta III, 2017)
Bandung	5. Advanced Diploma of Midwifery under the Ministry of Research, Technology and Higher Education (Padjadjaran University) (Fakultas Kedokteran Universitas Padjadjaran, 2015)
	6. Institute of Health Sciences Dharma Husada under the Ministry of Research, Technology and Higher Education (STIKES Dharma Husada, 2016)
Purwokerto	7. Midwifery Department, Faculty of Health Science, Muhammadiyah University under the Ministry of Research, Technology and Higher Education (Kebidanan Universitas Muhammadiyah Puwokerto, 2014)
Yogyakarta	8. Midwifery Department, Faculty of Health Science, Aisyiyah University under the Ministry of Research, Technology and Higher Education (Universitas Aisyiyah Yogyakarta, 2016)
	9. Midwifery Programme, Yogyakarta Polytechnic Health Ministry under the Ministry of Health (Politeknik Kesehatan Yogyakarta, 2016)
Surabaya	10. Bachelor of Midwifery, Airlangga University, under the Ministry of Research, Technology and Higher Education (Universitas Airlangga, 2016a, 2016b, 2017).

Malang	11.	Bachelor of Midwifery Programme, under the Ministry of Research, Technology and Higher Education Brawijaya University (Midwifery Undergraduate Degree Programme Fakultas Kedokteran Universitas Brawijaya, 2016)
Mojokerto	12.	Midwifery Department, Majapahit Polytechnic under the Ministry of Research, Technology and Higher Education (Politeknik Kesehatan Majapahit Mojokerto, 2014)

The research was conducted in 12 midwifery schools (government and private; diploma, advanced diploma and bachelor's) in various cities (Jakarta, Bandung, Purwokerto, Yogyakarta, Surabaya, Malang, Mojokerto, Padang) which were situated in six provinces (West Sumatera, Jakarta Special Capital Region, West Java, Central Java, Special Region of Yogyakarta, and East Java). This study also included the central board of the Midwifery Association in Indonesia.

5.3 The preparation process prior to data collection in Indonesia

Before commencing data collection, in several Indonesian cities, I had undertaken intensive preparation and consultation. While in Auckland, New Zealand, during the development of the research proposal, preparation occurred via email and international calls with mentors and several persons located in midwifery associations and midwifery schools across Indonesia. Communication was established to engage Indonesian midwives and obstetricians to assist with recruitment and data collection. All individuals who were contacted welcomed me and were ready to offer assistance.

5.4 Selecting and recruiting participants

Purposive and snowball sampling techniques are often used in qualitative descriptive studies (Merriam, 2009; Sandelowski, 2000). Purposeful sampling is used to obtain cases deemed information-rich for the study. Creswell and Poth (2018) stated that employing purposive sampling means that the researcher “selects individuals and sites for study because they can purposively inform an understanding of the research problem and central phenomenon in the study” (p. 158). However, a combination of purposeful and snowball sampling can be used to recruit subjects to gain a broad range of perspectives from the participants’ experience (Coyne, 1997; Merriam, 2009; Morse, 1991). The participants were those involved in midwifery education who could

share their experiences of midwifery education and illuminate the topic of what will strengthen midwifery education in Indonesia. The inclusion criteria for recruiting participants are summarised in Table 5.2 below.

Table 5.2 Criteria for recruiting participants

Category	Participant	Inclusion criteria
1	Midwives	1. Registered midwives 2. Have the experience to supervise midwifery students and/or graduate midwives, with at least five years experience
2	Midwifery lecturers	3. Have at least five years of experience guiding and teaching midwifery students
3	Midwifery students	4. Age 18 years upwards 5. In their final year of studies
4	Newly graduated midwives	6. Graduated within the last year
5	Obstetricians	7. Have at least five years of experience leading or teaching midwifery students

The sample size prediction was based on previous qualitative work by Marshall, Cardon, Poddar, and Fontenot (2013) where 11 to 20 or 15 to 20 participants was considered appropriate. A purposive sample of 6 to 10 participants with diverse experiences might, therefore, provide sufficient information for descriptions of a different category (Malterud, Siersma, & Guassora, 2016). Therefore, for this study, between 15 and 20 participants were sought (three or four from each group). This number of participants would provide an in-depth description that is appropriate to the qualitative descriptive methodology where semi-structured interviews are used to achieve data saturation.

Before beginning recruitment, I had identified the midwifery schools and

midwifery associations in Java and Sumatera. The Midwifery Education Association of Indonesia provided a cover letter to assist with recruitment in this step. I am a registered midwifery lecturer, midwife, and researcher in Indonesia. However, I was clear that my role was as a PhD student who is interested in knowing more about how midwifery education in Indonesia can be strengthened. Conflicts of interest were not expected to arise because there is currently no social, professional, and financial relationship between me and the participants. Selected participants would have real-life, hands-on experience central to the theme of the study, and be willing to have a genuine conversation regarding their views, thus enhancing the possibilities of capturing precious and unique stories (Denzin & Lincoln, 2000, 2013; Sandelowski, 2000). Such stories would be elicited through questions such as, "Tell me about a time you cared for a woman (pregnant woman, birthing, etc) while you were in midwifery school which prepared you for your current position?"; revealing participants' experience of untangling factors to strengthen midwifery schools in producing competent midwives.

I anticipated that the recruitment process would be complicated because of the geographical access and possible cultural resistance from potential participants due to the topic of investigation. Poster advertisements, purposive and snowball methods, and contact with key people were utilised to recruit the target number of participants. Participants were recruited through poster advertisements and an email distributed amongst midwifery schools and midwifery associations in Java and West Sumatera, Indonesia. Participants were asked to contact me through verbal discussion, email, text or phone communication. The contact details of participants were collected by me when contacted in response to the advertisement or an email. Once the participants had contacted me, an appointment was arranged to ensure the participant had read the information sheet and to answer any further questions about the study. If, after reading the information sheet, the potential participant was interested in taking part in the study, an interview time was set up. A consent form, translated into Indonesian, was completed. The selection of participants was based on a first-come, first-served basis until the required number was reached (see Table 5.3).

Table 5.3 Mode of communication channels among the participants

No	Communication	Newly graduated midwives	Midwifery students	Midwifery lecturers	Midwives	Obstetricians
1.	Poster advertisement	√	√	√		
2.	Purposive and snowball methods			√	√	√
3.	Contact the principal people.			√	√	√

Meanwhile, I gained approval letters from several midwifery schools. Next, I received a message, email and/or phone call from potential participants such as midwifery students, newly graduated midwives, midwives, and obstetricians from several midwifery programmes. Next, time for an interview at a mutually agreed venue was set.

In reality, finding participants who were willing to participate was not difficult. They wanted me to come and share my experiences of studying overseas, including the challenges and opportunities, and how I confronted problems abroad. All the participants felt curious about the research project and wanted to assist with the research, encouraging me to complete my study soon and return to Indonesia following completion. During the recruitment process, I had conversations with potential participants about the focus of the research. The anticipated difficulties of geographical access and cultural resistance did not happen.

It should be noted that the participant' numbers exceeded the target (n = 15-20) for the study because of the interest of potential participants in contributing to the study. After reaching 37 participants, I had to stop recruitment. Two principles directed the number of participants who contributed to study. Braun and Clarke (2016) suggested that a considerable sample size would provide in-depth data which is appropriate to the qualitative descriptive methodology applied in this research. According to Braun and Clarke (2016), for interview-based qualitative

research, a small number of participants is considered appropriate. Secondly, it was determined that after 37 interviews, data saturation had been achieved, and further interviews would not generate new information.

5.4.1 Description of the participants

The 37 participants consisted of nine Indonesian newly graduated midwives, nine midwifery students, six midwives, seven midwifery lecturers, and six obstetricians. The previous section explored the processes undertaken to recruit all the participants for this study. All participants were recruited from 12 midwifery schools and two central boards of midwifery associations in eight cities situated across six provinces. All of the participants answered various questions using the in-depth interview guide to share their thoughts around midwifery education.

5.4.1.1 Demographics

The participants in this study were aged between 20 and 78 years old. There were five male participants; the rest were female. Participants came from different cities, ethnic, social, and cultural backgrounds (Java, Sunda, and Padang). The variety of settings, as described above, meant that participants provided a range of diverse and unique stories and personal experiences. An outline of participants' demographic data are provided in Tables 5.4 to 5.8.

Table 5.4 Newly graduated midwives's information

Participant (pseudonyms)	Graduated from	Position at interview	Year of graduation
Butterfly	Master of Midwifery	Midwifery lecturer	2015
Yuni	Diploma of Midwifery	Midwife at Community Health Service	2015
Cici	Diploma of Midwifery	Midwife apprentice at Community Health Service and waiting for a midwife registration certificate	2016
Okta	Advanced Diploma of Midwifery from Diploma of Midwifery programme	Midwifery lecturer and part-time midwife at the hospital	2015
Rully	Diploma of Midwifery	Midwife apprentice at Community Health Service	2015
Rin	Advanced Diploma of Midwifery from senior high school	Midwife apprentice and waiting for a midwife registration certificate	2015
Far	Bachelor of Midwifery from senior high school	Junior midwifery lecturer	2015
Ani	Bachelor of Midwifery from Diploma of Midwifery programme	Midwifery lecturer	2015
Siti	Diploma of Midwifery	Waiting for a midwife registration certificate	2016

Table 5.5 Midwives' information

Participant (pseudonyms)	Education	Experience as midwives (years)
Bilbina	Bachelor of Midwifery	26
Happy	Master of Midwifery	13
Arum	Master of Health	45
Shinta	Doctoral degree	31
Widya	Advanced Diploma of Midwifery	25
Evi	Master of Science	26

Table 5.6 Obstetricians' information

Participant (pseudonyms)	Education	Experience as a midwifery educator (years)	Gender
Atmojo	Professor in Obstetrics Gynecology	40	Male
Husni	Doctoral degree	28	Male
Sony	Specialist	10	Male
Agha	Specialist	6	Male
Alim	Specialist	10	Male
Ratna	Doctoral degree	5	Female

Table 5.7 Midwifery lecturers' information

Participant (pseudonyms)	Education background	Experience as a midwifery educators (years)	Description
Ummi	Master of Arts	14	Senior midwifery lecturer
Dhendra	Master of Midwifery	12	Senior midwifery lecturer
Dib	Master of Science	6	Midwifery lecturer
Ana	Master of Health	8	Midwifery lecturer
Juju	Master of Health	12	Senior midwifery lecturer
Ina	Master of Midwifery	8	Midwifery lecturer
Suri	Doctoral degree	39	Senior midwifery lecturer

Table 5.8 Midwifery students' information

Participant (pseudonyms)	Programme
Syifa Khoirunnisa	Diploma of Midwifery programme
Joule	Diploma of Midwifery programme
Lisa	Diploma of Midwifery programme
Dyah	Advanced Diploma of Midwifery
Ismi	Bachelor of Midwifery programme
Aura	Master of Midwifery
Sas	Bachelor of Midwifery programme
Lembayung Mawar	Bachelor of Midwifery programme
Al Syifa	Master of Midwifery

5.4.1.2 Participants' background

Except for midwifery students and newly graduated midwives, all participants were currently working in midwifery schools and had between 6 and 40 years' experience working in midwifery schools and midwifery services in Indonesia. Nearly all of the obstetricians were heads of midwifery programmes in midwifery schools and decision-makers in midwifery programmes. Some of the midwives were working in the hospital, community public health service, and maternity clinic as midwifery managers and mentors for midwifery students. All of the midwives had extensive experiences in midwifery school and the maternity clinic. All midwifery lecturers were active in a midwifery association, had extensive clinical experience in the hospital or community health centre, and some had received an award for their achievement from the government and public organisations. Some of the newly graduated midwives were doing apprenticeships at community health services and waiting for the midwife registration certificate. One of the newly graduated midwives was working part-time at a hospital.

5.4.1.3 Participants' education background

Midwifery students were in the final year of their studies in Diploma of Midwifery, Advanced Diploma of Midwifery, Bachelor of Midwifery or Master of Midwifery programmes. All of the midwifery students were undertaking their clinical experience when the data were gathered. The newly graduated midwives were educated through a variety of midwifery programs: Bachelor of Midwifery, Advanced Diploma of Midwifery, Diploma of Midwifery and Master of Midwifery programmes. One midwife completed her Bachelor of Midwifery in Indonesia in which the language of the class was Bahasa Indonesia. The remaining participants had completed a master's degree and doctoral degree. Three midwifery lecturers completed their midwifery education (master's degree and diploma) in the United Kingdom and the Netherlands. Except for the midwifery students and newly graduated midwives, all the participants were well-experienced internationally and had built a relationship with midwifery education and midwifery associations abroad. At the time of the research, some were doing a short course about midwifery abroad in countries such as New Zealand, the United Kingdom, Netherlands, Australia. Many had visited developed countries to find out

about midwifery programmes and actively attended international midwifery conferences abroad.

5.5 Ethical considerations to provide protection for participants

The Council for International Organization of Medical Sciences (CIOMS) in collaboration with the WHO pointed out that research involving human subjects, especially women of reproductive age, would require individual consent for participation (CIOMS, 2008). The regulation suggests that a researcher should not let any harm occur to the participants and the research sites. The participants should be informed regarding the research and are required to confirm their willingness to cooperate and conduct this study together with the researcher. Participant information sheets and consent sheets must address the purposes, aims, and procedures of the research and a description of any possible personal risks. Ethical considerations in this study include informed consent, confidentiality and anonymity, and autonomy (Denzin & Lincoln, 2000; Orb, Eisenhauer, & Wynaden, 2001; Silverman, 2013; World Medical Association, 2001). All of these criteria were applied in this study.

The study was conducted as approved by Auckland University of Technology Ethics Committee (AUTEK), Auckland, New Zealand (Ref 16/259 on 19 July 2016) and the Health Research Ethics Committee (HREC), Faculty of Medicine, Padjadjaran University, Bandung, West Java, Indonesia (No 953/UN6.C1.3.2/KEPK/PN/2016) (see Appendix B). Moreover, approval letters from midwifery schools run by universities, institutes of health science, polytechnics of health science, and private organisations from Muhammadiyah societies, across Java and West Sumatera, which work under the Ministry of Research, Technology and Higher Education and the Ministry of Health as well as the Midwifery Association of Indonesia and Indonesian Midwifery Education Association, were provided prior to commencement (see Appendix C).

Ethical approval from Indonesia, as well as the approval letters from the research settings, was gathered because the research was conducted and presented overseas and cross-cultural safety needed to be addressed. Even though, Indonesia is my homeland, I needed to demonstrate an understanding of local customs and cultures,

as I acknowledged being away from Indonesia once enrolled as a PhD student and being potentially influenced by Western approaches. For example, for Indonesians, directly approaching people through email is culturally recognised as a Western-style of communication, whereas most people in Indonesia emphasise face-to-face communication.

In the process of obtaining Indonesian ethical approval, I learned about the different kind of schools and their respective administration processes required to get the approval letter released (see Table 5.9).

Table 5.9 Communication channels among the midwifery schools and Midwifery Association

No	Communication	Universities	Institutes of Health Science	Polytechnics of Health Science	Midwifery Association
1.	Email	√	√	√	√
2.	Official letter	√	√	√	√
3.	Face-to-face meeting	√	√	√	√
4.	Phone calls	√	√	√	√
5.	International seminar				√
6.	Social media	√	√	√	√

Utilising the modes of communication above, most of the research settings gave their approval. Some midwifery schools did not answer. At one midwifery school that I contacted, the head of the midwifery programme provided verbal permission. However, I did not receive the approval letter from this institution, despite several attempts with the administration. Due to the bureaucracy involved, I decided to withdraw from this school.

5.5.1 Informed consent

This research explores people's voices as paramount in expressing their experiences, values, and beliefs. An information sheet provided by me explained that participation was voluntary, and all participant' data would be anonymised. This information was reinforced verbally in conversation, as well as via poster and an email that was sent to all potential participants. Many of the participants wanted the information explained verbally. For example, a midwifery student participant asked

whether there would be any impact on her study if she shared her views about midwifery education. I reassured the midwifery students that her studies would not be impacted by participating in the research project. I also assured students that their involvement in the study would not affect their progress in their final programme. Participants were also assured that no identifiable information would be published; this was particularly important to protect the potential vulnerability of midwifery students and newly graduated midwives who may have critical viewpoints on the education received. No midwifery student participants were under the tutelage of me or dependent on my decision-making. Immediately before an in-depth interview, and once I had ensured the participant had read the information sheet and had answered any questions to the participant's satisfaction, a consent form was signed by the participant. Consent forms have been stored in a locked cupboard at South Campus, AUT, Auckland, New Zealand. No participants received cash to be part of the research. Souvenirs were provided to appreciate their contribution to the in-depth interviews. All tools for data collection can be seen in Appendix D.

5.5.2 Confidentiality and anonymity

Before commencing an in-depth interview, each participant chose or was given a pseudonym to maintain confidentiality in the presentation of participant information. All recordings, transcribed interviews, notes, and translation files relating to the research have been stored in a password-protected external drive and/or USB stick to which only I have access. All paper information will be shredded and electronic files deleted after six years.

5.5.3 Autonomy

Sharing ideas about how midwifery education in Indonesia can be strengthened might lead participants to feel uncomfortable or inconvenienced. I was aware that it could be difficult for the participants to share their experiences freely. It is possible that the participants, such as midwives and midwifery lecturers, may fear recrimination from their employer. The interviewer assured participants of confidentiality and sought consent from participants before asking sensitive questions. Each participant was informed that they could decline to answer any question in the in-depth interview,

take a short break, or ask for the digital recording to be stopped at any time. Participants were informed that they would receive a transcript of the in-depth interview, and that they would be able to change the text or delete quotes.

5.6 Data generation methods

Semi-structured interviews were used as the primary data collection technique in this study to gain an in-depth description of participants' experiences (Denzin & Lincoln, 2000; Merriam, 2009; Silverman, 2013). Semi-structured interviews, with open-ended questions, were conducted in Bahasa Indonesia. Interview guide questions gave me structure and flexibility in the interview. I encouraged participants to talk freely in response to the interview guide questions (Merriam, 2009; Polit & Beck, 2006; Rubin & Rubin, 2005). Interviews in a qualitative descriptive methodology are used to gather rich and unique descriptive information concerning the human experience. Through the semi-structured interview, I strived to gain entrance into the informant's world and have access to his/her experience as lived to get detail, depth, vividness, nuance, and richness. The face-to-face nature of the interview allows for immediate clarification of the participant's thoughts and access to nonverbal action such as gestures and facial expressions (Denzin & Lincoln, 2000; Rubin & Rubin, 2005; Saldaña & Omasta, 2018; Silverman, 1997).

5.6.1 Learning from pilot interviews

A pilot interview process in the native language (Bahasa Indonesia) was conducted with mentors to polish my interviewing skills. The mentors were known colleagues: Mrs Ita is a midwifery lecturer with more than ten years experience, and Mrs Ratna is an experienced nursing lecturer with more than 18 years experience. One of them was interviewed more than once. The pilot interviews aimed to get the essence of the participant's experience. Before starting the pilot interview, I briefly explained what the research was about, the aim of the research and the purpose of having the pilot interview. The prompt question that I begin with was "Please tell me about your experience as a lecturer: "how do you organise and manage a successful course of study?". From discussion with my mentor, and listening to the audio recording of the pilot interview, it was determined what should and should not be

done in the interview. I discovered that I needed to speak slowly and clearly as some words could not be heard on the audio recording. In the pilot interviews, the mentors did not read through the transcription thoroughly. However, it was discussed verbally, and some comments were made to ensure the logical sequence of the questions. Final questions were then developed and consultation with supervisors occurred because the questions, once translated into Indonesian, were worded, slightly different.

5.6.2 In-depth interview

The interviews used face-to-face semi-structured questions (see Appendix D). Questions were developed with my supervisors and were adapted from the research conducted by Turkmani et al. (2013) in Afghanistan. A sample of the in-depth interview questions was provided to all participants, in the information sheet, before data collection. Each participant was interviewed at a location and time determined by both myself and the participant. Nearly all of the interviews took place on the campus. Participants could withdraw their participation in this research within the data collection period. None of the participants withdrew. Most participants chose a pseudonym that reflected their self. For example, one participant selected “Far” which is an acronym from her name; another chose “Rin”, the name of her cat. A newly graduated midwife wanted the name “Butterfly” because she believed that life is changeable, and she needed to learn and try to be a better person. Another one selected “Okta” which means someone talented and nimble in action and decision-making. Thus, participant pseudonyms may be a meaningful representation of the participants themselves. This was one of the exciting and profound parts of this study for me. Each participant was interviewed once. The interviews were conducted in Bahasa Indonesia, as Bahasa Indonesia was their primary language. It is advised in qualitative research that questions be asked in the primary language of the participants. The use of primary language creates a comfortable atmosphere for the participants. An interview schedule with indicative open-ended questions was used to ensure the same opening template for each participant, drawing on participants’ insights to discuss their thinking and capture the unique information and views of respondents (Braun & Clarke, 2013; De Vries et al., 2010; Stake, 2010). All of the participants were excited and enthusiastic about the topic of midwifery education in

Indonesia. Even though some midwifery students and newly graduated midwives appeared nervous at the beginning of the interview, they relaxed as time passed. At this point, all the participants indicated that they were open to speaking out about the subject. Capturing their experiences, understandings and opinions of how midwifery education can be enhanced is explored in the findings chapters.

The exciting part of the interviewing process included participants sometimes answering with local languages such as Javanese, Kromo Javanese, Ngoko Javanese, Sundanese, Padang and Islamic expression in Arabic, such as Alhamdulillah, InshaAllah, Subhanallah, MashaaAllah, Ya Allah. In Chapter 1 (Introduction), the diverse ethnicities in Indonesia were described. Bahasa Indonesia is an official language; yet during the interview, participants spoke about the topic with their local language, slang language and Islamic expressions. This led me to realise the richness of the language itself. As a researcher, I ensured the participants' belief, identity, and understanding to let them talk freely about the research topic.

Another interesting aspect that I learnt when conducting the interviews was how to schedule the interviews with midwives, obstetricians, and midwifery lecturers. Several times interviews were rescheduled for each participant, which was challenging given the different locations – the cities and provinces of me and participant. For example, in going from one city to another city, train travel from Jakarta to Purwokerto, Central Java, can take more than six hours one-way to reach the destination. The research sites were diverse geographically which required the use of multiple transportations such as car, train, bus, minivan, air flights, as well as accommodation expense (see Figure 5.1 below). Additionally, I had to contact the secretary or personal administration first to make an appointment. For example, one participant was finally interviewed three months following the first attempt. In another example, the participants had to go on pilgrimage or attend an emergency meeting and rescheduling the interview required me to stay in one city longer than planned. The process was a tremendous experience and an exciting story, although at times frustrating. I learned to make quick decisions in unexpected circumstances to avoid high costs of accommodation and to optimise time.



Figure 5.1 Fieldwork in Indonesia

5.7 Transcribing and the challenge of the translation process

Some of the data were transcribed by myself, and the rest were transcribed by a typist who signed a confidentiality form. All interviews were transcribed verbatim. The data from the transcribed interviews were returned to participants for verification and they were allowed to remove things which they would not wish to have in the research and to add things which they may have missed. Most agreed with the transcripts, and only a small number gave commentary on the documents. During the transcribing process, local languages such as Javanese, Ngoko Javanese, Sundanese and Padang were written verbatim and then translated into Bahasa Indonesia and finally translated into English. Some Islamic expressions/words were directly translated into English, such as Alhamdulillah (all praise is to Allah), and InsyaAllah (God willing). At this stage, the real name of the participants, locations of midwifery schools and midwifery associations, names of schools, and the types of accreditation of the schools were removed for anonymity.

All transcripts were first prepared in Indonesian and then translated by myself into English for cross-checking of the data by my supervisors. The translation process was required because although the study context is Indonesia and participants do not speak English, findings will be presented and disseminated in English. The translation stages in this study posed a critical step since the translation could be interpreted differently. Hence the change in methodology for this research, as previously described. I was aware of the translation process and sought to ensure that meanings were not lost in translation. Regarding cross-language qualitative research, there is no gold standard agreed upon for the process of translation and cultural adaptation (Cha, Kim, & Erlen, 2007; McGreevy, Orrevall, Belqaid, & Bernhardson, 2014). The translation file was reviewed, read, and reread to ensure the precision of the translation.

As Santos Jr, Black, and Sandelowski (2015) wrote, in cross-language qualitative studies, "language-related challenges are much greater because of the added complication of having to transform life as told from a source to a target language; to life as told as translated and then to life as interpreted from translation" (p. 135). Two fundamental principles in the translation process of a cross-language qualitative

descriptive study are conceptual equivalence and single-translation (Larkin, de Casterlé, & Schotsmans, 2007; Regmi, Naidoo, & Pilkington, 2010; Squires, 2009; Sutrisno, Nguyen, & Tangen, 2014). Equivalence can be defined as the parallelism between lingual remarks in one jargon to another prose (Sutrisno et al., 2014). The single translation is the straight translation scheme where the input of knowledge is translated from the original sound to the destination expression (Sutrisno et al., 2014).

However, for the translation process to generate the composition of meaning, the four dimensions of conceptual equivalence: cohesion, congruence, clarity, and courtesy (Larkin et al., 2007; Squires, 2009) have been applied (see Figure 5.2). Cohesion can be defined as the sensitivity of the researcher to connecting and creating a pattern. Congruence is equivalence and agreement, while clarity provides clear meaning in detail and courtesy is the balance between formal and informal language (Larkin et al., 2007). Even though Indonesia has local languages, the Indonesian alphabet and consonants, as the root of words, is the same as the English alphabet. Both supervisors played an essential role in the collaboration of the translation process to render results in the target language and to ensure outcomes were understandable, to reduce personal bias and to increase the accuracy of the translation process.

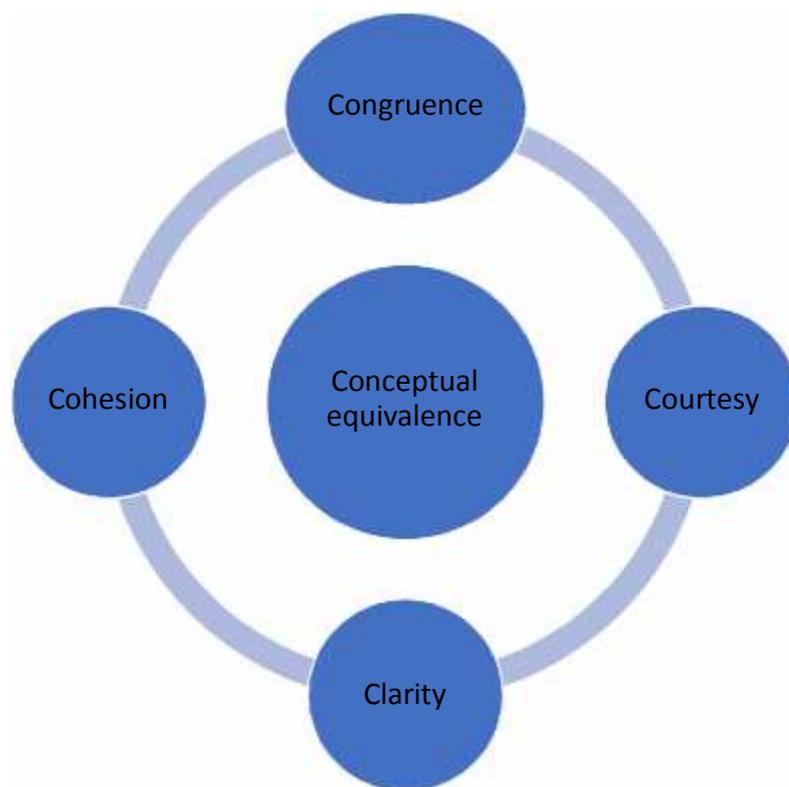


Figure 5.2 Dimension of translation process adapted from Larkin et al. (2007)

There has been debate about the role of the professional and certified translator to enhance rigour during the process of translation into the target language (Al-Amer, Ramjan, Glew, Darwish, & Salamonson, 2016; Campbell, 1998; Larkin et al., 2007; Squires, 2009; Sutrisno et al., 2014; van Nes, Abma, Jonsson, & Deeg, 2010). However, it is considered that the bilingual researcher has a responsibility to acknowledge her work and that the translator had a limited role in the research process (Campbell, 1998; Croot, Lees, & Grant, 2011; Larkin et al., 2007; Santos Jr et al., 2015). Transferring the textual meaning of the text from one language to another language (Chidlow, Plakoyiannaki, & Welch, 2014; Regmi et al., 2010) is an intercultural process (Liamputtong, 2010). There are no “right” ways to do the translation process because of the sophisticated view of the translation process in qualitative research and the characteristics of language as the essence of being human (Campbell, 1998; Chidlow et al., 2014; Temple & Young, 2004). This offers the opportunity to see that the richness of language allows the researcher and the participants to share and understand the experience, and reach an entire expression of it within the same language (Liamputtong, 2010; Regmi et al., 2010; Temple & Young, 2004).

Even though I am from the same cultural background as participants, the explanation of the timing of the translation process assist the reader in understanding the complexity of cross-language qualitative research in regard to maintaining the rigour of the research (Al-Amer et al., 2016; Chidlow et al., 2014; Regmi et al., 2010; Santos Jr et al., 2015). In this study, translation entered the research process early because the interview questions were translated prior to data collection. Further, I translated the verbatim transcripts prior to data analysis for member-checking with both supervisors. This consideration was in line with Regmi et al. (2010) who noted that although the translation process before analysis is time-consuming, the translation of the entire data set before data analysis adds rigour to the research processes. In this research, verbatim quotes from the participants used in the findings chapters are presented in English. Therefore, multiple translation processes were faced: prior to data collection, which produced an Indonesian version of the interview guide and ethical considerations in Indonesia: conducting face-to-face semi-structured interviews in Indonesia; verbatim transcribing; analysing the data in English; and reporting the results in English (see Figure 5.3 below).

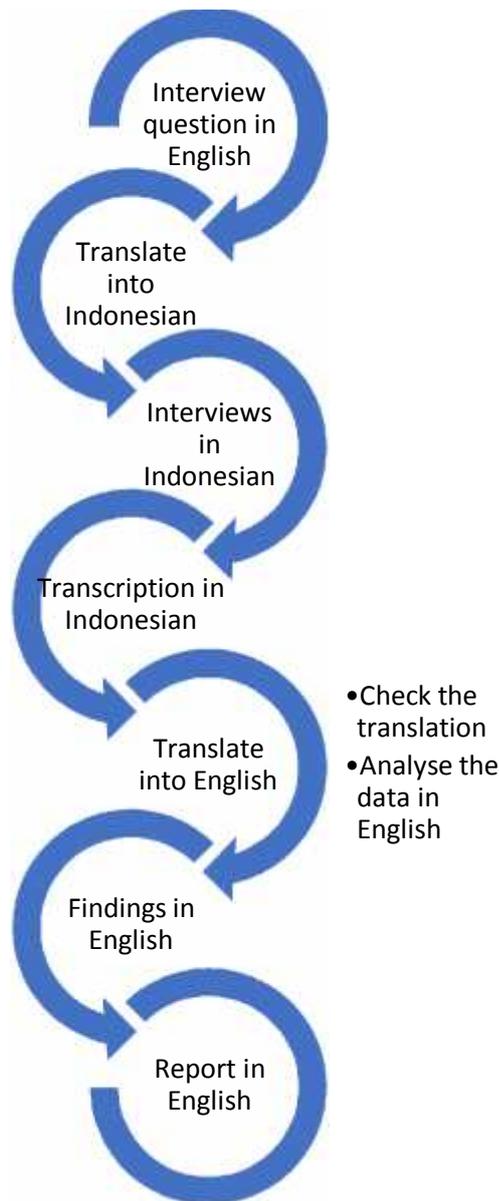


Figure 5.3 Translation process adapted from Sutrisno et al. (2014)

The translation process in a qualitative study is evolving. The initial obstacle of the translation is inadequate translation, followed by misunderstanding the meaning of English vocabulary itself. In this stage, I carefully made several checks to ensure I did not lose the original contextual meaning when translating the data into English from Indonesian. As a bilingual researcher (Indonesian, English) who is fluent in Javanese, understands Sundanese and Padang, and is able to read/write Arabic, I made sure to maintain the content and conceptual equivalence of what participants said during in-depth interviews by reviewing the translation and ensuring the sentence structure was understandable for the English reader.

In this study, the exact word-by-word translation created a problem. The English version of the transcript reflected a technically and conceptually accurate translated communication of the interviews with participants. However, the process of translating one interview was time-consuming and, at times, frustrating for me. For example, one translation took over nine hours to finish. It took around four months to transcribe 37 interviews and translate these verbatims into English. The process of translation also demonstrated the decision-making regarding the equivalence of the Indonesian word in English, for example, when participants used a slang word. In this step, I looked for the common phrase in the Indonesian language. Hence, I checked and double-checked for the accuracy of the transcript content in English (single translation). It is stressed that the conversion process from one language to another language can be an opportunity to reach an understanding by focusing on the text rather than strictly translating word by word.

5.8 Summary of data collection

I interviewed midwifery students, newly graduated midwives, midwives, midwifery educators, and obstetricians from August 2016 until the end of January 2017. All the participants had the opportunity to read through and add to or delete the content of their transcript. It took roughly six months to complete data collection. Altogether data available for analysis consisted of 464 pages, 2,539 minutes and 179,468 words from the 37 participants' face-to-face semi-structured in-depth interviews (see Appendix E for more description).

5.9 Thematic analysis

Thematic analysis was used to analyse and interpret the data and was seen to be an appropriate method for this research (Braun & Clarke, 2006, 2013). Thematic analysis was chosen because it is flexible, straight-forward and accessible, and is suitable for most qualitative methods (Braun et al., 2015; Braun, Clarke, & Terry, 2012; Clarke & Braun, 2018). Thematic analysis was considered to be an appropriate approach as it provides detailed information by identifying patterns across the data (Braun & Clarke, 2006, 2013; Vaismoradi, Jones, Turunen, & Snelgrove, 2016).

Unlike other approaches, such as interpretative phenomenological analysis, grounded theory and discourse analysis, the flexibility of thematic analysis means that this approach can be used within most theoretical frameworks, including Bolman and Deal's Four Frames approach as employed in this study (Braun, Clarke, Hayfield, & Terry, 2018; Braun et al., 2015; Clarke & Braun, 2018; Terry, Hayfield, Clarke, & Braun, 2017). As Braun and Clarke (2006) wrote:

"It can be a method which both works to reflect reality, and to unpick or unravel the surface of reality. However, it is important that the theoretical position of thematic analysis be made clear, as this is all too often left unspoken (and is then typically a realist account). Any theoretical framework carries with it some of the assumptions about the nature of data, what they represent regarding the world, reality, and so forth. A good thematic analysis will make this transparent". (p. 8)

Moreover, thematic analysis allows flexibility in data collection, including the type of data, for example, face-to-face interviews, and considerations of sample size. For a doctoral project, the recommended sample size is 15 to 30 interviews (Braun et al., 2015; Terry et al., 2017). In this study, it was considered that saturation was reached at 37 participants since there was new data gathered from the last few interviews.

One critical aspect of thematic analysis is that a theme is elaborated early on in the analytical investigation through immersion in the material or data, usually following some data familiarisation which guides the coding process (Braun & Clarke, 2016; Braun et al., 2018; Terry et al., 2017). In the thematic analysis, each theme has an "essence" or core concept that underpins the study being investigated (Braun & Clarke, 2013, 2016; Clarke & Braun, 2018). The coding process is conceptualised to find evidence for the themes. A code-book can be seen as a tool that guides a coding process undertaken by multiple researchers and provides quality assurance of thematic analysis as a uniformity in the coding approach assumes a reality that all researchers can approve of (Braun & Clarke, 2016; Braun et al., 2018; Terry et al., 2017). Coding and theme development are assumed to be subjective processes. Therefore, quality assurance strategies, such as reviewing the possible themes with another researcher, adds to the quality of the thematic analysis.

Thematic analysis was used to understand the experience of midwifery students, newly graduated midwives, midwives, midwifery lecturers, and obstetricians regarding midwifery education in Indonesia. The data for the analysis were drawn from the transcription and translation files produced by the face-to-face interviews. Within the thematic analysis, both supervisors reviewed and checked the process from the beginning stage of thematic analysis, which is familiarisation with the data, through to the coding process and writing up the results. Thematic analysis in this study was conducted using English. The verbatim transcription was translated into English prior to data analysis. Member-checking with both supervisors was crucial to maintaining the rigour of the study. The process of coding in cross-language studies requires a high degree of sensitivity to data to ensure lingual translation. The coding process was applied to the data and reviewed by both supervisors who were working independently and had limited background knowledge of midwifery education in Indonesia. For the novice qualitative researcher, translation of research data is considered necessary to ensure the rigour of the research (Regmi et al., 2010). Consistent with thematic analysis outlined by Braun and Clarke (2006), this study employed six-stages of thematic analysis involving identifying, coding, and categorising themes.

5.9.1 Step one: Becoming familiar with the data

I became familiar with the data through listening to the audio recording after the interview and then transcribing verbatim some of the interviews. This process was time and energy consuming and was challenging, given my limited typing ability. However, it was a beneficial process for me to be exposed to the data in the early stages (Bailey, 2008; Davidson, 2009). I was further exposed to the data when the verbatim transcripts were translated from Indonesian into English. Audio recording and transcriptions were listened to and read several times for a better understanding of the data. Careful and accurate reading and re-reading of all the participants' transcripts and translation files assisted me in getting closer to and making sense of participants' descriptions (Braun & Clarke, 2006, 2013). I had to review each person's transcript and translation several times to ensure that nothing had been misplaced in transcription and translation. Rereading and reviewing a transcription of around 12-

pages and a translation file for each of the 37 participants was noted as the starting point for involvement with the data.

5.9.2 Step two: Generating initial codes

Initially generating codes inductively was employed to identify the patterns, repetitions, differences and similarities which reflected the participants' thought about midwifery education. At this point, initial coding was conducted manually. Each transcript was analysed individually - read line by line then highlighted with colour and annotated on the right side of the transcript file (see Appendix F). I produced a Microsoft Word file for each transcript and created another Word document to paste in all the colour codes. This was the starting point for generating possible categories. For example, "hands-on experience of midwifery student in clinical settings" were all coloured yellow. Each of the transcripts had some colours highlighted in the Word document for simplicity of identification of that theme. This was not done simply to draw attention to large portions of the text, but also for deep thinking, and bringing to a close all that was linked to the category. The coding tree and tables were regularly referred to, and frequent re-reading of the transcripts and translation files was done to avoid losing valuable data. There was a tendency to put too much information under each category. Another challenge for the researcher was that some of the information could go under more than one coding heading. For example, there were 22 categories for newly graduated midwives, with massive amounts of data under each of the headings. At this point, a read-and-review process was utilised (Braun & Clarke, 2006, 2013; Braun et al., 2018; Braun et al., 2015), and I was required to revisit the central research question and ask how these categories answer the question of how midwifery education can be strengthened in Indonesia?.

5.9.3 Step three: Searching for themes

The next stage was to capture the data from each of the codes and categories and further analyse this data looking for themes (see Appendix G). After the first-stage coding was applied, second-stage coding continued to identify possible themes and sub-themes. At this point, the significance of the repeated phrase indicated how important it was to the participants and the research. The technique of cut-and-paste was used on the computer to format categories into themes. Initially, at this stage, 59

sub-themes and themes were identified that reflected the stories of all the participants; for example, when the midwifery students referred to hands-on experience, the way they spoke about hands-on practice and the frequent phrases they used informed the potential sub-themes. Hands-on experience was a common thread to strengthen midwifery education and ensure the competence and confidence of midwives. What were the keywords used when the participants spoke about hands-on practice? This step was another very time consuming process, but incredibly valuable, as often another critical piece of data would be exposed that could assist in responding to the research question. Further analysis continued to form the central themes.

5.9.4 Step four: Reviewing themes

The thematic map approach involved taking coloured Word documents, large sheets of paper and keywords, and categorising them to review the themes. Using this method, key themes were identified in different documents which were analysed individually, separating the Indonesian midwives, midwifery lecturers, midwifery students, newly graduated midwives, and obstetricians' data sets into separate documents. Possible themes in the second-stage coding were reduced with the realisation that further work was required to look at the data and purify the particulars of each theme. Possible themes and sub-themes were re-evaluated in regard to how these themes answered the research question. At this point, I allocated time to continuously go back to the transcripts and first-stage coding, always thinking of how codes would answer the research question. The third round of coding continued and involved pulling together all the data sets into one document. Reviewing the themes occurred alongside data to ensure that key themes reflected the data. During this process, consideration was given to the contextual features, such as positive and negative mirroring, across participant groups.

5.9.5 Step five: Defining and naming themes

The richness of the data created some frustration as I tried to fit the data into an exact framework. However, both supervisors positively encouraged me to continue the coding process, letting the data rise and speak and not forcing it into sub-themes and themes. The participants were analysed by group (midwifery students, midwives,

newly graduated midwives, midwifery lecturers, obstetricians) as it was assumed that different themes would arise from the data. The first-stage coding confirmed this assumption, but, as data analysis continued into second- and third-stage coding; similarities appeared between the different participant groups. Using the cut-and-paste technique, the data were transferred from all the participants and reduced. The possible sub-themes and themes from the various groups were refined and integrated into the three major themes identified below. This step required ongoing analysis to carefully read through every theme and the overall analysis which generated an explicit name for each theme and sub-theme to answer the research question, which asks how midwifery education in Indonesia can be strengthened.

The themes that emerged from this process were:

1. Midwifery teaching and learning of theory
 1. motivation to study and stay in midwifery: the status of a midwife, passionate about midwifery, family reasons, make them love the profession, fulfilling of the women's need, blessing of Allah, influence of peer support.
 2. teaching and learning strategies: tutorial system and class sizes, storytelling, the impact of English language, method of assessment and practice to be a competent graduates.
 3. availability of midwifery lecturer and ability to do midwifery practice.
 4. learning resources.
2. Midwifery clinical experience
 1. having effective hands-on clinical experience: not only clinical skills but empathy, women-centred care is also needed to be a competent midwife; focus on skill numbers and targets rather than quality clinical experience; developing critical thinking skills; continuity of care experience.
 2. theory-practice gap: types and length of clinical placement on midwifery experience, role conflict with obstetricians.
 3. the role of a mentor in practice: the guidance of a mentor.
 4. effective clinical experience for competent midwifery practice.
3. Structural and external factors
 1. the structures of midwifery programmes: standardisation of midwifery programmes, the midwifery curriculum and competency test, collaboration

across many parties, the hospital should be integrated with midwifery school, and who is in control of midwifery education?

2. midwifery accreditation impacts on midwifery education.
3. the requirement for post-graduation competency training.
4. the need for a Midwifery Act: a Midwifery Council.

5.9.6 Step six: Producing the report

In this research, this step is seen in the findings chapters of the thesis. At this point, the concern with presenting the results was to capture the experiences of all the participants (Braun et al., 2018; Terry et al., 2017). Pseudonyms are used in the excerpts from the verbatim quotes of the participants and presented in English.

5.9.6.1 Applying Bolman and Deal's Four Frames

Following qualitative data analysis, Bolman and Deal's (2008) theoretical framework was applied to the data. The Four Frames: structural, political, human resource, and symbolic of Bolman and Deal (1997, 2003, 2008, 2017) were utilised to explore and articulate the complexity and possible tensions that were identified in the research that impact on midwifery education in Indonesia (see Appendix H). The application of the framework to the data followed a five-step process:

1. Reading and digesting the data and reviewing it as informed by Bolman and Deal's Four Frames as the theoretical framework.
2. Applying the Four Frames and analysing the data.
3. Looking for the links, complexity, and tensions that emerge from the data when using the Four Frames.
4. Writing this up exploring the complexity that has been revealed by using the Four Frames to inform further what can strengthen midwifery education in Indonesia.
5. Alongside this, using the complexity identified to articulate further points for discussion.

5.10 Rigour in this study

Commonly, validity or reliability are utilised in quantitative research; however, qualitative studies have emphasised the idea of trustworthiness or rigour to assess the comprehensiveness of the research outcomes (Holloway & Wheeler, 2010; Lincoln & Guba, 1985; Merriam & Tisdell, 2016; Mills & Birks, 2014; Rolfe, 2006; Sandelowski, 2008, 2015). Lincoln and Guba (1985) pointed out that rigour is one-way researchers can ensure themselves and their readers that their research findings are truthful, applicable, consistent, neutral, and have value. Rigour, as Delamont and Atkinson (2011), Merriam (2009) and Merriam and Tisdell (2016) have stated, is an appropriate way of assessing the quality of qualitative research. This study relied on the concept of rigour (Lincoln & Guba, 1985) as well as the four criteria discussed below as a way for me to establish the quality of the study and as a means for readers to assess the value of the research findings (Delamont & Atkinson, 2011; Lincoln & Guba, 1985; Merriam, 2009; Merriam & Tisdell, 2016; Mills & Birks, 2014; Patton, 1999). The principles for maintaining the rigour of this study are credibility, dependability, confirmability, and transferability, as explained in detail below.

5.10.1 Credibility

Credibility refers to the deliberate intentions of the research and how well the individual facets of the research are constructed to accommodate these targets. Credibility relates to the processes put in place to maintain the accuracy of the data that have been gathered and interpreted (Delamont & Atkinson, 2011; Lincoln & Guba, 1985; Merriam & Tisdell, 2016). Maintaining research credibility is stated as one of the factors for a robust qualitative inquiry (Holloway & Wheeler, 2010; Liao & Hitchcock, 2018). In order to ensure the credibility, this study applied the major strategies suggested by Lincoln and Guba (1985), including member-checking, peer-debriefing, prolonged engagement, and persistent observation. Member-checking was applied in this study to confirm the credibility of the research. According to Lincoln and Guba (1985), member checking is the most critical part of maintaining the credibility of the qualitative study. For research member checking, two research supervisors independently reviewed the verbatim transcripts translated into English. Further, the process of returning the transcripts to the participants for review added to the credibility of this study.

Peer-debriefing is a process in which the researcher exposes himself or herself to disinterested peers or seeks external checks with, for example, academics, peers, or colleagues familiar with the research or someone new to the phenomenon explored, for scrutiny of the research project (Creswell & Poth, 2018; Lincoln & Guba, 1985). Peer-debriefing is a step in investigating analysis and conclusions with peers to interpret and discover the bias of data clarification. The role of the peer debriefer is to make sure that the researcher is honest and to critically ask questions about methods and interpretations or any other issues related to the research project (Lincoln & Guba, 1985). The present study was undertaken with mentoring from two supervisors who were knowledgeable on both the research topic and the methodological issues. They were actively and critically involved in addressing any issues related to the research project, including the procedures of the study and the process of data analysis. Accordingly, academic supervisors have a crucial role in establishing rigour in their students' investigation. Both of my supervisors and I held regular meetings throughout the study, from designing the research project to reporting the final results and conclusion.

In addition to having a debriefing session with my supervisors, I presented the preliminary findings of this research project at some academic events. Since 2016, sections of this study have been presented at my peer mentoring group, research forums, a symposium, international conferences in Indonesia, New Zealand, Australia, United Arab Emirates, and on the virtual International Day of the Midwife which joins midwives around the world (Adnani, 2017a, 2017b, 2018a, 2018b, 2018c; Adnani, Mc-Ara Couper, & Gilkison, 2016, 2017, 2018a, 2018b, 2018c, 2018d) (see Appendix I).

Through these occasions, I have been open and responsive to feedback from others. I have met and discussed the research with doctors, midwives, midwifery lecturers, midwifery students, newly graduated midwives, researchers from many different midwifery schools and other parties, receiving positive feedback and sound argument regarding this research. Primarily, at some conferences presentations in Indonesia in 2016 and 2018, some midwives and midwifery lecturers who were present were very emotional about and greatly interested in the importance of this study for midwifery education in Indonesia. After listening to my presentation in Jakarta, Indonesia, as

well as at the ICM regional conference in Dubai, United Arab Emirates, in the same year (2018), some Indonesian midwives and midwifery lecturers who were present, as well as midwives from developing countries such as Bangladesh, Nepal, East Timor and India, suggested that I write an article about midwifery education in Indonesia and indicated how important my study was to the midwifery profession in Indonesia and developing countries.

Prolonged engagement is defined as a long-lasting engagement with the participants in the field to build trust, understanding and closeness with the research site, culture and context, and also to test for misinformation (Creswell & Poth, 2018; Lincoln & Guba, 1985). Prolonged engagement provides scope for the researcher to be open to any kinds of influences that might contribute the phenomenon under the study (Lincoln & Guba, 1985). Persistent observation provides depth as it requires the researcher to identify which characteristics and elements in the context are likely to be most relevant to the issue being investigated and, then, to focus on a detailed exploration of them (Lincoln & Guba, 1985). Persistent observation is used to identify the characteristics relevant to the research analysis. In other words, prolonged engagement and persistent observation enable the researcher to make “field-based decisions about what is salient to study, relevant to the purpose of the study, and interest for focus” (Creswell & Poth, 2018, p. 262). The development of an early familiarisation with the context and culture and the research site was also established throughout the study. Being in the research setting for around six months enabled me to become familiar with the research setting. By recruiting midwifery students, newly graduated midwives, midwifery lecturers, midwives, and obstetricians from differing midwifery programmes and research sites, this study has been able to benefit from a wide range of views and experiences to provide the richness in the data. At this point, credibility is also enhanced when there is no existing relationship between me and the research sites. Also, I have no current midwifery students, and no-one depends on my decision-making.

5.10.2 Dependability

Dependability refers to the consistency and reliability of data collection and data analysis (Merriam, 2009; Merriam & Tisdell, 2016). In order to address dependability

issues, a qualitative researcher is required to ensure that the data are analysed according to the accepted standards for a particular design. Dependability can be ensured through reporting the processes within the study in detail to enable the other researchers to repeat the work and to allow the readers to evaluate whether the research follows appropriate research practices. One strategy to address dependability is by using an audit trail to examine the transparency of the research process. In this study, strategies to demonstrate dependability include the detailed exposition of a research process that explained the research methods step by step, including prompt questions for a semi-structured interview. Further, using the thematic analysis approach of Braun and Clark (2006) throughout the research process, both of my supervisors have read my work and provided constructive feedback as they have guided me through this study.

5.10.3 Confirmability

Confirmability refers to the degree to which the research findings of a study represent the participants' responses and the contexts of the research rather than the researcher's preferences, characteristics, and viewpoints (Lincoln & Guba, 1985). Confirmability can be ensured through the use of an audit trail. In this study, an audit trail was developed by having a peer review of the research proposal, which was examined by an internal reviewer, before undertaking data collection in Indonesia. Also, obtaining ethical approval from the ethics committees (both AUTEK, New Zealand, and HREC, Indonesia) was inherent to demonstrating an audit trail. Presentation of the preliminary findings of this study in a symposium to peer PhD students at AUT and at international midwifery conferences, as explained above (in section 5.10.1, Credibility) was insightful and provided constructive feedback.

An audit trail was employed at all stages of this study with both supervisors, included at all stages of data analysis, and included the justification for analytic decisions for the themes, mapping the preliminary findings, and decisions regarding the final themes to ensure confirmability. In this study, the audit trail is detailed in the methods chapter with supporting appendices. Rich quotations from the participants in reporting the research results presented in Chapter 6 to 9 of this thesis provide a strong argument that explores the participants' experiences. An audit trail was maintained to

demonstrate confirmability, which is in line with Merriam and Tisdell (2016). Further, the researcher's reflexivity is also an essential indicator of credibility and confirmability of the research. According to Merriam and Tisdell (2016), some information regarding the researcher is required to offer any personal and professional information that may affect data collection, analysis, and interpretation. In this study, my reflexivity was explained in detail in Chapter 4, Research Methodology.

5.10.4 Transferability

Transferability identifies how a study's findings could be transmitted to other environments or situations (Creswell & Poth, 2018; Lincoln & Guba, 1985; Merriam, 2009; Merriam & Tisdell, 2016). According to Guba (1990), the transferability concept refers to "providing sufficient description of the particular context studied so that others may adequately judge the applicability or fit of the inquiry findings to their context" (p. 236). This qualitative study never had any intention of being generalisable to a broader population. One strategy to address transferability is by using thick description and maximum variation (Creswell & Poth, 2018; Lincoln & Guba, 1985; Merriam & Tisdell, 2016). The provision of thick description recognises the potential application to other sites (Guba, 1990; Lincoln & Guba, 1985; Merriam & Tisdell, 2016) and is carried out in a manner to attain transferability by including illustrating the research steps and results. Providing a specific, rich description of the study settings offers ample information for the reader to be able to recognise the relevancy of results for other sites (Creswell & Poth, 2018; Merriam & Tisdell, 2016). It can be said that if similar conditions and contexts were created, the person would act the same way. In this study, transferability is supported through providing adequate information in terms of the research participants, settings and locations, and methods of data collection, which enable the readers to assess whether the research findings are transferable to their settings. Also, in this study analysis, the processes of the findings are detailed with sufficient excerpts from participant interviews, and presented in Chapter 6 to 9.

Further, according to Merriam and Tisdell (2016), another strategy for enhancing transferability is to give careful attention to selecting the study sample (maximum variation). Maximum variation allows the possibility for a broader range of the

research sites selected for research or the participants interviewed. In this study, a broad range of research settings was selected as well as multiple perspectives from various participants being obtained to demonstrate transferability. Snowball and purposive sampling applied in this study were intended maximim variation to recruit diverse participants, including Indonesian midwives, midwifery lecturers, midwifery students, newly graduated midwives, and obstetricians.

A summary of the techniques used to maintain rigour in this study can be found in Table 5.10.

Table 5.10 Rigour in this study

Rigour	Techniques
Credibility	Member-checking Peer-debriefing Prolonged engagement Persistent observation Reflexivity
Dependability	Audit trail
Confirmability	Audit trail Reflexivity
Transferability	Thick descriptions Maximum variation

5.11 Summary of Chapter 5

Undertaking a study seems easy when the research is conducted in the researcher's home country. However, the reality revealed real challenges regarding ethical consideration, personal contact, potential participants, and the interview process. In this chapter, the specific methods that were employed in this study to explore participants' experiences regarding midwifery education have been detailed. Data were gathered using face-to-face semi-structured interviews, then analysed and interpreted thematically. Challenges in the transcribing and translation process, which influenced the alteration of the methodology, have been discussed. The rigour of findings of this research was determined by careful consideration of all aspects of the study. The next four chapters present the findings of the study which arose from data collection and analysis.

Chapter 6.

Findings Part One: Midwifery Teaching and Learning of Theory

6.1 Introduction

This chapter and the subsequent three chapters present the themes from the data, which emerged in response to the research question and address the study aim, which is to ask how midwifery education in Indonesia can be strengthened. The data from 37 participants were explored through a qualitative descriptive methodology, and the viewpoints, understandings, and opinions of the participants are presented. The data obtained from newly graduated midwives, midwifery students, midwives, midwifery lecturers, and obstetricians are presented in four findings chapters that explore in-depth the themes and sub-themes. These chapters have each been named using a major theme which arose from the thematic analysis. Findings from this study have three central themes: midwifery teaching and learning of theory, midwifery clinical experience, and structural and external factors. The themes have the potential to contribute to enhancing midwifery education in Indonesia. This first findings chapter presents the theme 'midwifery teaching and learning of theory' for strengthening midwifery education in Indonesia. Four sub-themes were identified: motivation to study and stay in midwifery, teaching and learning strategies, availability of midwifery lecturers and ability to do practice and learning resources. See Figure 6.1, below.

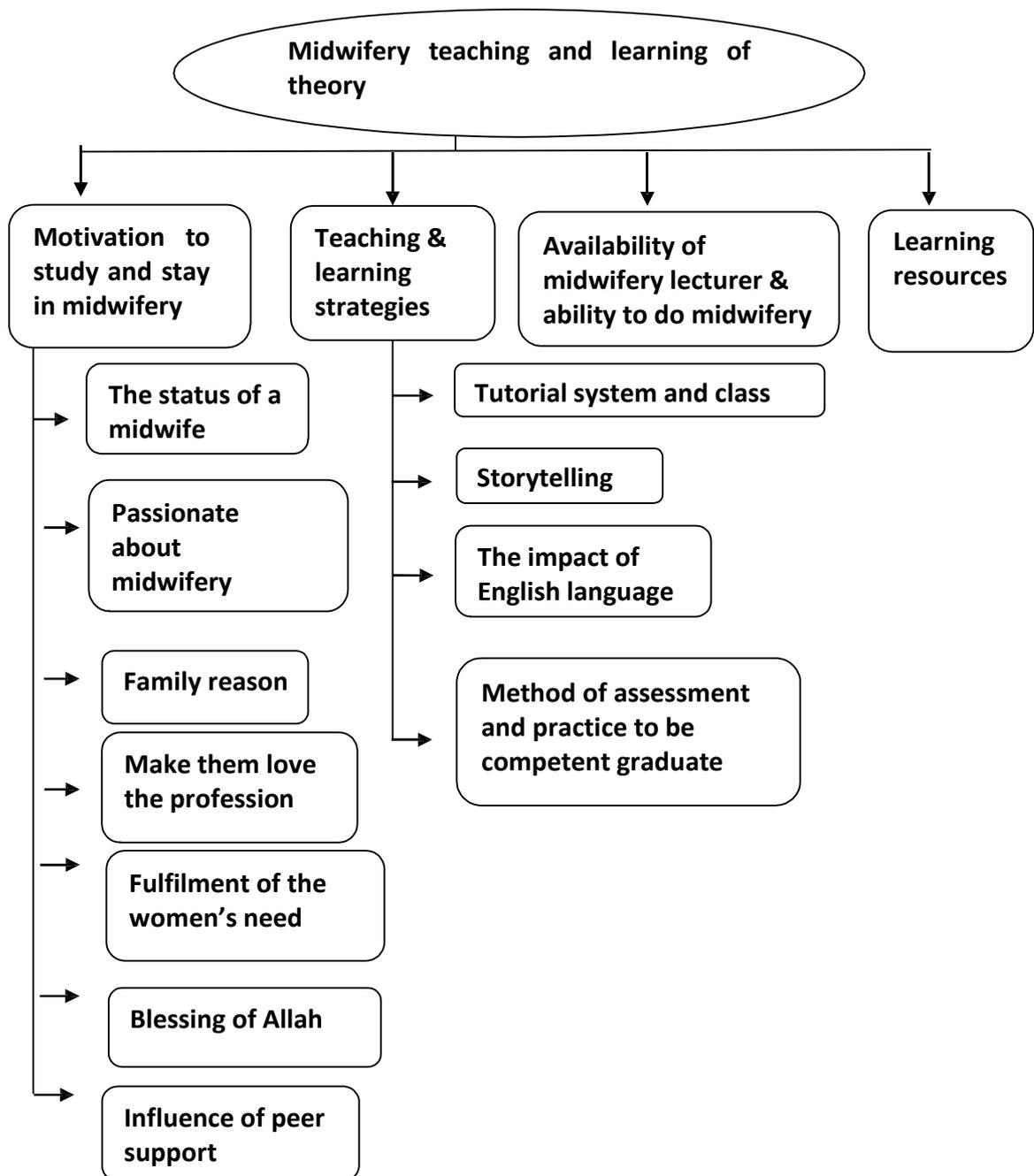


Figure 6.1 Theme and sub-themes of midwifery teaching and learning of theory

The first sub-theme under theme ‘midwifery teaching and learning of theory’ is the motivation to study and stay in midwifery. The term ‘motivation’ was mentioned throughout the in-depth interviews and was believed to be the foundation for learning midwifery and staying in midwifery. In this study, participants indicated how motivation was as a reminder to remain in midwifery programmes. Various motivations to study and stay in midwifery were identified in this study. The motivation found in this study demonstrates uniqueness because it was shown to be

not only an enabling factor, but it also a constraining factor when people were attracted to enter midwifery school for family reasons (external factor). Participants suggested that the motivation to learn and stay in midwifery was important as motivation impacted on midwifery teaching and learning processes. In the section below, the findings related to motivation to study and stay in midwifery are discussed.

6.2 Motivation to study and stay in midwifery

Analysis of the interviews indicated that participants' motivations for studying and teaching in midwifery schools varied. It became clear that the motivation to be *bidan* ranged from personal interest to professional development. When students were passionate about becoming *bidan*, they were concerned about the health outcomes of mothers and babies and this motivation influenced them to stay in midwifery as a career.

6.2.1 The status of *bidan* in the community

One aspect that motivated participants to study midwifery was the status of midwives in the community. Syifa Khoirunnisa spoke of the place of the *bidan* profession in her family and community, which was the motivation for her to become a midwife:

I just want to become bidan and help my village. I came to study here far away from my hometown, and I was motivated to study hard. I don't have relatives here, so I am alone. I am motivated and so accept the many hardships I have to through InsyaAllah (God Willing) I can finish it then come back to my village and become bidan. I will become a good bidan as there is no bidan in my village as it is in a remote area. I want to open private midwifery practice there, which is my goal. I can then apply what I learnt within these years in my village. I need not be an ordinary midwife but extraordinary and then I will be, respected and valued because people come to a midwife and ask about many health thing. I want to have midwifery practice which is different in fact entrepreneurship and provide for mother and baby needs as well. So, I need to be serious and deepen my midwifery knowledge, InsyaAllah I can do it. (Syifa Khoirunnisa)

Syifa Khoirunnisa is motivated to be *bidan* because of the needs of her family and community. These needs motivate her to study hard and to become the best midwife she can be. She wants to be extraordinary so that she will be respected and this motivates her to work extremely hard. Further, the needs of her community are great as she lives in a remote area and there is no midwife in her village or close by. Syifa sees herself returning to her village as a midwife once she is registered and providing a

full range of health and midwifery services (entrepreneurship) which will greatly benefit mothers and babies in her village. Understanding the value of *bidan* in the community attracts the participants to enter the midwifery school and study hard.

6.2.2 Passionate about midwifery

The midwifery students and lecturers in midwifery schools who contributed to this research revealed that when students and lecturers were passionate and motivated about midwifery, the teaching and learning processes were improved. With improved midwifery teaching and learning processes, the quality of midwifery education could be improved.

The participants described their experience of becoming a midwife and feeling passionate about midwifery. During interviews with the midwifery students, it became obvious that they were motivated to become *bidan* because of the difference they could make to women and families. Some reasons that have contributed to the passion for midwifery are explored below.

For Suri, a midwifery lecturer, passion lay behind her teaching and instilling motivation in her students to become a good midwives:

Being passionate about what you do is an important aspect of being a midwife. Because when you like what you do, you will be able to achieve everything in life. If I don't have passion in this field, I won't be able to do this for a long time and succeed.(Suri)

Suri believed that first she has to be passionate about her role as a midwifery lecturer in order to transfer the spirit to her students. She felt that being a lecturer required enthusiasm to impart passion to her midwifery students. She talked about her desire in motivating her midwifery students to become a good midwife. She stated that being passionate was at the heart of being a midwife.

Lembayung Mawar, one of the midwifery students, expressed her thoughts towards feeling passionate about midwifery:

*I am interested because midwifery is a noble profession. I intend to be women's companion. I believe that the philosophy of midwifery is absorbed into ourselves. Midwife's responsibility is not easy because it is tied to mothers and the babies' lives. I am aware that to be a good *bidan*; I have*

to be ready to improve my knowledge and skills. I want to be bidan yang lebih baik (a better midwife) and reach a good level of competence to be a professional midwife who can deal with the many challenges to providing a good and professional service, for mothers and their children. It is my goal. (Lembayung Mawar)

Lembayung Mawar was clear why she wants to be bidan and expressed in passionate terms, how she saw herself as the woman's companion and the responsibility that a midwife has in caring for a woman and her baby. This passion has led her to want to be a “good midwife”, one who has good knowledge and skills, and can make a difference to the outcomes for women and their babies. Lembayung’s passion motivates her to learn the knowledge and skills, and absorb the midwifery philosophy so that she can deal with the challenges and responsibility of a midwife. The internal motivation and the personal interest to become *bidan* was seen as one of the fundamental aspects to understanding midwifery knowledge and skills.

6.2.3 Family reason

In-depth interviews showed that the motivation to enter midwifery school did not always come from internal motivation. Some participants revealed that they were motivated because of their parents’ desire. Lisa, one of the midwifery students, expressed her thoughts that her parents were making her enter midwifery school:

I was not interested in becoming bidan. However, my father wanted his daughter to be useful in the community. He also said it would be easy to look for a job in the future and that it is extraordinary to become bidan. Alhamdulillah (All praise is due to Allah alone), I have been accepted. I accept the condition to enter midwifery school because it was not my decision but I want my father to be proud of me. My background is in accounting but thank Allah I can follow the material. I am the last child in my family, and my family is not a rich family, my parents were not educated and my brother is the backbone of my family. My brother and my parents want me to become a health worker, nurse or midwife. I was motivated as my brother sacrificed so much for me and spend all for my study so to open up a path for my family. My parents are farmers, they work early morning until night. My motivation is my family so, I’ve done my best. I am not talented in biological, physics, formula, but still, they always said that I have to become a midwife who knows and will be able to pave the way for others. (Lisa)

For Lisa, the motivation to become a midwife comes from her father and family. It seems that the value and belief of her family firmly indoctrinated Lisa into how to study harder in midwifery school. The value and belief that makes her parents proud

become extrinsic motivations which were embedded in Lisa's mind in studying midwifery at the midwifery programme, as she was struggling to learn midwifery matters. Material support from her family gave her no choice to study other subjects as her family had high expectations for her to become a midwife in regard to raising the dignity of her parents who had limited education.

When potential midwifery students enter school due to external motivation, that is their parents' desire; it creates challenges for midwifery lecturers and midwives instilling passion and motivating students to love the profession from their heart.

6.2.4 Make them love the profession

The experience of some midwifery lecturers and midwife participants revealed that it was a challenging process to facilitate the students in becoming midwives. Ummi, a midwifery lecturer, described enabling midwifery students to love to become a midwife as one of the hardest aspects of her job:

The hardest challenge was when I met students who went to midwifery school, not because of her of will but her parents. So that student took the class to respond to their parent's dream. It was difficult. Because deep in their heart, she did not want to be a midwife. It was the hardest moment because on one side, we cannot force someone to be something that she does not want to. However, on another side, they were asked or forced by their parents to finish their study. Therefore I said, my hardest job was to make them love this profession. I had to make "the parent's intention" became the call of their soul that "I like this profession and I want to dedicate myself to this profession." Every year there were students who were there because of their parents. However, Alhamdulillah, based on my experience in encouraging students and the help from my colleagues, I successfully can make that student love midwifery. (Ummi)

Ummi's quote illustrates the critical yet challenging process for turning a midwifery students' motivation from her parents' dream to a call from the student's heart. Ummi admitted that it is fundamental for midwifery students to be in love with the job and to devote themselves to being midwives. Ummi discussed how important it is for midwifery lecturers to facilitate students' desires about the midwifery world. Alongside a team of midwifery lecturers, Ummi has to structure planning, teaching, and communication in everyday practices in the class (school) to develop and nurture the midwifery students' motivation.

In the same vein, some midwives concurred that it was a challenging moment to guide midwifery students in the field who did not have the intention in their hearts to become a midwife. Widya, one of the midwives, expressed her concern about this:

Some students do not show interest and do not ask, they just kept silent, not even asking after listening to my explanation and seeing what I have done. They were just watching, seeing and waiting for instruction and were not proactive and doing in clinical practice. The students kept silent when I ask them too. I don't understand this attitude. I am here to guide them. I would like them active and work with midwives actively. Not only stand and watch and I hope they are active and will ask questions. Maybe, in school, her teachers always give everything to ensure she understands. I see students not engaging and reluctant to do things and then I ask, are you told by your parents or your own will? Surprisingly, sometimes they admit they did it because told by the parents. I felt different when guiding the students now compared several years ago because of that. (Widya)

Widya was very clear in her descriptions of what and how she should manage a clinic day and described the picture of being a mentor for unmotivated midwifery students. She felt she already gave support and encouragement to midwifery students, as well as opportunities for midwifery students to do the clinical practice. Conversely, some of the students were not able to understand what they needed to do in the clinical settings, and therefore just stood and watched rather than taking action in clinical practice. For Widya, it was not an easy process dealing with unmotivated midwifery students. For her, she needs to stimulate situations to offer students the opportunity to learn. She felt that passion about midwifery from midwifery students was essential. She expressed that students would demonstrate correct and safe midwifery skills and knowledge if the passion was there.

The midwifery lecturers and midwives need to work with midwifery students who are unmotivated, because of family reasons, and move students from this place to having the heart of a midwife. Doing so will improve the learning process and strengthen midwifery schools. Furthermore, the participants also identified the crucial factors needing to be improved to enhance midwifery education in Indonesia.

Another motivation for studying midwifery, expressed by participants, was the satisfaction of working with women and their families.

6.2.5 Fulfilment of the women's need

Fulfilment of the women's needs tended to boost their motivation. Siti, who has graduated from her midwifery programme, expressed her feelings about the influence of clinical learning to her motivation to become a midwife:

What I had to learn was not interesting but when I started to practise my interest started to grow. Meeting with several women who needed me and I could help them such as helping the women to deliver the baby; I felt very proud although I felt tired at the same time. At that point, I felt very proud. I felt valued especially when she thanked me. (Siti)

Siti revealed that she had three years of education and only now felt that she was gaining competence in practice in the year after graduation when she was preparing for the competency examination. During the midwifery programme, clinical experience contributed to nurturing and fostering her desire and internal motivation to become a midwife since she felt valued and needed by the women and their families during the labour process. She felt proud and useful as she was able to help the woman to deliver the baby. She drew attention to the significance of supporting the delivery process and the role of the midwife. It was not until this fourth year that Siti's interest grew from the clinical experience when she started working with the women. Only then could she see the links between practice and the learning processes at her midwifery school.

Dyah, a midwifery student from an undergraduate programme which has access to the hospital, developed her passion for midwifery prior to graduation:

It is nice to work in partnership with the woman. Mothers are happy when they are having a baby and have birthed their babies and I work with them about how to care for babies, I am also motivated as one day I will be a mother and so I learn about all these things for my future. I enjoy working with women who are different and have different personalities and needs. This is what I was taught in midwifery school about humanity, and so my passion is in midwifery and I want to make a difference for women. We are women's partners; we are families' partners. (Dyah)

Dyah thought that it was an exciting feeling to be part of women's and families journey to becoming parents. The relationship between women and family within the labouring process was significant to Dyah making a difference to women's and families' lives as they welcomed the new member of the family. Emotionally, Dyah felt connected to becoming a mother herself one day and learning how to deal with this condition. Realising her role as a midwife, Dyah hoped to offer women and their family

excellent midwifery care in maternity service. Her learning was enhanced because during her training she had quality clinical experience, which grew her passion for midwifery.

During the conversation about midwifery education, most participants' responses showed that what motivated participants to stay a midwife in Indonesia related to religious belief.

6.2.6 Blessing of Allah

The quotes below revealed the importance of religion to direct what participants did in their life. The participants stated that remembrance and sincerity to Allah (God) would be rewarded. Joule, a midwifery student, was motivated to study midwifery through her religious beliefs:

I will be able to help others and in the Eyes of Allah it will be a charity for me as I will serve the community and help those who need me Alhamdulillah. There are many challenges though as I am afraid of needles. However yes, my motivation to enter midwifery school is to help others it is my motivation now.
(Joule)

Joule's quote illustrates that becoming a midwife and assisting women and their families would become a charity and seen as a good deed for her in the Eyes of Allah. She prays to Allah that Allah will answer her will and worship to become a midwife, despite the many challenges involved in studying midwifery. The blessing of Allah fortified her mind and heart to remain in midwifery school and Joule believed that she would be able to achieve her goals to become a midwife.

The influence of the culture and religion was also expressed by midwifery lecturers. Suri expressed concern related to blessings from Allah:

We have to emphasise that everything we do, we do it for Allah. We do it for helping people. Then, if we have passion for working, everything becomes so interesting. The foundation is about Allah. We have to ikhlaslillahita'ala, (sincerity and remembrance because of Allah alone) InshaAllah, Alhamdulillah. I can maintain a good relationship with people if we behave nicely with them. That kindness will spread everywhere. It is important that as a midwife, we have courage and are brave in taking a decision. If there is bleeding patient, the midwife must be brave and act to do what is required otherwise the patient will suffer and even die. This is the reason why I need to be brave and teach others to be brave too. Midwives must understand the law and comprehend what is required so that we can really do

what's necessary. (Suri)

Suri explained that the foundation to teach is to get a blessing from Allah. Allah is the only reason for her to do her role, and she believes that she would get a reward from Allah if she spreads kindness and goodness to others, such as her midwifery students. Her passion for teaching students to become good midwives is significant because the students need to be brave and deal with various conditions including decision making in an emergency case. Sincerity to Allah is the reason why Suri loves her job. Suri's quote reveals several attributes required for being a good midwife, including feeling passionate, studying hard, and practising in the field. For Suri, her career and being a midwifery lecturer is for the primary purpose of achieving the blessing of Allah.

Understanding the cultural and religious context in the community was seen as an essential factor to improving midwifery teaching and the clinical facilitation of midwifery students and newly graduated midwives as well as midwifery colleagues.

6.2.7 Influence of peer support

Some participants felt frustration working in the education institution and clinical sites. A supportive environment working with midwifery colleagues and others was an enabling factor in dealing with the challenges of improving the school, as evidenced by one of the participants below:

We always tried to advocate to make improvements in human resources, the facilities or make a guidebook for practice. Yes, we tried to improve things through policies and procedural material. However, because we are all women it is sometimes tricky to find the time as we have other duties with our family and children. Even though we really tried and worked overtime, until Isya, until 10 pm. If we wanted to leave and give up we could but we support each other because we love this profession, I love it and are part of this team so I keep doing it. At times we felt undervalued and not appreciated but despite that we continue to lobby. The togetherness is the positive thing that I learn so we all share the work and then we make the worker easier. (Far)

Far, a newly graduated midwife, who is already working as a lecturer, realised that many factors needed improvement in midwifery schools and clinical sites. Far expressed her frustration with the current system and suggested that advocacy and lobbying was needed to create better conditions for midwifery lecturers. The inner conscience to love the profession was one of the things that kept Far going. Far felt the

sense of belonging and working in a supportive team was what kept her going. Far believed the positive relationship would empower and enable one other and would be professionally beneficial to the successful teamwork and improvement of the teaching processes and midwifery programmes.

Furthermore, a primary concern of midwifery school which is mandated by the government for all of the midwifery programmes is midwifery teaching and learning processes. In the Indonesian context, all of the midwifery teaching and learning processes are written in the midwifery curriculum. As explained in Chapter 2 in the overview of midwifery education in Indonesia, only the diploma of midwifery programme has a national curriculum which is used for three-year midwifery programmes in Indonesia. The rest of midwifery programmes, which are the advanced diploma, bachelor's and professional midwifery programmes, develop their own midwifery curricula themselves in their institutions, guided by the Indonesian Qualification Framework (Kementerian Riset, Teknologi, dan Pendidikan Tinggi Republik Indonesia, 2018). In this study, most participants called for change in midwifery teaching and learning strategies to improve midwifery education. Participants in this study considered that improving teaching and learning strategies was needed mainly due to the fact that "new" approaches, the globalisation era, and the quality of evaluation at midwifery school would provide the academic atmosphere among midwifery students, midwifery lecturers, midwives, and all people involve in midwifery programmes.

6.3 Improving teaching and learning strategies

Participants identified many factors that contribute to the potential improvement of the midwifery school. Midwifery students and newly graduated midwives highlighted the need for an improvement in the teaching and learning techniques of midwifery lecturers with: the tutorial system and the small class sizes; the use of storytelling; the impact of English language; and methods of assessment and practice.

In this study, data were gathered from a broad range of midwifery schools and midwifery programmes. Therefore, there was variety in learning strategies used across the midwifery schools. From some of the midwifery schools, the learning strategies

utilised large class sizes (80 students and more in one class). Hence, the tutorial system described by some participants as the 'new' approach was challenging for some midwifery lecturers and students.

6.3.1 Tutorial system and class sizes

Rin, a newly graduated midwife, felt that the newly implemented tutorial system provided valuable learning:

Our learning improved with the tutorial system. So one lecture focused on some students only, not like during my years when all students were included in a single class, that was too much. We were not monitored one by one. There were 80 students at my time, in one class. So, I think that was not efficient and effective for the learning process. However, now it's different as they have tutorial there are only a few students that they can focus on so it is SCL (student-centred learning). But now, everything already changed into the tutorial system and midwifery students gained better learning. (Rin)

Rin was conscious that the tutorial system, with its small groups of students, identified opportunities to develop the participation of midwifery students in the classroom. The tutorial system and small class sizes were viewed as a positive learning process because her teacher was able to understand the progress of each midwifery student. Rin testified that the previous approach (large lectures) was a less effective way of learning. Rin suggested that this new way of learning would foster the midwifery students' knowledge and skills, and confidence in understanding the material. The tutorial system and small class sizes were considered to be one of the essential factors in improving the learning process at midwifery schools, thereby enhancing the quality of the school.

Al Syifa, a midwifery student, also explained that the style of teaching and big class size made her only imagine, rather than understand, the midwifery materials:

The class is not supposed to be big because it's difficult and uncomfortable, it should be small with fewer people. During the learning process, students trained to have critical and fast thinking, they should learn to solve a case with tutorials and laboratory practice. A small group of students with one lecturer absorb the material better but learning process by listening to videos is not enough. (Al Syifa)

Al Syifa said that the large class was difficult and uncomfortable because she could not pay attention. Al Syifa wanted to gain critical and quick thinking, which she felt was better learned with a small group with one lecturer in tutorials and laboratory practice.

She found that the tutorial system with case studies and scenarios enhanced the critical and fast thinking of midwifery students required for simulated practice and later in the clinical experience.

At one midwifery school, problem-based learning was utilised where students decide on their own learning objectives in relation to a particular case scenario. Sas, a midwifery student, testified that the new approach was challenging as she did not learn in the right way:

I think that we have boundaries such as we have our standards and it is a different process, it is indeed new. We were given a case about how and what the best practice should be and used problem-based learning tutorial. At the beginning I thought, am I learning something? Because we learned from the papers that created for the tutorial. I felt not ready because we have to figure out the materials by ourselves, early detection, prevention, and so on, not from the teacher. We have to learn the material (midwifery) from the discussion. I thought that the teacher would give hand-out about the knowledge because we had the assignment. Nevertheless, in the end, I felt happy because I understand how the process to get the knowledge and skills. (Sas)

Sas felt frustrated having to learn by herself with her peers; especially when she would have an assignment at the end of the semester. The problem-based learning tutorial required the understanding of a midwifery topic, and how to prepare and deliver the material to her peers. In the beginning, she had to figure out the purpose of the tutorial as she did not learn anything in the classroom. On the other hand, through participation in problem-based learning, Sas testified to a remarkable change in that her understanding about midwifery science increased and she felt prepared. She found that the problem-based learning tutorial was associated with the level of understanding and improvement of midwifery students regarding midwifery science.

Ana, a midwifery lecturer, was challenged by the tutorial system which offered different learning experiences, as expressed below:

We are using the block system, so it's a difference from when I was in midwifery school. They were participating in class, so we play as a facilitator, being a tutor, divided into some small groups. We have developed the theme of learning and use best practice. Usually, in the end, there was a knowledgeable lecturer. The lecturer also needs variation where they can be creative and innovative. It's teamwork, seen one team, not only midwife, commitment and supported by students. (Ana)

Ana was challenged by this new approach to teaching. She realised that the new approach, the tutorial system, would be different from the traditional form of a teacher lecturing in front of the classroom. In the beginning, the tutorial system was seen as problematic for Ana. Ana expressed concern that facilitating the small group as a tutor was a different way of teaching requiring the students to be active learners, thinking and working together. She explained that being a facilitator was a challenging process that required creativity and innovation because the group would be interactive and relevant.

6.3.2 Storytelling

Participants in this study spoke of the value of storytelling which was helpful for their learning. Participants discussed the improvement in the learning process by storytelling to sustain what they had done and develop the stronger personality and teamwork to improve the midwifery school. Suri, one of the midwifery lecturers, said: *"If not us (lecturers) - who else to give inspiration?"*.

Suri found that sharing midwifery stories inspired the midwifery students, enabling them to learn about midwifery practice. For Suri, the stories from practice, shared between the lecturers and the students, provide inspiration for learning which cannot be learned from midwifery text books.

Furthermore, an obstetrician who teaches in the midwifery school concurred that his position at the midwifery school was valuable for sharing inspiring stories with the midwifery students and newly graduated midwives.

A good teacher is the one who gives inspirations, so I talk about 70% knowledge and tell stories about 30%, to provide inspiration, which has relationship to religion, to Indonesia's culture. They usually like it. I want to be like this, I mean, because I see the problems in the real world. (Agha)

Agha indicated the significance of lecturers sharing fresh stories and enthusiasm while delivering material to help students do their best. He saw the importance of integrating knowledge with practice stories to inspire the students. He explained that he is not only passing on knowledge, when he tells the students a story, he is also inspiring them to learn. Agha explained the stories about midwifery in relation to the diversity of Indonesia, such as religion and culture, stimulate the motivation and

improve the learning process for the midwifery students. If he just lectured and gave 100% knowledge, Agha imagined that his students would be bored and not know the real practice issues he faces every day. Storytelling stimulated a positive student response to improving practice in becoming a midwife.

Ismi, a midwifery student, found that her teacher's stories instilled motivation, as well as awareness of the midwifery science:

The main impression, most touching, yes, very touching stories when one of my teachers (he is an ob-gyn) shares in that way. He mixed the physiological anatomy with the religious things, with midwifery. So exciting and made me aware of the midwife, and what a midwife needs to know and so I want to understand anatomy, physiology. (Ismi)

Ismi recognised that the stories had been an essential aspect of role acquisition, particularly in her motivation to become a midwife and how to become a good midwife. Ismi seemed enjoyed the way her lecturer delivered the stories, mixing physiology and religion with midwifery material.

Shinta, a midwife, said that, in her experience, some lecturers were not practising midwives, and so their stories were not real:

Our lecturers are not a practical person, even not ever such as a person. How can they (midwifery teacher) transfer knowledge and skill? (Shinta)

Shinta felt that storytelling was effective when it was derived from the lecturer's personal clinical experience. For Shinta, if lecturers did not have clinical experience, it was a barrier for her learning. Shinta considered that storytelling from a lecturers' past clinical experience could encourage students to link what they learned at the school with their own clinical experience in the clinical sites.

6.3.3 The impact of English language

In Indonesia, midwifery students are educated in the official language Bahasa Indonesia. Generally, in midwifery programmes, all midwifery students are required to take two credits in English language. The midwifery curriculum of a bachelor's midwifery programme stated that English language is one of the compulsory subjects that all midwifery students are required to pass. At the end of the midwifery programme, midwifery students are required to submit the result of a Test of English

as Foreign Language (TOEFL) (Midwifery Undergraduate Degree Programme, Fakultas Kedokteran Universitas Brawijaya, 2016). Even though in the midwifery curricula of diploma and advanced diploma programmes, the requirement to learn English is not stated, in reality, English language is taught as part of the supplementary midwifery curricula. For the professional midwifery programme, none of the educational institutions that run this programme publish their academic guidelines or midwifery curriculum. It is considered that the midwifery curriculum is a secret document. The significance of learning and understanding English language is very much related to the globalisation of English as the standard language of research publication. At the midwifery schools, calls for understanding English language in regard to teaching and learning processes are considered essential. In this study, participants needed improved skills in English language in order to improve midwifery teaching and learning processes.

Participants expressed the view that having limited English language, necessary to understand the midwifery material, was challenging. Sas, a midwifery student, expressed this difficulty:

English language, is sometimes lacking, and a lot of journals and textbooks are in English. It may be different from my skill, but it's vital to read a journal. I learned English in semester one, but I cannot talk and apply it actively. (Sas)

Having only learned English in her first year, Sas felt limited in understanding the specific context of the journals and textbooks. She would have preferred to improve this skill which would assist her in understanding more about midwifery from the literature.

Umami, a midwifery lecturer, also stated that the English language would improve her learning process:

One of the challenges is mastery of the English language, to support the learning process. There are various midwifery references in English which mean a lecturer should keep on improving her capacity to read English as there are good references about midwifery. (Umami)

Umami felt improved English language abilities would facilitate the learning process through an understanding of midwifery references. Umami said that the number of

references in midwifery available in English that she was required to read would enhance the teaching process. She saw that being a teacher involved continuous learning which required reading English references. Umami discussed how English language fluency inhibits the learning and teaching process in midwifery schools.

6.3.4 Method of assessment and practice to be competent graduate

Participants in this study voiced the view that midwifery students have to pass written and clinical tests before clinical experience, and complete all layers of assessment before graduation to fulfil the standard of graduate' competency. Nevertheless, a number of participants said that the method of assessment and practice required improvement to ensure a competent midwife at graduation.

Rully, a newly graduated midwife, explained the different types of assessment she had at midwifery school, including a written test, Objective Structured Clinical Assessments (OSCA), and comprehensive test:

So, before going out on the practice, we did the OSCA. At the end of the fourth semester, theoretical (academic) subjects had lessened, so it focused more on the laboratory practice including neonates' obstetric care. We had a mid and final exam. In the sixth semester, we had the last practice in the community when it was over, we had the final assignment. Even though I had finished programme and graduated, I had not done all the requirements of the programme and I still had to do the COC (continuity of care) experience. It's difficult and hard to do it. (Rully)

Rully had to conduct layers of assessment, such as a written test and practice tests prior to clinical practice and advancing to the next stage. For Rully, it was a big challenge as she was not achieving the number of continuity of care experiences in the midwifery programme that were required for graduating from the programme. She articulated her frustration at having to complete continuity of care experiences even after passing all of the various tests at school. The problem seems to be that the continuity of care experience is not seen as an essential aspect of completing her education, whereas there are so many other tests to do, on which students have to focus.

Dhendra, a midwifery lecturer, explained that midwifery students at her school went through the laboratory practice before clinical experience:

They (midwifery students) use laboratory practice as a learning experience. They will be given the standard of competence for doing practical work, followed by a correction to improve their practice according to the standards they have and they will do self-learning through peer review. It is hoped with them doing laboratory practice before they go on clinical practice they could see what the mistakes they did so it will stick longer in their memory. When they are competent with models then they will face the real situation (real setting) to practise directly with patients. (Dhendra)

Dhendra revealed the several stages of learning for midwifery students include theory, learning on mannequins and practising in the laboratory, and learning in the real clinical settings. The midwifery skills demonstrated by the midwifery lecturer in the laboratory practice cover what the student's need and are expected to do in clinical practice. The standard of competence and practice module is utilised to review the midwifery students' performance at simulation and assess their midwifery skills. Dhendra also described how the students work with each other through role play and peer assessment prior to the skills test. She explained how the peer assessment process would assist the students in having knowledge, as well as the midwifery skills, required in the real clinical setting when they will meet real women.

Alim, an obstetrician, further suggested improvements to the quality of laboratory practice and how the students learn in the laboratory:

It is better to increase the frequency of practice, mainly the routines that will be done by a midwife. The laboratory practice can be started in the form of simulation, and it is then evaluated. They can be sent to the field when it is considered they are able to do in the real practice. (Alim)

Alim stated that midwifery students need more practice in the laboratory to focus on the activities of midwives in the field. He described how simulation appears to be valuable in developing the midwifery skills of students before clinical experience. He thought that each midwifery student should practise her skills individually before being sent for clinical experience. He suggested that appropriate opportunities for laboratory skills practice would increase the preparedness of midwifery students in the clinical sites.

The data collected from a broad range of midwifery schools conducting different midwifery programmes and learning strategies revealed that the participants strongly believed in the benefits of preparing midwifery students in small classes using various

teaching strategies. Participants saw quality of assessment, learning about practice, practising skills, and having lots of opportunities for laboratories as essential parts of the learning process.

Nearly all of participants also discussed the quantity, as well as the quality, of the midwifery lecturers at midwifery schools. Based on the Presiden Republik Indonesia (2005b), one of the minimum requirements to become a midwifery lecturer is holding a master's degree, which is in line with the programme taught at the school. A registered lecturer is someone who has an academic qualification, is competent, has a minimum of two years' experience as a lecturer, and passes the government certification of lecturer test. The competencies of a lecturer include pedagogical, personality, social, and professional elements.

In this study, participants identified the process of midwifery teaching and learning as relying upon on the midwifery lecturer. In regard to the needs and limitations of a midwifery lecturer in midwifery teaching and learning processes at midwifery school, the critical factor in meeting the variety of needs and limitations found in this study is the quantity and quality of midwifery lecturers. A balanced number and capacity of midwifery lecturers was crucial to prepare midwifery students in the midwifery learning process to gain their qualification and be ready at the workplace once graduated from midwifery school.

6.4 Availability of midwifery lecturer and ability to do midwifery practice

The participants indicated that the midwifery lecturer was a vital source of knowledge transfer and support for the midwifery students. The participants discussed the need for greater numbers of midwifery lecturers and how to develop the lecturers' midwifery skills associated with clinical tasks in the real setting.

Far, a newly graduated midwife, commented on the limited teaching and guidance process due to the limited time and number of lecturers. One of the lecturer's tasks is carry out education, research, and devotion to the community (Presiden Republik Indonesia, 2005b). The responsibilities get bigger if the lecturer holds a structural position and other obligations.

The problem is the lecturers are very busy, and there are a lot of students and more every year. So, one lecturer at least has to guide around 24 students. They have to supervise the clinic, teaching, administrative things, meeting and so on and so on so they don't have time sometimes for supervision of students. The lecturers also have to study. (Far)

Issues with the number of midwifery lecturers were identified by newly graduated midwives. Far was counting the ratio between the midwifery students and midwifery lecturers which created unbalance in the learning process, especially in the classroom, and the laboratory and when receiving guidance at the clinical sites. She suggested that midwifery students felt unsupported when there was a lack of quality midwifery lecturers. Far suggested that having enough good quality midwifery lecturers was one of the ways that midwifery education could be strengthened in Indonesia.

The critical position of the midwifery lecturer was noted by Butterfly, a newly graduated midwife, who underlined that knowledgeable midwifery lecturers were needed to support the midwifery students' learning:

The position of midwifery lecturer is very critical. If they have the wrong view about midwifery, they will create the wrong perspective of the new midwife. (Butterfly)

Butterfly stated that the role of the midwifery lecturer is more than transferring knowledge and skills onto midwifery students. She said that the position of the lecturer is critical as the lecturers can give a midwifery perspective (or philosophy) which underpins all teaching. With a well-qualified midwifery lecturer, Butterfly felt that quality of teaching and learning process would translate to enhanced midwifery practice.

Al Syifa highlighted the need for the midwifery lecturer to have clinical experience to support the midwifery students and improve the art of teaching:

For the lecturer, they must have working experience in the clinic because we teach clinical things like attending births, it would be very strange if the lecturer have not attend any births. Lecturer obliged to have master degree, but have minimal clinical experience is unacceptable, because what we teach to students is practical things and experiences not just oral teaching. There is lack of soul in the learning process when the lecture can't give real examples. Practice needs more examples like how to this this way or that way and if you don't practise it you won't have it. (Al Syifa)

She noted the need for the midwifery lecturer's clinical experience and thought that paradigm-shifting would happen as midwifery lecturers transfer both knowledge and midwifery skills. She discussed how not having clinical experience would be a constraint in the art of midwifery teaching.

Ummi, a midwifery lecturer, acknowledged that the learning process was not run well because of the limitation of clinical practice:

I feel that I did not have my soul at all during my teaching time. When I taught about palpation, I felt empty. Why? Because it's been a while, I haven't done palpation. I decided then with several of my friends to open an independent practice to maintain our ability. Because as a lecturer, we do not only have the theory, there is a skill. I experienced if we wanted to be considered as a midwifery lecturer, we should be practised in the real setting service. We cannot teach if we don't understand. My hands have become numb, do not have skill. A midwifery lecturer for me must maintain her skill. (Ummi)

Ummi stated that she felt empty and did not have a soul when teaching palpation to midwifery students because of having not practised for a while. She expressed that she did not feel able to teach and facilitate the learning process for her students to gain the skill. Clinical practice was acknowledged as one step to maintaining and facilitating the way of teaching. The quotes above show what it feels like for a lecturer when she is not practising midwifery and how it impacts her teaching process.

Suri, a midwifery lecturer, testified that the midwifery lecturer is the primary driver of the learning process in midwifery school:

You know that being a lecturer is not about understanding theory, but it is about the experience in the field. That's very important. Why are we talking about a lecturer in the first place? Not only quantity but also the quality. Why must a lecturer have experience in the field too? Because if we just read the textbook, it is not real and based on what happens in the field. That's why being a lecturer, not only graduated from master degree and then she can directly teach. It's more than that. She must learn how to be a good midwife and she must practise in the field first. That's how they know the real life of a midwife. (Suri)

Suri agreed that the midwifery lecturer has a critical position in facilitating and passing on the knowledge and midwifery skills to midwifery students to pursue their intention to become midwives. She commented on the quality of the midwifery lecturer, including the attributes of competency and experience. She discussed that to become

a midwifery lecturer requires clinical experience, not only mastery in education. She believed that the midwifery lecturer would influence the student's head, heart, and hands. Therefore, the midwifery lecturer has to understand both the knowledge and midwifery skills. She acknowledged that midwifery lecturers should not only chase the minimum degree required to be a midwifery lecturer as the primary human resource in the midwifery school.

Shinta, a midwife, was cynical regarding the clinical experience of a midwifery lecturer:

This is ironical thing, we perform clinic or clinic service but the lecturers have never had clinical experience. This is the difference with medical education (the faculty of medicine). Most of lecturer in faculty of medicine are practising. Whereas our lecturers are not practising midwives. How can they transfer knowledge and skill? Something that is tranferred from experience not only as a story in the book. The big problem is a lecturer. (Shinta)

Shinta has clearly described the need for clinical skills in midwifery lecturers as graduates will perform midwifery skills on women and the family. She compared the lecturer of the midwifery programme with the medical faculty. The lecturer at the faculty of medicine has a clinical practice or a clinical background. She described the perils of the midwifery lecturer who has no clinical experience as a lecturer has to transfer knowledge to midwifery students. She acknowledged and identified the attributes of a good midwifery lecturer as including clinical capability.

The participants in this study were critical of the idea of only fulfilling the minimum degree to become a midwifery lecturer. Increased numbers of midwifery lecturers as well as clinical experience, are also required. The participants' point of view stressed that a deficiency in midwifery lecturers' clinical experience would result in newly graduated midwives with lack of knowledge and midwifery skills.

In this study, the limitations in learning resources were explored by nearly all participants and this issue has become one of constraining factors for improvement of midwifery education as it inhibits the midwifery teaching and learning processes.

6.5 Improving learning resources

The participants recognised the availability of learning resources to improve the

teaching and learning process in midwifery school and strengthen midwifery education. It was highlighted by the participants that the learning resources would facilitate the human resources in the learning process to improve the quality of the midwifery school. The participants identified the lack and quality of many resources, such as the availability of appropriate clinical sites, funding, the library, internet connection, the mannequin and equipment for the laboratory, and infrastructure. All of these are needed to support the learning process.

When addressing questions about learning and the facilities for teaching the finances are seen to be a major problem. The tutorial system example one class divided into six so we have to pay six teachers. We have to modify the process. The models that are bought are not the best models and there is not adequate infrastructure such as the laboratory. (Ana)

Ana, a midwifery lecturer, identified the learning resources needed to improve the quality of the school. Ana has reported that a lack of resources made learning a challenging process and she needed to adjust the resources. Issues with the learning resources in this situation gave her no choice except to accept this condition. Thus, midwifery lecturers who want to undertake new approaches to the teaching process should be able to do so in their way.

Far, a newly graduated midwife, also echoed the need for improved learning resources:

Well, except the lab, so the mannequin at that time only one and so it was not enough for us and so not everyone gets to practise. We were not able to practise before we went out to work with the real patient. We were luckily taught and guided by senior midwives, but the facilities need to improve. The facility for the students limited, as well as the teacher. (Far)

Far identified that her learning process was enhanced by exposure to the clinical experience and direct practice with real women and the family. She recognised that her midwifery skills and knowledge increased because of guidance from the mentors at the clinical sites. She criticised the learning tools at the midwifery school, suggesting it had inadequate equipment, laboratories, and mannequins. The learning resources such as mannequins would provide opportunities for midwifery students and newly graduated midwives to learn, as they were not prepared well in the laboratory.

Cici, a newly graduated midwife, concurred with the need to improve the learning resources such as the library resources, equipment, and the internet connection:

The textbooks are out of date and we are pushed to reference anything within the last five years. The internet also has a slow connection. So unstable internet for browsing and searching and more slow loading. Laboratory as well, I felt not proud of my almamater because of this. Nothing changed until now even I fulfilled the survey and explained what should be improved. (Cici)

Cici testified that learning resources would offer more opportunities for her to develop midwifery knowledge and midwifery skill, which is essential in her learning process at school. Cici suggested that addressing the lack of learning resources by improving support to provide a stable internet connection, library resources, mannequins, and infrastructure may make her feel proud of the midwifery school. Cici stressed that even though she filled in the evaluation form each term at her school, which aimed at gathering feedback from the current students (an internal survey), in reality, the improvement was still far from her expectation.

In this study, the improvement of learning resources was seen to be required for the sake of the future of midwifery programmes. Participants in this study were concerned about the need to improve the learning resources at midwifery schools to enhance midwifery education.

6.6 Summary of Chapter 6

This chapter has discussed midwifery teaching and learning of theory with regard to strengthening midwifery education in Indonesia. It has explained what motivates participants in midwifery, including the status of *bidan* (a midwife) in the community. Motivation was found to be one of the critical factors related to the success of midwifery students, and student motivation also impacted on the teaching and learning process in midwifery education. The findings revealed the benefits of the tutorial system, small class sizes, and storytelling, which all impacted on the learning process. The findings also highlighted the impact of English language which demonstrates the need for more understanding of English language, since English is the lingua franca for important teaching and learning processes in midwifery programmes. English language impacted on the preparation of the midwifery students and lecturers to understand midwifery knowledge and skills. The participants described

the ideal qualities of a midwifery lecturer. They described the midwifery lecturer as the primary driver at the midwifery school who runs the teaching process and transfers knowledge and midwifery skills to midwifery students. Participants spoke of the necessity for midwifery lecturers to be experienced in midwifery practice as this enhances their authenticity as lecturers. All of these teaching and learning strategies need to be supported by learning resources, including mannequins, library resources, internet, and environmental infrastructure that would support the teaching and learning process. This chapter has provided insights into theme 'midwifery teaching and learning of theory' and how this theme set the issues that need to be addressed to strengthen midwifery education in Indonesia. The following chapter will explore deeper theme 'the midwifery clinical experience'.

Chapter 7.

Findings Part Two: Midwifery Clinical Experience

7.1 Introduction

In this chapter, the essential aspects related to midwifery clinical experience from the participants' experiences are discussed. There is a strong message about midwifery clinical experience as a critical feature in developing the competence and confidence of midwifery students and newly graduated midwives at midwifery school. As the participants examined their experiences at clinical sites, it became clear that clinical experience and hands-on practice leads to midwifery knowledge and skills, and a competent midwife. In the previous chapter, what motivates a person to stay and become a midwife and the factors required to improve midwifery teaching and learning of theory were highlighted. An explanation of how the motivation grows and moves from pleasing the family to becoming passionate about midwifery was also provided. Although clinical experiences for midwifery students and newly graduated midwives were set at clinical sites, most of the participants had different experiences in clinical practice. The participants' views regarding their experiences of clinical practice in the midwifery settings are provided in this chapter. This chapter discusses four sub-themes: having effective hands-on clinical experience, theory-practice gap, role of the mentor in practice, and effective clinical experience for competent midwifery practice. For an overview of the sub-themes refer to Figure 7.1.

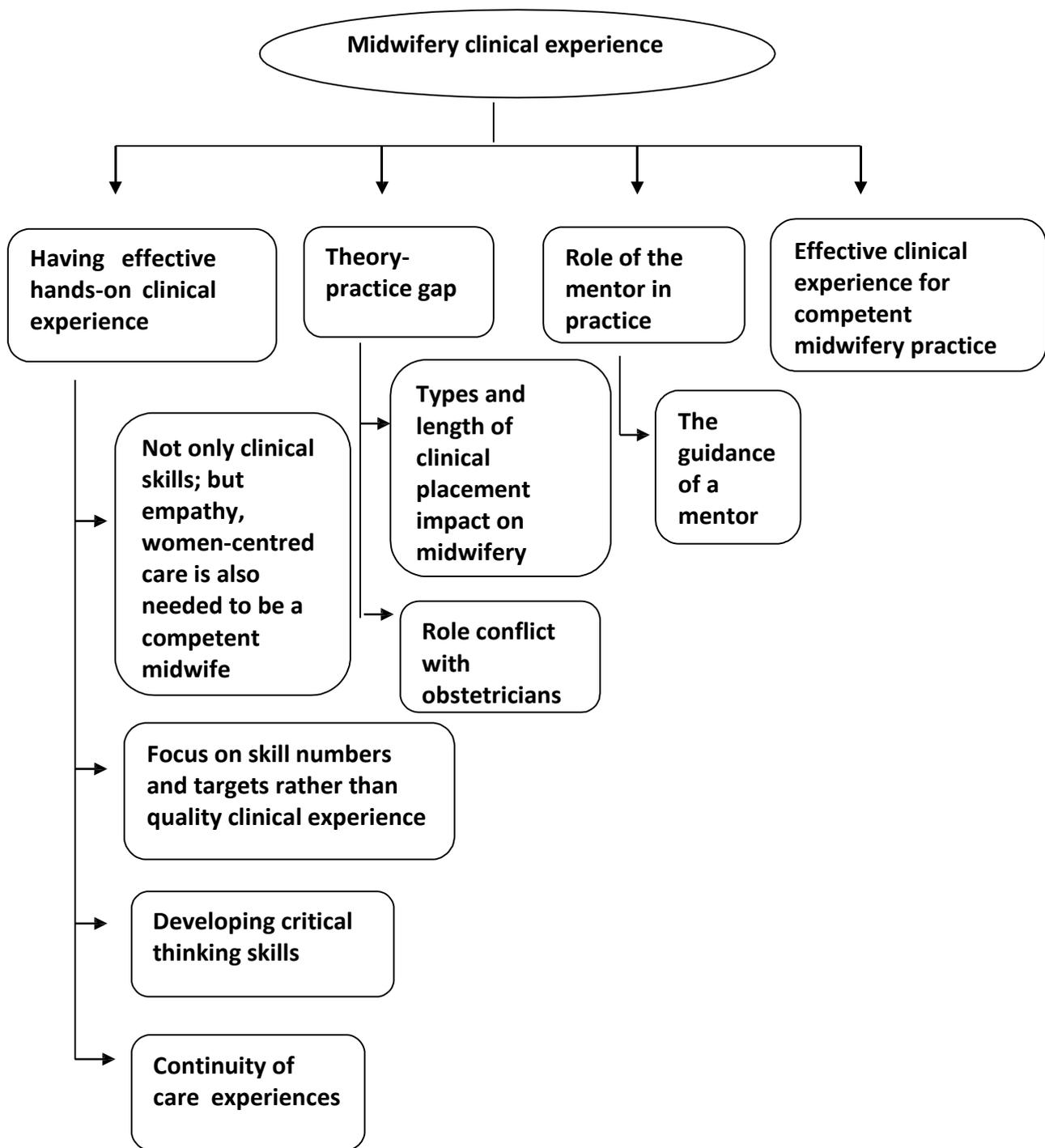


Figure 7.1 Theme and sub-themes of midwifery clinical experience

The interviews with participants about what would strengthen midwifery education in Indonesia revealed several issues with regard to clinical practice that impacted on midwifery education. Clinical practice seems very problematic and needs more explanation, as this is perhaps another way that clinical practice education could be improved. This chapter describes participants' perspectives on what will strengthen midwifery education in the clinical area.

7.2 Having effective hands-on clinical experience

Syifa Khoirunnisa, a midwifery student, stated that she gained profound insight from practice. Once in the clinical setting, she captured and matched the theory from the midwifery school with reality in practice. Syifa highlighted the importance of clinical practice and having hands-on practice early on in her education:

The big difference I feel is that I do not know at all what the science of midwifery is, because we have to know everything from pregnancy until elderly and complications as well. In the clinical field, I found and learned what I couldn't find on the campus. On campus, I know the theory only. Now, in practice it's fascinating and exciting to see it. I have hands-on in the delivery process with midwives, have to assist normal labour process, cut the umbilical cord, deliver the placenta in private midwifery services, maternity clinics, and in public health care. It is such a fantastic feeling when I see the real cases in the clinical field such as macrosomia, atonic uterus, not only theory but know how to deal with the cases. In clinical practice, I learned a lot. I saw a case when bleeding happened to the real patient, I then understood how to treat with it and have so become a competent bidan. (Syifa Khoirunnisa)

Syifa Khoirunnisa verbalised that clinical experience builds her midwifery skills and knowledge. She explained that clinical experience had significantly influenced her learning and understanding of the midwifery world. The first lesson was linked to the theory of midwifery that the student first perceives in class and laboratory, and then turns into reality in the clinical setting. The second aspect articulated by Syifa was related to gaining hands-on experience and was a reminder of how to become a good midwife. She identified that she has to be competent because she is the one who has the responsibility for the woman and the baby, including the complications that happen to them.

Leading on from concerns about their midwifery skills and knowledge, the participants further voiced how valuable hands-on experience was to achieving the confidence of midwifery skills. This is expressed by Siti, a newly graduated midwife:

However, after helping a baby born, I felt so proud just like the light of the firecracker blast. (Siti)

Siti expressed that having hands-on experience in a clinical setting and the opportunity for the acquisition of midwifery skill was a valuable aspect of developing confidence in midwifery skills. Siti explained that she felt pride and excitement, as bright as the light when a firecracker blasts off, when having an opportunity to assist a woman to deliver

her baby.

Bilbina, a midwife, who mentored midwifery students, also strongly emphasised clinical experience as an essential and critical process for midwifery students and newly graduated midwives from across different midwifery programmes:

Here, there were midwifery students from many different kinds of midwifery programmes. Yes, bachelors, diploma, and advanced diploma. I was mentoring them for basic midwifery skills, such as helping women to deliver their baby. They have to be able to do this, to become a qualified midwife. Clinical experience is essential for them. They have practised in the laboratory at the campus. They have studied midwifery materials and skills in school. They have all the theory and simulated practice, but not with real patients. Now, they have to apply their learning to the actual patient in the hospital. Experience in the obstetric ward makes them absorb learning efficiently and quickly because they were learning by doing it with real cases. Students can learn then get all the theory best when they practise. (Bilbina)

Bilbina was clear that whatever midwifery programme students took, they gained midwifery skills in their practice when they were assisting real women at clinical sites, such as the hospital. Bilbina stated that clinical practice in the real setting would make the midwifery students and newly graduated midwives learn easily and quickly because they were learning by doing and would then become competent by keeping on doing the practice.

The ideal focus of midwifery students and newly graduated midwives in clinical practice is to develop competence and confidence in their knowledge and midwifery skills. In addition to conversations around the clinical experience, the lack of appropriate clinical experience was explored by participants. When there is lack of quality clinical experience, midwifery students and newly graduated midwives do not gain the skills they need, potentially compromising their ability to practise midwifery.

Despite midwifery programmes requiring a large number of clinical hours, the participants who contributed to this study suggested that they need more quality clinical experience because, without ensuring good clinical experience, they cannot become a competent midwife or have good midwifery skills. Participants in this study stressed that clinical experience is not only the number of hours. The quality of hands-on practice is essential to reach optimal skill development.

I have not been able to do a full labour and birth, just bits. Therefore I want to keep learning. For example, how to do normal delivery care, I have not tried it directly. However, I want to do by myself because it is the real practice in the hospital. However, I was not given the opportunity even though I am keen to assist women in delivery process. I want to do it; that's why I participated and undertook extra practices so to get a chance to do the normal delivery care. I was just watching the normal delivery process and only got to deliver the placenta. When the baby was on the perineum, I have just touched the head. I am aware that I have to be able to assist with childbirth, antenatal care, baby and family planning because I cannot be a midwife if I have not mastered real practice, rather than just watching the techniques. I just hope as time goes by, I can do so InsyaAllah. (Joule)

Joule, a midwifery student, expressed concern that she has not adequately assisted women in the delivery process because she has not had enough opportunity for hands-on practice and has only observed the normal delivery process. To be a midwife is to practise midwifery, so she realised that she has to have more than just *Partus Pandang* or only viewing the labouring process, in order to have good midwifery knowledge and skills. More hands-on practice was required as it makes for better learning – one learns best from hands-on practice. For Joule, hands-on clinical experience impacts her perspective on what it means to be a good midwife. Developing and gaining competency means that midwifery students and newly graduated midwives need more clinical experience and hands-on experience.

Partus Pandang - when students only watch the labour and birth process rather than having a full hands on role - was said by some participants to be a “well-kept secret” in midwifery schools, as well as in the clinical sites.

I have been appointed as a speaker for midwifery association in X branch. The chair of midwifery organisation and so on, I ask, how many births to become a midwife? She answer 50. I asked the midwives who had never assisted the women to deliver the baby? Many audiences (new midwives) pointed hands. Many of them. They already completed in midwifery school. They said they don't have opportunities to do that. (Ratna)

Ratna, an obstetrician, questioned the quality of midwifery schools because of the quality of the newly graduated midwives themselves, many of whom have rarely or never assisted a woman to deliver a baby. She felt sad and conflicted that even graduate midwives had no opportunities to assist in the delivery process. Therefore, she questioned how she would become a midwife if she was never helping women in

the labour process. She also agreed that the valued and the vital experience of hands-on practice for midwives was essential.

7.2.1 Not only clinical skills; but empathy, women-centred care is also needed to be a competent midwife

The participants agreed that midwifery skills include clinical skills and dealing with emergencies but being empathetic was also required to become a good midwife. As Dyah, midwifery student explained:

I really helped a mother, she felt pain. I gave her pain relief, caring until the end. Until she got angry with me, "Yes you don't feel how painful it is, you haven't got married, miss? You haven't." Oh, yes she is right. But I can still learn to be professional if I haven't had a baby yet. I still have to be empathic, placing myself as if I am the labouring woman and understanding that the pain is extraordinary. So I release my own ego and I think about what the mothers are feeling. So I have more empathy for women. (Dyah)

Dyah explained that being empathic and supportive, and providing counselling and education are essential aspects of becoming a midwife. She believed empathy was required because of the uniqueness of the woman and the family, and of midwifery as a profession. Being a midwife allowed her an excellent opportunity to provide individual midwifery care for women and their families. Such skills are needed because, as a midwife, she has to be caring and fulfil the different needs of women.

Widya, a midwife, further discussed the importance of women-centred care and ethics to be learned by midwifery students at clinical sites:

Yes, students need to learn about ethics, and also woman-centred care. They (students) should see the woman and the family. So there is a woman with suspected anaemia, and the student doesn't ask more about nutrition, she hasn't fulfilled the midwives' role. Possibly the woman has had a complication during pregnancy, but the woman said nothing, and the students don't ask her. I just felt students pay less attention to that. The students only focus on filling in the written form. They should discuss things like zinc tablets, explaining the myths. Sometimes they are so busy with their phone. I think there should be rules about using the phones at the clinic. (Widya)

Widya advised that the midwifery students should be exposed to clinical placement by supporting women from pregnancy, recognising the danger signs, and knowing the culture of the community and how to provide midwifery care. Widya suggested that

midwifery students tend to focus on filling in the maternity record (the form), or paying attention to their mobile phones rather than developing their relationship with a woman.

7.2.2 Focus on skill numbers and targets rather than quality clinical experience

Midwifery students must achieve a specific set of midwifery skills before graduation. However, inappropriate clinical experience created difficulties for midwifery students to achieve the target. This requirement for a competency assessment had to be achieved within clinical placement and practical learning, which is 42 weeks for a bachelor's programme. There were differences in the number of hands-on births required between the schools. Some participants stated the number of hands-on births was 30, some 50, and some 15. The diploma core curriculum does not specify the number of births that midwifery students must achieve. Paradoxically, the focus on clinical placement was shifting to chasing the number of midwifery reports because of the pressure of the target rather than the ability to do it. Rully, a newly graduated midwife, criticised an inappropriate hands-on practice in clinical placement because of many factors:

So how do I become a competent midwife if I don't have relevant clinical experience? I feel I don't have that much practice. Yes, I was drilled in the field, and one patient was shared with other students there. I was rarely allowed to do by myself. One woman who delivers a baby is divided into several students, so every student has an opportunity to handle the women. One student did the first stage, another student did the second stage and another student did placenta delivery, so on. Every student writes up the midwifery report as one patient and one woman can have about 10 students and the midwife signs the midwifery report because she feels sorry for us and knows we have to get our numbers. I want to do myself, to assist the women to deliver the baby because I am bidan. To be a midwife, yes I have to be able to do it. (Rully)

Rully said that too many midwifery students at a clinical setting made it hard for her to have hands-on practice. Rully realised that more and more she has to practise directly with real women to gain knowledge and midwifery skills. She identified that the mentor was trying to provide support and give opportunities for hands-on experience. The situation in the clinical setting made the mentor divide the women among several student groups and every student felt engaged in real practice even though it was across different stages. For Rully, there were too many students for the numbers of women, so that each student did one part only and all were signed off for the whole.

Yuni expressed concern that the midwifery report requirements are sometimes signed off but that does not mean the student had that experience:

I had to reach the target for midwifery skills; the target for assisting women to deliver her baby, antenatal care, postpartum care, family planning and much more. We have to target 30 or 50 births. However, it is only the report that needs the original signature from a midwife in the field, and the midwife signs it, whether I have had hands on at a birth or not. It feels like just chasing the number, because some of my friends had a false report. I just wrote and collect the reports signed. I understand the importance of being able to do ANC (antenatal care), INC (intranatal care) etc. to become a midwife. I realise that needed many clinical experiences to gain that experience. However, at that time I just focused on collecting the target and chasing the number of targets and then I graduated. Even though I didn't actually complete those skills adequately because there were often too many students in one room, but I wrote it in my report though. I want to do it, but if I did not fulfil the target, I would have to practise more and pay more for clinical placement. (Yuni)

Yuni said that observations count as births and the number of students at one birth all count that as a birth. She realised the need for midwifery skills, especially assisting women to deliver the baby, but the reality in the field was that often the students only chased numbers for the midwifery reports they have to get signed off. She seemed quite stressed about the midwifery target because she has to do practice within the exact timeline of clinical placement. Yuni focused on fulfilling the target, thus ensuring valuable learning in the clinical setting is not prioritised. She also highlighted that she was chasing the midwifery target to avoid the financial strain associated with the need for additional clinical placements.

The unpredictable nature of childbirth and range of clinical rotations in different clinical settings were mentioned by the participants; however, a newly graduated midwife explained that the target was unachievable:

The target is not achievable because there are many students from other places. Even though the location of practice used by this school was tightly selected and I had a clinical rotation, there are many patients and we have proper guidance, and so on, there are still too many students there. I had 15 births signed off but the reality is I only got 7, because we can't predict when the woman will deliver her baby, it's about luck. If you are fortunate, then you can get women to the birthing process. The obligation from the school is that we care for women from the first stage until the fourth stage, but this isn't possible, so the clinical instructor feels pity for us because of the midwifery target. They sign the report even though you only touch the head or the placenta. (Far)

Far was unable to realistically achieve the targets set by her midwifery schools because of the number of students from her school and others all trying to achieve their targets at the same time. Even though she had a clinical rotation, she could not achieve the midwifery target due to the unpredictable nature of childbirth. Far also suggested that, on occasions, the clinical instructor might provide her signature for the student even though she has not done the hands-on birth herself.

Juju, a midwifery lecturer, also suggested that the midwifery target for birth numbers sometimes might make students write up a false report.

The hardest thing, sometimes, is for midwifery students to achieve the target number of skills. Sometimes, I don't know; whether the reports are honest or not, because the target is too high. If they lied to the teacher, that makes me disappointed. We have to explain that to be honest is crucial, no matter how many are obtained. There should be no need for them to falsify the report. Now it's a little bit reduced so it's achievable for students. (Juju)

Because of the requirements for the midwifery report, Juju identified that students' priority lay in the numbers versus the learning process in the clinical settings. Juju explained that she was aware of the midwifery target number which was a burden for midwifery students and suggested that sometimes they made false reports. She said that now the target numbers have been reduced in an attempt to reduce the number of false reports.

In the same vein, an obstetrician criticised the midwifery target and suggested revising the midwifery curriculum and midwifery-led clinic:

The target is 50 but in reality the number of births may be only one or two. I wonder how to achieve the target. I wonder what it takes for a student to be competent. The delivery process is from A to Z, it is not only touching the baby's head that's not it. I think it takes at least 15 births from A to Z to be skilled. If it's just about reaching the target then should the midwifery curriculum should be revised. The numbers of midwifery students, the tuition fee, having a mentor in the field, a midwifery educator, and the clinical settings all need to be revised if we want to improve midwifery education. Because being skilled is only achieved in the clinic, not in the classroom. (Atmojo)

Atmojo stated that some high midwifery targets (50 births) were unachievable for midwifery students because of fewer opportunities existing in the field; the birth rate in Indonesia is around 2.6 per family. Atmojo commented that the birth is not just about catching a baby; rather it is the full care throughout labour that is crucial. It is

getting that head onto the perineum that takes real skill. He stressed that, first and foremost midwifery students need the real experience.

7.2.3 Developing critical thinking skills

Another participant discussed how clinical experience will develop the critical thinking skills of midwifery students:

Midwives need to have the critical and analytical thought, capable of making the right decision based on her analysis, competent of determining the action which should be carried out based on all examination. All of them seem to exist on the SOAP template. (Husni)

Husni, an obstetrician, stated that midwives need to move beyond a maternity report. Midwives have to think critically and make safe midwifery decisions and actions built by clinical experience. The midwife's role is not merely about the woman's physical condition but also managing the psychological aspect of the woman's condition, as well as management skills to ensure the partnerships with women and their families run well.

Ani, a newly graduated midwife, further voiced the view that her clinical experience at midwifery school boosted her critical thinking to handle different kind of women and cases.

My clinical experience here is invaluable for me, probably because I come from a small city. Here, I learned and got many opportunities to practise. It entirely boosted my critical thinking and confidence and my ability to be a midwife. I am so grateful I was accepted here and through all the experience, especially in the teaching hospital which is one of the biggest hospitals for transfers. Before I came here I felt I didn't know much behind the reasons to do particular skills. For example, women with preeclampsia, before I came here I didn't understand the origin of preeclampsia, the different treatments and the reasons for those treatments. (Ani)

Ani felt happy and enjoyed having clinical experience because of the model of the hospital and the supportive environment in the big hospital. When explaining her clinical experience, Ani felt supported to assist the women giving birth and handle the complications of pregnancy, which led her to have critical thinking skills, confidence, and competence. She also made links between the theory from school and practice reality at the hospital.

For Al Syifa, a midwifery student, the goal of clinical experience is to reach the essence of being a midwife:

I understand that the critical aspect for students is knowing and understanding the essence of a midwife, not only pursuing the target number of skills without the underpinning knowledge. If students think that they must achieve their mark, the soul of becoming midwife is lost. (Al Syifa)

Al Syifa said that the soul of a midwife would be achievable if she learns by doing at clinical sites, not only focusing on the number set in the midwifery target. She found it difficult to develop critical thinking which tended to be neglected and she lost the soul of becoming a midwife when faced with the challenge of reaching the midwifery target. Al Syifa said that it is not about lessening the midwifery targets; rather it is about making sure that midwifery students have real opportunities to achieve the targets.

7.2.4 Continuity of care experiences

Essentially, within a clinical rotation, midwifery students and newly graduated midwives had an opportunity to provide midwifery care through continuity of care experience. The participants discussed the positive experience of the continuity of care.

*I am doing continuity of care too. I targeted two patients for that, so I have to follow the women from antenatal care, delivery process, postpartum until she goes back at home. I felt delighted for this experience and it helped my learning, making a partnership with the woman and her family. I know the reality of being a midwife with one to one midwifery care, because of an example of the labouring process, full from the first stage until the fourth stage. Oh yes, of course, I cannot be a *bidan* if I cannot assist a woman to deliver her baby. (Far)*

Far, a newly graduated midwife, valued the partnership with women and their families through the model of continuity of care. Continuity of care experience provides the opportunity for learning how to work with women within the scope of practice of a midwife. She expressed that continuity of care experience provides a glimpse into what is called the reality of being *bidan* and being a real *bidan* in the community. She believed that this experience impacted her competence development because she was assisting women entirely from the first appointment until when the woman went home. Far learned of and valued the relationship with the woman and the family.

Furthermore, this experience increased her awareness that she could not be a midwife if she cannot assist women to deliver their babies.

Al Syifa, a midwifery student, also valued the relationship with the women and the family by doing the continuity of care experiences:

The process of birth is not just about listening and watching it. It is now not about the numbers. With COC (continuity of care) from the start of pregnancy until after the birth is more memorable as a lesson, knowledge and experience. The learning from 1-2 COC feels more in depth than 50 childbirths, especially if the student didn't understand but just wrote the report even though she only watches or listens to the birth. (Al Syifa)

Al Syifa targeted two continuity of care experiences; nevertheless she gained invaluable experience, more so than had she done in 50 labouring processes. She further described that the continuity of care experiences were seen as a positive experience for practising midwifery skills. Al Syifa highlighted the importance of the continuity of care experience and how much this experience contributed to her clinical learning.

Juju, a midwifery lecturer, also recognised the value of continuity of care for midwifery students to gain knowledge and skill:

Students need to do three continuity of care. It used to be only one patient and when we evaluated it the students had less knowledge and skills. This experience is essential to provide the good way for students to learn all the scope of practice of the midwife. It is a lot to organise because we need to arrange for the method, schedule, fee, and the field so the students and all parties care comfortable, and it's not too hectic because they have to follow the women from the pregnancy, labouring process, postpartum, home visit, neonates until the determination of contraception. (Juju)

Juju explained that the continuity of care experience offers students the essential opportunity to experience the responsibilities of a midwife in the community. She explained that allocation of continuity of care should be added as a strategy to midwifery education which might encourage more *bidan* to develop continuity of care for women in their district or area. However, she explained that the current system of organising continuity of care experiences for students was expensive and difficult. Despite the difficulty, Juju said that this experience is essential and extremely valuable.

7.3 Theory-practice gap

Participants highlighted the gap between what is taught at midwifery school and what is practised at clinical sites. Midwifery students and newly graduated midwives need to gain clinical experience regarding midwifery care for women and their families in various clinical settings. However, the midwifery students and newly graduated midwives who were interviewed commented on a theory-practice gap that affected the learning process and obtaining knowledge and midwifery skills.

I was asked about the Leopold manoeuvre. I had forgotten about that. Even though it had already been explained, but that was in the first semester. Then in the second semester we only imagined it and revised it. When the lecturers gave us materials we should directly practise it and we should be given more time to practise. If we were only given the material, we tend to easily forget, it was better learning when we practised it. We were taught to memorise it, not to comprehend it. (Lisa)

Lisa, a midwifery student, believed education at the midwifery school was fragmented; receiving large blocks of theory at the beginning of the semester, yet only getting to practice at the end of her study. Lisa said her education made her only imagine things not understand midwifery. Without practice she would forget. Lisa found it hard and confusing to remember the theory when separated from practice, and felt she was not learning midwifery. As a consequence, Lisa found that the way of learning impacted on her clinical experience and she subsequently struggled in clinical sites to retain the knowledge. She suggested that she should be exposed in practice directly related to what is taught in theory. Lisa was saying she needs the practice to reinforce the learning or she forgets.

Siti, a newly graduated midwife, explained how clinical experience plays a significant part in her understanding of knowledge and midwifery skills:

As midwives we should be able to read the mother's personal character, it might be we could see the mother who's high risk, such as her sudden weight gain in pregnancy. I got lots of insights from my practice and my observation. Besides, sometimes I also encountered some problems as there were some differences between the book and reality in practice, sometimes I felt surprised and was confused as to how to handle it. (Siti)

Siti described clinical experience facilitating her clinical learning when she tried to link the theory to practice. Nevertheless, she portrayed a gap between what she was taught theoretically and the reality in the clinical sites. She also felt that she needed to

be able to “read the mother’s personal character” so that she can identify small changes, which might identify things like a high-risk woman during pregnancy. The theory-practice gap created problems when she tried to relate her observations of a woman’s conditions and the lessons at school.

Widya, a midwife, further discussed that the theory-practice gap as a common issue at clinical sites:

My role in clinical is to give guidance to students. When I met the teacher here, she talked about the theory, she explained this and that, the theory that she was teaching to her students. However, now at the clinical sites, they (students) practised with us. In practice it was sometimes different to the theory, and we teach that. (Widya)

Widya said that her role in the clinical site is guiding the midwifery students who take the clinical placement. Regularly, the midwifery lecturer from the midwifery school will supervise midwifery students while doing clinical experience. This involves considerable discussion between her, as a mentor, and the midwifery lecturer regarding the ability of the midwifery students. She explained that the midwifery lecturer who actively sought out the teaching process only reviewed the theory-based knowledge. She stated that practice in the real setting in the clinical sites, was not always consistent with the lessons taught at school.

7.3.1 Types and length of clinical placement impact on midwifery experience

Rin, a newly graduated midwife, expressed the view that gaining experience from various clinical placements was significant for improving and developing her midwifery skills:

I think that the skill in the field must be emphasised, so to be a good midwife the focus is more toward clinical practice because we need to sharpen midwives’ capability. We have been increasing the pathology knowledge of midwives, but to improve midwifery, there should be a lot more practice. Even at the hospital there is a lot of practice already. The practice needs to be increased; previously it’s been more about field practice at the villages, but we also need to improve the hospital practice. The hospital practice should be more than it is now. (Rin)

The more prolonged clinical practice at the hospital and the community was acknowledged as allowing meaningful clinical learning, and was valued by Rin to hone her midwifery skills.

Ina, a midwifery lecturer, described the variety of clinical placements arranged to ensure the midwifery students and newly graduated midwives gained the relevant skill acquisition:

Students need to strengthen their skills, in practice. There is an arrangement for that, so the students get the proper clinical placements and maximum guidance from the mentor. We arrange for different places for their clinical practice, for example outside of the town, in the mountain, it takes a half day for the transportation. (Ina)

Ina explained that different clinical sites would enhance the midwifery students' and newly graduated midwives' insights from clinical practice. Allocation of the different clinical sites was highly valued by the midwifery teacher as a strategy to better prepare the midwifery students and newly graduated midwives to offer midwifery care.

7.3.2 Role conflict with obstetricians

Midwifery students and newly graduated midwives saw the relationship between midwives and the obstetricians in the hospital setting impacting on midwifery education. In hospitals, it is frequently seen that the midwife's role is to assist the obstetrician. In some hospitals, the obstetric units are headed by professors of obstetrics-gynaecology and midwives work side by side with nurses in the obstetric units. The senior midwives supervise the management and supplies, such as the availability of medicine, birthing set, emergency set, and all supplies needed in the obstetric wards. The junior midwives would assist the obstetrician-gynaecologist in handling complicated labours as well as normal labours. At this point, the midwifery students and newly graduated midwives see that they would become an obstetric-gynaecology assistant in the hospital setting.

Rin, a newly graduated midwife, spoke about an unclear scope of practice and described how, in the hospital setting, she would become an obstetric-gynaecology assistant:

Pathology should become a priority in midwifery education because most of us will become the assistant of ob-gyn (obstetrics-gynaecology) so the doctor doesn't need to provide too many materials because I already have the basics. However, I am a bit confused about the area of ob-gyn (obstetrics-gynaecology) and midwife from the regulation. (Rin)

Rin is concerned about adding more material related to obstetric pathology into the midwifery programme. During situations in hospital settings involving an obstetrician-gynaecologist and a midwife, she saw the midwives under the role, practice and preferences of obstetric-gynaecology. Rin appeared to accept that the midwife had a role to be performed to fulfil the expectations of the obstetrician-gynaecologist. The need was theoretically in high-risk situations and based on managing the requirement of the obstetrician-gynaecologist in the hospital setting.

Midwives who interacted with the doctor had a skill and understood more than the others. Therefore we consider; why not implement it in education? It supposes to be like that in school, and it is developed. Perhaps there is still a difference; in the educational institution, the intensity of interaction (with patients) was low because too many people. That's why we modified the model (practice). Why occurred it; our assistant (midwives), do they smart? Was their input good? Not always, it was normal, generally, apparently, continuity aspects of interaction made it (happen) because of direct teaching. (Husni)

According to Husni, an obstetrician, improving the interaction between obstetricians and midwives in the hospital would enhance knowledge and midwifery skills of the midwives. In the hospital, the obstetrician sees the midwives as the assistant of the obstetrician-gynaecologist. He further explained his involvement in midwifery education was to teach the midwifery students with the hope of increasing midwifery knowledge and skills.

7.4 Role of the mentor in practice

Within rotations on different clinical placements such as the hospital, private midwifery practices, the public health centres and the maternity clinics, all the participants explained that there was a midwife as a mentor. The midwife mentor has responsibility for providing midwifery care for women and their families, as well as guiding the midwifery student's clinical experience. It is commonly seen that the midwife mentor was appointed by the head of the maternity room to guide midwifery students. Midwife mentors are commonly senior and more experienced midwives.

Participants recognised the hardship of clinical teaching in supporting midwifery students and newly graduated midwives within clinical practice.

I find it hard when performing learning practice in the field which can be very difficult to build a shared commitment with mentors in the field for the achievement of student competence. (Dhendra)

Dhendra, a midwifery lecturer, identified the challenge to ensure appropriate feedback on the clinical performance of the midwifery students as she found it difficult to have an agreed defined criterion with the mentor. Achievement of the midwifery student's competency was interpreted differently by lecturer and mentor. Dhendra felt that she had to learn how to work with the mentor and required precise guidelines as well as a form of evaluation to support the midwifery students at the clinical sites. Clinical practice guidelines, including the feedback and achievement of the midwifery students, should be apparent to improve the teaching and the mentoring process.

Widya, a midwife, realised the need to provide mentorship to midwifery students from a different kind of midwifery programme:

I strive to be the best that I can to be a mentor for midwifery students here-We have students from different programmes and there is a difference between private and non-private institution students. There is a difference in their intellectual ability, and being active learners. However generally, they don't have enough skills when in the clinical sites. For example, when they assess a pregnant woman, the students should learn about the culture, the myths in the community, in the family, what they do and don't do. Students tend to focus on the written form, without digging deeper. They seem confused about what they should do, but they should see the individual woman. Also, I want less than 10 students, but practically we are given more than 10. We are overloaded too. Can you imagine? Ten students (midwifery) in one room. (Widya)

Widya is passionate about mentoring and strives to be the best mentor she can be. However, she felt frustrated by the poor clinical performance and numbers of the midwifery students and newly graduated midwives in the birth ward. She found that some students focused only on the tasks rather than discussing culture and providing health education. She was trying to adapt to her role as a mentor to guide midwifery students and deal with the unrealistic conditions in the maternity room, such as too many students.

Furthermore, participants stressed the position of a mentor in the clinical sites. In this study, the participants said that the midwifery mentor's position was critical and significant to guiding midwifery students and newly graduated midwives in ways which

then boosted the development of a competent midwife. However, it was evident from the data that the participants had different experiences in the form of mentorship at the clinical sites.

7.4.1 The guidance of a mentor

Positive and negative relationships with the mentor are captured by one of the participants. Ani, a newly graduated midwife, said:

I have had clinical experience in some big hospitals, X,Y, Z hospitals so at that time I felt thrilled. Yes, even though the fees were expensive, but I got many cases also excellent guidance from the midwife so it was very balanced. Because the midwife mentor taught me many things, I didn't know. After handling many cases, there I was feeling guilty because I realised I had made mistakes in the past because of the limitation in my knowledge and skill. The midwife mentor was very facilitative, better than my previous study when I was studying the diploma of midwifery. I am very satisfied because I got a lot, the knowledge, the skills, emergency cases. That experience was so different and make me feel good and right. (Ani)

Ani explained that she had an opportunity in a different clinical placement. Although, she had to pay an expensive fee, it was worthwhile, with many cases and excellent guidance from a mentor in the field that she attended. A positive mentor facilitates students' learning. Ani considered that her mentor in the clinical sites was supportive and helpful, which left her feeling satisfied and supported. Ani expressed her confidence in the development of her knowledge and skills. She considered support from her mentor across the clinical sites that she attended impacted on her midwifery skills and helped her gain confidence in demonstrating those skills.

However, negative relationships with a midwife in the field was also observed and this influenced the ways of learning in clinical settings. Lisa, a midwifery student, explained:

When I had the practice in some X districts, the midwife rarely gave guidance. She was not only working in the public health centre but also vice chair of the midwifery association. It was a private midwifery practice, but she gave me less guidance during my practice. Also, the practice was not applicable to the standards. During immunisation, she was still using alcohol cotton, not in line with professional standards. They seem too busy with their business to guide me. They are genuinely not good role models. The perfect lesson from this was I don't want to be a midwife like that. (Lisa)

Lisa felt that the negative attitude of the midwife mentor through her unsupportive behaviour and the hostile environment limited her ability to develop her midwifery skills in different clinical settings. She expressed frustration at not being supported and recognised for the role by her mentor in the clinical sites. Lisa perceived that her mentor was too busy and did not seem to be a good role model. Rather than gaining sufficient clinical experience, Lisa learned that she did not want to be a midwife like her mentor.

Negative behaviour of midwifery mentors towards students was identified as poor role modelling, a neglect of midwifery students, and consequently this affected their learning process at the clinical sites.

When I made a mistake, the midwife suddenly started screaming and yelling in front of the woman and me. I felt uncomfortable because the woman did not trust me anymore. After the delivery process, I had put medical rubbish into a non-medical bin and in front of the woman and the family, the midwife was screaming, "where are your eyes, how many eyes do you have? Look at the bins properly, take it" angrily. I understand that I made a mistake because I am so nervous at that time, but it was unpleasant. I feel I don't want to come back to the hospital and look at her face again. It was inappropriate and nasty. I still remember her face. Why can she not talk nicely and not scream and be angry in front of the woman and family? Just talk to me. (Cici)

The mentor's cynical manner and aggressive behaviour had a significant influence on the process of learning, developing confidence and competency, as well as self-esteem. Cici, a newly graduated midwife said she realised her lack of confidence and skill when supporting women during labour, and was intimidated by her midwife mentor because of her nasty words. She felt less confident and could not manage the labour process and the reaction of a midwife to her lack of midwifery skills. Despite the negative attitude from her mentor, she felt prepared to move forward to learn midwifery skills.

Happy, a midwife, concurred with the significant position of the mentor in the field of practice because of the task of guiding the midwifery students in clinical settings:

I am happy guiding the students. So I have to become a role model for them. It means that I have to up-to-date information and training, and do the skill correctly, because the students are more with me, with us. Because if I am right as a mentor then I will transfer the right things to students, won't I?. (Happy)

Happy acknowledged the attributes of mentors for midwifery students in the field included being informed and keeping up to date with information and training or workshops in the midwifery area. Happy identified the importance of keeping up to date with best practice through professional development. She believed that attending training or a workshop would instil her professionalism to guide the midwifery students professionally.

Nevertheless, another participant questioned the mentoring process because the business of a mentor is to be present for midwifery students at the clinical sites.

Now, who guides the students about the delivery process in the field? Who chooses the mentor and the hospital? The mentor doesn't have time because there are too many students there, midwifery students, medical, and nursing. Who wants to guide students without receiving any fee? (Atmojo)

Atmojo, an obstetrician, said that the mentors have so many students, including medical and nursing, at the clinical sites that it had become a challenge for the midwifery students to reach the midwifery target. He noticed that midwifery students felt clinically confident if they were accompanied by an experienced mentor and given the appropriate midwifery experience in clinical sites.

Participants recognised that optimising the clinical placement of midwifery students was facilitated by a clinical system that supported and hosted the proper mentor for midwifery students. The mentor was deemed the primary source of developing midwifery skills, mainly the labouring process. Participants saw that mentors would face difficulties in controlling and providing appropriate guidance to the midwifery students because of the number of midwifery students at clinical sites.

7.5 Effective clinical experience for competent midwifery practice

Participants also expressed concern about adequate clinical placements for clinical experience. Far, a newly graduated midwife, discussed the condition of the clinical placements for midwifery student and newly graduated midwives:

I was just wondering why the clinical setting was not utilised by the school. There was an excellent hospital that I attended but was no longer used in the following semester. Now, I know it was not an easy to process for clinical requirements and for clinical placements until we looked outside the city. We have to advocate to the midwifery association and to public health officials.

Have to have the memorandum of understanding, relationship, and connection, otherwise there are less patients and too many students. Each clinical setting has its own procedures for clinical placements, so it's like a vicious circle for us. (Far)

Far said that it took time to get to know the processes at clinical sites before they became clinical placements. She identified that it was not a simple process for collaboration and building the relationship between a midwifery school and clinical sites because many requirements were needed such as advocating with the local midwifery association and public health officials, and the availability of the memorandum of understanding to ensure preparation and facilitation of the clinical sites for clinical placements. She also identified that different clinical settings had various procedures held each term to update the clinical sites. There was no guarantee of long-term relationships between a midwifery school and clinical sites which made a vicious circle and challenged the implementation of adequate clinical skills in the clinical sites. The system before clinical placement was classified as complicated to manage.

An obstetrician also noted the complicated system regarding the clinical sites:

We want the students to be skilled, but we have to compete to get the hospital for the students because of the number of midwifery schools. There are a lot of students and many complaints about the low quality of education. It is difficult if we have to compete for the hospital to ensure students gain practice experience. There is no guarantee that is students if get the place, that the student will be skilful. Midwifery school has no hospital or its own clinic for practice. There are less patients because the clinic prioritises them rather than for students. The fees are higher there too, of course. (Sony)

Sony, an obstetrician, felt unsupported by the system, especially the processes of perceived appropriate clinical sites for the clinical experience of midwifery students and newly graduated midwives. It seemed that there was a significant hindrance to clinical placements for the students. He felt responsible for producing skilled midwives, and was concerned about the hardship of finding available clinical sites and supportive midwife mentors in the clinical placements. The unsupported system was not congruent with the expectation of developing and building the knowledge and skills of midwifery students. Moreover, sometimes, in clinical placements, there were midwives who took the training for standard delivery care which generated fewer patients for students to practise.

Another participant saw the complexity of the reality and expressed ambivalent feelings about how to prepare the clinical placements before midwifery students commenced their clinical experience:

It's complex, complicated and makes me sometimes want to give up because I am so tired. However, I can't do that. We want to make sure the graduates are competent and work, as a government employee or in the clinic. I have to teach, manage the management, the availability of funding. Sometimes, the bureaucracy, the systems make me desperate. Because of all the processes needed before clinical placements. (Ana)

Ana, a midwifery lecturer, described the complex system in place for managing clinical sites before clinical placement for midwifery students. In her journey towards managing the clinical placements as a midwifery lecturer, she endorsed the challenges of bureaucracy and the system. Ana considered the challenging process to reach the clinical sites for midwifery students created a psychological issue, such as desperation, or frustration, and resulted in some students wanting to give up.

To strengthen midwifery education, the participants explained they must have quality hands-on clinical experience and a mentor, as well as appropriate clinical experience and placements. The midwifery students were placed in different kinds of clinical sites to develop their knowledge and midwifery skills. The participants in this study recognised appropriate clinical sites as an essential aspect of supporting the quality of clinical experience. Nevertheless, the participants recognised that arrangement of clinical sites could occur in a number of places.

7.6 Summary of Chapter 7

This chapter has discussed the importance of having midwifery clinical experience while studying at the midwifery school. The participants in the research settings addressed the critical need to have clinical experience and hands-on practice in developing competent midwifery students and newly graduated midwives. Regarding clinical experience, the midwifery students and newly graduated midwives considered they have to be empathetic and women-centred in their care; it is not about chasing the number of midwifery targets. Therefore, they enjoyed and learned more from continuity of care experiences that offer comprehensive midwifery care. Furthermore, the participants acknowledged that there were some conditions in the clinical sites

which explained why midwifery students and newly graduated midwives did not have appropriate clinical experience and hands-on practice. The midwifery students and newly graduated midwives wanted to have ample clinical experience and opportunities for hands-on practice in the delivery process. Also, the participants mentioned that a gap between clinical theory and practice can be seen during the clinical experience, where what they were taught in theory did not match what was happening in practice. The participants discussed the essential position of the mentor in guiding midwifery students and newly graduated midwives in the clinical sites. Regarding the clinical sites for the clinical placements, support for and guarantees of clinical placements with maternity services are essential to ensure that midwifery students and newly graduated midwives receive appropriate clinical experience and hands-on practice during their education at midwifery school. The next chapter will discuss the final set of findings, part three, which relate to findings which participants shared on the structural and external factors which they felt would strengthen midwifery education in Indonesia.

Chapter 8.

Findings Part Three: Structural and external factors

8.1 Introduction

This chapter explores the theme 'structural and external factors', which research participants described as being some of the barriers and enablers for midwifery education in Indonesia. In the previous chapters, the themes 'midwifery teaching and learning of theory' and 'midwifery clinical experience' were explored. The theme 'structural and external factors' included the following subthemes: the varied structures of midwifery programmes, midwifery accreditation, the requirement for post-graduation competency training, and the need for a Midwifery Act to impact on midwifery education (see Figure 8.1). Structural and external factors were seen as significant factors in the development of midwifery education in Indonesia. A brief explanation of the position of the government, which is responsible for regulating the midwifery profession, is presented in this chapter as the part of the findings.

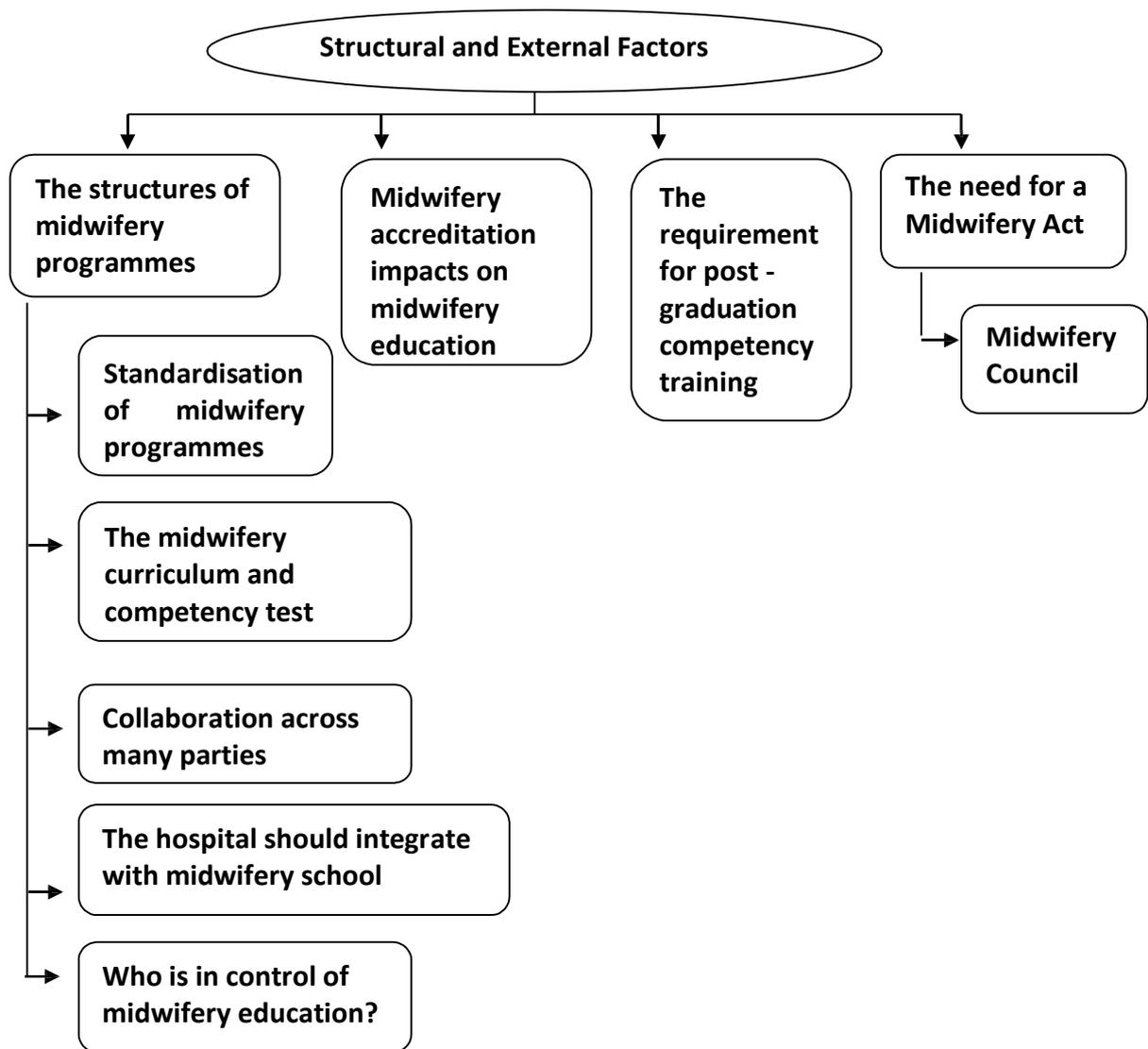


Figure 8.1 Theme and sub-themes of structural and external factors

Participants identified numerous barriers and enablers related to the structure of the midwifery programmes which impacted on the strengthening of midwifery education in Indonesia.

8.2 The structures of midwifery programmes

Participants in this study discussed the differences between and impacts of the programme structures between DIII, DIV, and bachelor's degrees in midwifery education.

Ismi, a bachelor's midwifery student, identified that, whatever the programme, all graduates are going to be working as *bidan*:

*At the clinical settings, there are not only students from diploma but also the advanced diploma and bachelor's programme. I think that clinical settings do not bother about the diploma students because they have more clinical than the bachelor students. Yet what happens after we graduate? We are both *bidan*. We should be humble and don't feel that one is better than the other. We are the same. If we passed and graduated from a midwifery school, we become a good midwife, we are devoted to the community, and will give service to the community, mothers and babies. We work in partnership with mom and family; our service will become valuable, and we play a part in the maternal and infant health. So, don't be like that. Don't disparage another. Don't be demeaning, or humiliating to each other, just because we are from a different kind of midwifery programme. We should work together to make midwifery stronger. (Ismi)*

Ismi was keenly aware that the different types of midwifery programmes are seen differently in the clinical areas. The diploma students, for example, are seen as more practically skilled. She was aware that all midwifery students, whatever their programme, will become midwives working in partnership with women and their families. Ismi was aware that sometimes the students from different types of midwifery programmes were demeaning of each other in the clinical settings she attended for clinical experience.

Dhendra, a midwifery lecturer, stressed:

It (the midwifery education system) is very confusing and raising different implications for students, graduates and an employer. Sometimes it hurts students for their career and finance. For example, in practice, it's hard to identify and make an agreement with mentors in the field to have a shared commitment to the student competency achievement for the different programmes; bachelor, DIII, DIV. I hope there will be some design of unified and continuous midwifery educational development. (Dhendra)

Dhendra noted that the different kind of midwifery programmes was confusing. The difficulty for her as a lecturer was that the mentors who worked with the students in clinical sites did not always understand the different learning outcomes from different midwifery programmes. When a mentor does not understand the programme that a student is coming from (diploma, advanced diploma, or bachelor's), the impact this can have is that the student needs to spend more time and pay for extra clinical time in order to meet the required learning outcomes. Dhendra suggested that a strategy is needed to design a midwifery education programme which will be consistent and

avoid confusion between the different programmes.

Ani, a newly graduated midwife, also raised the inability to describe the differences across the midwifery programme and the difficulty in finding a job:

I am still confused, what is the difference, so difficult to understand, about the learning outcomes, competencies across the programme, diploma, advanced, and bachelor (professional). I hope whatever the result from the central board, the important thing it's the quality of graduates, and they can work, because the difficulty to find the job recently. (Ani)

Ani seemed to be confused about the current midwifery education and differences between the types of midwifery programmes. She recognised that it could be challenging and confusing for new graduates to have a sense of what was required to be a midwife. This could also be confusing for employers, and potentially be contributing to the difficulty in finding a job. Ani recognised, however, that whatever the competencies of each midwifery programme, the most important thing was the quality of the graduates at the end of the programme.

Bilbina, a midwife mentor, said she needed to provide students with a supportive process - whatever the midwifery programme they are enrolled in:

Because I am here to guide midwifery students. Many kinds of midwifery programme practice here, DIII, DIV, and Bachelor. Yes, I do my task. Because the new midwife, we can see, sometimes cannot help the labouring process. The need to do a lot of homework. (Bilbina)

Bilbina was committed to guiding midwifery students in her facility and suggested that many new midwives lacked skills in caring for women in labour. She focused on the midwifery skills and knowledge of all midwifery students rather than the programme that they are from. She was firmly convinced that all midwifery programmes exist to provide women and their families with the best practices of midwifery care in the community.

Participants discussed the system of midwifery education, and suggested that a National Midwifery Education framework would help to standardise midwifery education in Indonesia. The idea of a National Midwifery Education framework was echoed by participants because of the variations in midwifery programmes.

8.2.1 Standardised midwifery programme

There was an acknowledgement that a standardised model of midwifery education could provide all stakeholders with a clear understanding of what the graduate midwife profile should be. Arum, a midwife, spoke of the struggle their school had to rearrange the system of midwifery education:

We have to struggle for rearranging the system of our midwifery education, which has been established for almost ten years—no, nearly 20 years. In fact, it was complicated for us to choose between DIII and S1 (professional undergraduate). Moreover, our choice was still questioned by the consultant (who came to approve the programme). He asked what made the two programmes different, why we made our decision, and so on. Since DIV is quite similar to S1, we eventually agreed that there was no DIV. Thus, the nomenclature of DIV is not used nowadays. DIV midwifery education is a crash programme to cover the temporary need. If there is another programme which is more effective, then the crash programme should be removed. Nonetheless, in fact, it has been still used until today because the programme maker did not know that it was a crash programme. (Arum)

Arum spoke of needing to decide between different programmes, at a vocational or bachelor's level. The consultant who came to approve the programme asked them what made the two programmes different, why they made their decision and so on. The DIV midwifery education was a temporary programme set up to cover a short-term need. Arum suggested that the DIV programme is not as effective as the bachelor's degree and that it should be discontinued.

Sony, an obstetrician, expressed his views on the significant factor of the government policies in the standardisation of the midwifery programme:

They (the government) thought it was an easy answer, to increase the numbers of midwives, open up more different schools. Based on education bill, midwifery is academic as well as vocational. For an academic qualification the bachelor moves to master to doctoral, and development of knowledge. How about the vocational though? To be a midwife? Is midwifery academic or a vocational? Now, we have a bachelor, DIII and DIV. It's about politics. From the beginning, we sat together, including the Ministry of Health and Ministry of Higher Education and started to make a standard policy, but five years later the officials were replaced. Now we have a different person who has different taste, different policy. It's a big homework for the government. (Sony)

Sony suggested that simply increasing the numbers of midwifery schools is not the answer to increasing the numbers of midwives. The government decided on the types of programmes and approved them. He said there is no clear understanding of what

types of midwifery programmes produce the midwives needed for Indonesia. He suggested that there is a difference between an academic programme and a vocational education programme. In his view it is the role of the government to decide and set the precise regulation of midwifery education. Even though both the Ministry of Health and Ministry of Higher Education, Research, and Technology had sat together, as time passed and the officials changed, the policies also seemed to change.

Another participant echoed the standardised midwifery programme as entailed below:

After having a certain level is still asked; is she suitable for vocational matter or academic? There are already existed in DIKTI UU (law); what definition of vocational education is, what definition of academic is. Because already explicit, it is better no differentiation anymore. It must be one. For authority "it", its competence only one. One skill, it should be one level, not many levels. How could it be possible; facing people with the similar problem, similar value, many levels?. (Husni)

Husni, an obstetrician, recognised the political dimension when vocational education was compared with separate academic education. He hoped in the future for an agreement on the model of midwifery education, one without multiple levels. This participant recognised the need to advocate and develop strategies to support the model of midwifery education. Husni expressed concern that the aim of all midwifery schools was educate midwifery students to develop competent midwifery skills.

Suri, a midwifery lecturer, was also concerned about the lack of agreement about the best type of education for midwives:

However, there is still no agreement. That's why we need to propose to the government. Well, we have to go back to the purpose of this education itself. We need to think further, learn, provide school to make them skilful. How can students have skills? First, we have to educate them appropriately, a comparison between students and lecturers became number one priority. How can someone have a skill? They have to give education for human resources then apply for the program, share the experience. The theory is 40%. The practice must be 60%. They have to be careful when dealing with pregnancy. It (a midwifery programme and its midwifery curriculum) has to be tested. Midwifery teachers must have the certificate of their skill. To make sure that they can be tested in good hands. (Suri)

Suri raised the dissatisfaction of having a variety of midwifery programmes and the different perspectives on this matter. She stated that the parties involved need to be

reminded of the purpose of midwifery education. The primary goal of midwifery education was to create skilful newly graduated midwives with the expectation of being with women and their families. She identified the importance of midwifery lecturers having good midwifery skills themselves in order to be effective lecturers.

Ina, a midwifery lecturer, felt that the problem was that curricula were not standardised:

Improving midwifery curriculum, yes it's important because of the many and not standardised programmes. There is a regular workshop where the curriculum is reviewed with stakeholders because it is important new midwives have the skills and are competent and the learning process maintained. There are a number of issues after graduation the midwives are not sure what they should do, some maybe are too immature or young and so they need support to take on the responsibility of a midwife. (Ina)

Ina identified that a standardised midwifery curriculum across all kinds of midwifery programmes was needed to improve skills of the graduates. She noted that even though the curriculum was reviewed, the newly graduated midwives felt confused and did not know what to do after graduation. Ina highlighted the challenging period of being a new midwife at a young age. Because of this matter, Ina identified that the midwifery curriculum should be improved to build a support system for new graduates to take more significant responsibility in the future for being an independent midwife.

The different kinds of midwifery programmes affects the midwifery curriculum and content. Some participants suggested that there was wide variation in the learning process and assessment of competence between the schools. The variation could affect the competency of the graduates.

8.2.2 The midwifery curriculum and competency test

Some participants who contributed to this study expressed concern about the skill of newly graduated midwives. A significant number of new midwives did not pass the competency test which they sat in the year after graduating from their midwifery programme. Therefore, a number of participants discussed the need to strengthen the curriculum so that graduates passed the national competency test.

Ana, a midwifery lecturer, asserted that the midwifery curriculum needs to be developed and reviewed with the focus on midwifery skills.

Our content follows the national curriculum. We have about two or three times a curriculum review (workshop) because there are changes for midwifery competency-based curriculum. So there is a process of trial, learning and evaluation of the learning outcomes. It is teamwork, we are seen as one team, not only one midwife, as there is commitment from all because we are under the medical faculty. We are hopeful graduates are ready to work as midwife.
(Ana)

Ana explained that the midwifery curriculum had changed many times to achieve the set of midwifery competencies. From Ana's point of view, reviewing the midwifery curriculum in a curriculum workshop was a complicated process. She said that each lecturer has a personal perspective on how to reach the learning outcomes and battled to avoid overlapping the midwifery subjects. Ana and her midwifery colleagues have made conscious efforts in the midwifery curriculum to ensure the content of the curriculum is in line with the needs of midwifery students.

Competence to practice means more than only competence in clinical skills. As Husni (an obstetrician) stated that, along with training midwifery students in theory and practice, opportunities to build a student's character are essential:

The educational institution has the right to make its curriculum. It is important the curriculum is not only skills and knowledge but also character and entrepreneurship. Yes they are a midwife but also they have skills in other areas. Probably skill as a great researcher. We evaluate and change curriculum yearly. The midwife must be educated in a way that she is ready to work wherever hospital or the community. The curriculum needs to ensure it produces a graduate with these skills. (Husni)

Husni explained that, at the school where he taught, the midwifery competency-based curriculum enabled the midwifery students to increase their capacity by building other competencies such as entrepreneurship (independent practice) or being a researcher. He recognised the importance of reviewing the midwifery curriculum regularly so that the appropriate acquisition of knowledge and midwifery skills of students was developed.

Rully, a newly graduated midwife, shared her concern regarding the improvement of midwifery curriculum to enable graduates to take the competency test:

It's about ensuring the curriculum runs well and the students are competent. Sometimes, the school chooses only the best students to take the competency test. Sometimes, the schools do not put all their students forward for the competency test as they doubt their knowledge and skills. Surely this is the responsibility of the school to ensure the student has the knowledge and yet the new graduates can't handle some cases. The curriculum must be clear as to what skills and knowledge should be mastered to be graduated and if the students are not at that level then the curriculum should be strengthened.
(Rully)

Rully reported that the midwifery curriculum was not sufficient for midwifery students to gain appropriate knowledge and midwifery skills to answer the question in the competency test. Rully described her surprise at how her school selected “the best students” to take the competency test first. It may happen to know the best students would pass or not pass the competency test. To her, it was a dissatisfying and weird situation that her school doubted their midwifery students ability to take the competency test. She suggested that the midwifery curriculum should be improved and students should learn the “right things” while studying in midwifery school and focus on the competency questions. She felt that she was struggling to pass the competency test.

Dyah, a midwifery student, further echoed the issues with varied midwifery curricula:

Yes, I mean the midwifery association (IBI) is our mother and provides the guideline for the curriculum. So what's the difference between DIII, DIV and S1 (bachelor), curriculum? This is still unanswered and unclear but can affect the competency test. The competency examination has to be different for each of them (III, DIV and S1 (bachelor)) or how?The standard? DIII and DIV graduates are the assistants of S1? What? Wow! Maybe it is not synchronised between what the schools and what the professional organisation wants. What does the government want about the midwifery education's graduates in Indonesia?The direction, oh a midwife is like this. (Dyah)

Dyah thought that the Midwifery Association should provide the guidelines for the midwifery curriculum. She found it confusing to know the difference between the midwifery curricula of different midwifery programmes. She recognised the status of the Midwifery Association and that it has the authority to exert power and emphasis in reviewing the midwifery curriculum standards across different kinds of midwifery programme. She described how the system of midwifery education and the midwifery curriculum would affect her national competency test. Dyah felt frustrated about the

lack of synchronisation between the midwifery schools, the Midwifery Association, and the government in relation to the competency test. She thought that the competency test should be matched to each kind of midwifery programme. Dyah questioned the congruence between the midwifery graduates' profile and the midwifery competency standards from a different midwifery programme.

The striking moment for Ina, a midwifery lecturer, was when a number of students she had taught did not pass the competency test:

I evaluate my teaching when the students take the examination (the competency test). I felt so sad because of the result unsatisfactory, just wonder what happens, is it because of me or what else? Is it because of the lack of attention from students? (Ina)

For Ina, the inability of her midwifery students to pass the competency test led her to self-reflect on her teaching. Her perception was that they did not pass perhaps because of her teaching and learning process, the inability of the students to pay attention, or for another reasons.

8.2.3 Collaboration across many parties

For the midwifery schools to be successful, active collaboration was needed between all parties. The collaboration is inevitable to make midwifery education stronger.

After graduation, midwifery students should be competent and helpful. It is expected that they are able not only to decrease mothers' death rate but also to improve the quality of women's and their children's lives, despite the fact that the indicators are difficult to measure. The indicators have an impact on their quality of lives in the future as expected by ICM, WHO, and UN, i.e. that the role of midwives is to guard our nation's future. We can be proud if it is realised. Nonetheless, to live up to our expectations, all systems should be well-managed, not instantly in a hurry. Everyone involved must be committed. (Arum)

Arum's quote illustrated the expectation of competent midwives to reduce the maternal mortality rate and to improve maternal health outcomes. Arum stressed that the graduate profile was expected to follow the ICM guidelines to fulfil the minimum requirement for quality new midwives. She would be proud if this desire became a reality. She hoped that the system is well-managed and committed to by the parties involved to ensure the quality of midwifery schools. At this point, she suggested that everyone involved needed to work together to support midwifery schools and

students so that the goal of reducing maternal mortality may be reached.

Bilbina, a midwife, concurred that the collaboration between many sectors has to be built to produce skilled midwives efficiently:

Between the association and the educational institutions, they should have a good co-working. Can we? So, later once the midwives have graduated, they will be skillful, professional and so on. Yes, midwifery professions, educational institution and the hospital are in balance condition. I understand that we should work together, but sometimes the communication was not run well.
(Bilbina)

Bilbina expressed the specific factors which made it challenging to work together in clinical sites. She identified that communication and professionalism should be evaluated to assist all parties to work efficiently together to improve the midwifery school. She realised that supporting side by side the Midwifery Association, educational institution and clinical sites would assist the midwifery students and newly graduated midwives to gain knowledge and skills while doing practice in the hospital. Collaboration from many sectors, such as the Midwifery Association, educational institution, and other stakeholders identified, should be efficiently built to enhance the quality of the midwifery learning process.

Another participant, Sas, suggested that competition between midwifery programmes sometimes led to less collaboration:

I understand the core of being a midwife. It is related to women and babies. That is, I learned knowledge and skills and had to be skilful because I will work with babies, toddlers, mothers and families. Of course, each programme has indicators later that fit and meet the requirement to make us, good midwives. Diploma, advanced diploma, and bachelor's programmes. I don't want to make a comparison. All the degrees should collaborate, not try to compare and compete that one is better than another one to make midwifery school stronger.(Sas)

Sas understood the core of being a midwife related to women, babies and their families' outcomes. Her intentions in studying midwifery were to provide positive experiences for women and families. Even though each programme has a different curriculum (indicators), in the end, we all want to be skilful and knowledgeable midwives. Sas stated that each midwifery programme will be stronger if it collaborates rather than compares and competes.

As described in Chapter 2 and the previous section, there are many varieties of midwifery programmes and public and private hospitals. Therefore, some participants recognised that the hospital should be integrated with the midwifery school to maintain the quality of teaching and learning process.

8.2.4 The hospital should integrate with midwifery schools

Shinta, a midwife, reflected on her view about integration between the hospital and midwifery school:

The other obstacle exists in the health service. Previously, when I went to school, a health facility was available. My school in X was part of the hospital. The example here in Y hospital is that the school is for medical students. The owner of that midwifery school is the hospital. That's a problem when the students need to practice. We should unite in one corporation, rather than a gap between us because we are part of the hospital. When the education and the hospital are separate it is not easy to enter and practice. We need to pay for the clinical experience. We need to advocate for student midwives. If midwifery lecturer could work with students providing hands on care this would be most beneficial. (Shinta)

Shinta recognised that the clinical site is a crucial feature at midwifery school for the midwifery student to gain appropriate knowledge and midwifery skills. She suggested that the hospital should integrate more with midwifery schools so the theory and clinical practice are integrated. Advocacy for student midwives was seen by Shinta as important for students' clinical experience. Ideally, Shinta believed that midwifery lecturers should be able to work alongside students to facilitate student learning and to maintain their midwifery skills.

Ana, a midwifery lecturer, also mentioned the importance of the existence of the hospital under the midwifery school for the long run for clinical placement:

I hope we can build a permanent hospital clinic so it can be a model for clinical sites, in line with midwifery care. (Ana)

Ana expected that the hospital was important for the clinical experience of midwifery students. The integration of the hospital with the midwifery school would provide more opportunities for clinical practice. She considered that model of midwifery care could be placed and prepared within the midwifery programme.

Atmojo, an obstetrician, also identified the importance of the integration between the hospital and the midwifery school:

I hope at the hospital there is a midwife, a specific lecturer to train midwifery students. Yes, integration between the hospital and the school, mentor from school, and the lecturer need to work together to provide clinical education for midwifery students. (Atmojo)

Atmojo recognised both the availability and quality of a mentor, and the existence of the hospital plays a crucial role in supporting the quality of teaching and learning process at the midwifery school. Integration between the hospital and the midwifery school could offer sufficient places, time, and models for the midwifery lecturer, as well as midwifery students, to offer the midwifery care they want for the women and families.

8.2.5 Who is in control of midwifery education?

Participants in this study further voiced their views about the significant involvement of obstetricians. The obstetricians in midwifery schools were appointed by the department under the Ministry of Higher Education, Research, and Technology to take responsibility in managing midwifery schools.

Husni, an obstetrician, discussed his involvement in a midwifery school because of the duty of the department:

At that time, there was a memorandum of understanding between this institution, and two private schools to build the programme and I was trustee coincidentally. Since 1998–1999 the process begins, and as an obstetrician, I start to interact with midwifery education. I was appointed by the head of department. (Husni)

Husni discussed how his obstetrician colleagues were planning and making the relationship to develop midwifery education. Once the agreement to set up the midwifery school was signed by the government, his involvement in leadership and management in the midwifery school started. He was appointed by the department leader to become a midwifery leader in midwifery schools and work with another midwife and midwifery lecturer colleagues.

Atmojo, an obstetrician, identified the starting point of his involvement in midwifery schools as a duty:

Assigned from the department due to the urgent need of midwives at that time, school health nurse. I was educating and examining for the final examination of midwifery students since a long time ago then school closed. We determine whether they lack skill, particularly birthing process. Previous midwifery schools have not fulfilled this requirement and the fund from the government. DIII midwifery programme opened. Then set the diploma midwifery programme followed the master of midwifery. They don't pay attention to the midwifery lecturers, the hospital for clinical sites because a lot of schools opened. So, I was teaching and giving the necessary knowledge and skill that required by midwives. Not look at up because they have to know the position midwives, their competencies. Built on the ministry of health. Especially competencies in practice, how to handle the patient, labour process, because at that time they lacked skill, lack of experience, there were no changes in the curriculum, their education. (Atmojo)

Atmojo explained how his involvement to work alongside the midwives and midwifery lecturers in midwifery schools was intended to share his knowledge, skills and experience, while being mindful of the need to strengthen midwifery education. He spoke about being involved in midwifery schools to perform the mandate from the government department. Atmojo felt that his medical knowledge was needed in midwifery education in the beginning. Other interviews with obstetricians revealed the historical link between medicine and midwifery in the shaping of midwifery education. The role of the obstetrician in midwifery education also has its challenges.

Ratna, an obstetrician, explained her involvement at the midwifery school is because of a mandate from the leader of the department:

I am so struggling with it. From the beginning of master in midwifery, bachelor, I was there, it was a considerable struggle, yes fight. Internal fighting because I am a member of ob-gyn (obstetrics-gynaecology), I did not know what is a bachelor of midwifery, or a master in midwifery? But if not ob-gyn (obstetrics-gynaecology) to teach these programmes, who is there?. The midwives must be educated, so they understand their scope of practice. I tell my medical colleagues that they cannot be a doctor, because of their competencies. As I know, the schools were built because the shocking number of maternal mortality rates is it because of dukun (traditional birth attendant)?. Well, the government took over, it's a mandate from the Ministry of Higher Education to educate the midwives. So, I am here because of the order. I know the reality that many midwives are not competent. (Ratna)

Ratna mentioned her struggle to raise the different perspectives of the obstetrician-gynaecologist on the existence of midwifery programme, which was later resolved by adequate information because of her position at midwifery school. She underlined that her involvement at midwifery school was a fragment of her overall duty to take part in managing and educating the midwives. She was also driven by the intention of the government to improve maternal health outcomes by investing in midwifery schools.

Participants who contributed in this study were mindful of the structure of midwifery programmes which impact on midwifery education. Therefore, the participants suggested building a national midwifery education framework and improving the midwifery curriculum, as well as the competency test, which required the collaboration of many parties, including the question of how the hospitals should integrate with midwifery schools. In this study, the participants also discussed the involvement of obstetricians in midwifery education.

8.3 Midwifery accreditation impacts on midwifery education

Participants spoke of the need for improvement of the accreditation process:

An educational institution is like a factory. How to create a product appropriate with demand by profession. Yes, there is accreditation, but in fact, this thing cannot assess operational things. It assesses more the documentation and administration. I see the trend with this competence examination. The institution of education has begun to improve their self accreditation status and passing graduation grade of competence; these new two things which carried out recently has given positive impact to the institution. (Shinta)

Shinta, a midwife, stated the nature of the midwifery schools as being a factory producing work-ready graduates. Shinta appeared to be cynical about the accreditation process. She described how the accreditation assesses documentation and administration rather than the actual teaching in the institution. Nevertheless, Shinta was positive and supportive through this process to ensure the midwifery school maintained quality together with the competency examination. She still insisted that the accreditation process and competency test was valuable for improving the quality of midwifery schools.

Another participant echoed the sentiment in explaining the accreditation process:

So when the midwifery school had its accreditation, it was all completed, documents, all, ok all good. When there was field visit, all completed. Then the assessor moves from school A to school B. Still, the same phantom was observed in both school A in school B (it had been moved for the accreditation). How come?. (Ratna)

Ratna, an obstetrician, was cynical about the accreditation process. The accreditation process opens the opportunities for a midwifery school to provide documents and fulfil requirements for the accreditation process. The effect for some midwifery schools was a lack of ability to prepare the equipment needed to practise at school, with it only being set up on the day accreditation happens. She recognised that improvement in the accreditation process would enable midwives to better tailor midwifery education and the profession.

Preparing the accreditation documents was a great event and depended on the midwifery team providing maximum effort. These points were identified by Ina, a midwifery lecturer:

It's hard, difficult, yes it's the big moment. Accreditation moment. Yes, because it took all of our time, energy, feeling. We worked overtime to prepare it, so the students become the victim. It seems that we need more time to do the accreditation, so we don't have enough time to supervise students. It sucks with accreditation. (Ina)

Ina commented that the accreditation process was a big moment for her and the midwifery school. Ina and her midwifery team put in strenuous effort, directly correlated with the overtime worked and the energy put in to address the preparation of accreditation. Accreditation is intended to encourage the midwifery school to fulfil the requirements and assesses how the educational institution maintains the quality that meets the standards.

For the midwifery students and newly graduated midwives, the status of accreditation of their midwifery school was vital to the job application. Therefore, participants in this study, particularly a newly graduated midwife, expressed concern on this matter. Cici described how accreditation status is significant when applying for the job:

I have lack of spirit at school, because of the result of accreditation of my school. I don't get it, just hope my school get better for that because I have to apply for the job. Some said because of the human resources, others explained about midwifery students, infrastructure, how long until fresh graduates get the first

job influenced the accreditation. (Cici)

Cici felt frustrated about situations that created difficulties for her after graduation because of the accreditation status of the school and the requirement to apply for the job. She explained that many aspects should be fulfilled and achieved to reach an excellent accreditation, such as the profile of midwifery students, infrastructure, and alumni, as she knows that her lecturer and school put in much effort to prepare for the accreditation process. The job issue identified that her period at school seemed not to be valued because of the accreditation status of her school.

8.4 The requirement for post-graduation competency training

A number of the participants in this study further discussed the issue of extra competency training required after graduation. Full training (training for standard delivery care or Asuhan Persalinan Normal (APN) is mandatory for a new midwife prior to applying for a job.

Sony, an obstetrician, concurred that the obligation of a new midwife with standard delivery care training was seen as a negative concept. This training should support the midwives to maintain midwifery skills, not be a requirement for newly graduated midwives applying for jobs:

They (newly graduated midwives) have to have APN certificate before going to the workplace. APN should be for re-certification of a midwife. Yes, registered midwives have to refresh their skill, yes, it can be, for an update, the training for them, not for fresh graduates. New midwives have been at school for three years, yet there is doubt about their quality. How can they be competent after 5-10 days of training for the APN? Because holding the certificate they are now identified as skilled midwives?. Many factors should be improved, the school, stakeholders, midwives would be unemployed if not supported. (Sony)

Sony appreciated the knowledge and skill of newly graduated midwives and overly criticised the obligation of APN training for fresh graduates as one of the requirements needed to apply for a job after completion of midwifery school. He reflected that the training exists because of possible doubt from the Midwifery Association about the quality of newly graduated midwives and the devaluing of the midwifery school. The requirement to have the APN certificate may reflect the lack of competent new

midwives able to work in maternity services. He acknowledged that the training was not efficient for newly graduated midwives to produce skilled midwives within 10 days. Sony identified that professionalism should be developed to improve the learning process which makes schools better.

Rin, a newly graduated midwife, alluded to the Midwifery Association and midwifery school regarding the requirements to apply for a job as a midwife:

I am still a new midwife right. I felt uncomfortable when thinking about the vacancy. Finding a job is hard, and there are too many midwifery graduates today. I apply to work at the hospital; it requires the normal delivery care certificate (APN certificate), then A, B and C. Filing up, is just the same besides having to pass a competency test. Yes, because it's from midwifery association. It was harder when I did not have the registration certificate of the midwife yet because it takes so long to issue this licence. It is already seven months since graduation and its hard to find a job. Yes, the competency examination too. Ages. So, until now I am still guessing why I don't get a job here. I need to keep the effort for my future. (Rin)

Rin described the challenges she faces as a new midwife. She seemed uncertain and thought that the role of supporting the new midwife should come from the midwifery school and the Midwifery Association. She felt numb because it took a long time to wait for the process of the competency test and her certificate as a midwife, in addition to the compulsory training for standard delivery care, midwifery and the contraceptive update. When people underestimated her, she felt worthless and lacked enthusiasm to attend the training, as she had graduated and learnt those midwifery skills at her midwifery school. She felt daunted by the requirements demanded of a new midwife. She felt unsure about how to take the next step and felt frustrated about the requirements needed to apply for a job. For Rin, it seems there was lack of support and preparation from the midwifery school as well as the Midwifery Association.

8.5 The need for a Midwifery Act

Prior to the submission of this thesis, a Midwifery Act was ratified in March 2019 which provided legislation around who can register as a midwife in Indonesia. Participants spoke around two years before the legislation was passed about how a Midwifery Act would provide a foundation for midwifery education.

Al Syifa, a midwifery student, thought that the development of midwifery education was being hindered by the lack of a Midwifery Act:

I see that the progress of midwifery education is plodding in comparison to other professions such as my fellow nurses. Why is it difficult to improve midwifery education? We are afraid of our future because the Midwifery Act has not been ratified because the agreement between the professional organisation and government had not been achieved. That's the obstacle; seems like never to be found soon. (Al Syifa)

Al Syifa described midwifery education as being of a plodding nature compared to other professions such as nursing which is moving ahead. She and others encounter difficulties in the nature of midwifery education which generate challenges in making improvements and create stressful situations. She wondered if influences, such as the Midwifery Act or political influence, are impacting on midwifery education and midwifery students. She and her peers felt frustrated about taking the next step, as the Midwifery Act was still not ratified by the government. Therefore, the uncertainties of a Midwifery Act were seen as a barrier to improving the redevelopment and reorganisation of midwifery education.

Sony, an obstetrician, stated the Midwifery Act that govern midwifery is complex:

The Act is complicated. There should be separate professions, so as not to overlaps between midwifery, nursing and medicine. (Sony)

Sony described the initiation of the Midwifery Act as needing to be multi-faceted with to overcome barriers because of egoism. The Midwifery Act was deemed essential in resolving the difficulties in the midwifery world, including midwifery education. He suggested that the midwives who have the authority to draft the Midwifery Act also consider the other health acts to avoid overlaps across professions, such as nursing and medical.

A Midwifery Act would give legal status for a separate Midwifery Council in Indonesia. Participants in this study spoke of the importance of having a Midwifery Council to strengthen midwifery education.

8.5.1 A Midwifery Council

Sony, an obstetrician, mentioned the absence of a Midwifery Council in legitimising the

standard of the midwifery education:

We have a Medical Council; midwives don't have it. As a professional guard, a midwife, you have to handle women and families, so the regulator needed to arrange it. (Sony)

Soni noted that midwifery does not have a Midwifery Council which regulates midwifery education in Indonesia. He recognised the need for a Midwifery Council to provide professional standards for midwives and midwifery education, including ensuring the competence of midwives.

Ratna, an obstetrician, also mention the existence of a Midwifery Council in Indonesia:

You don't have a Midwifery Council isn't right? Yes, it should be an independent agency, but how about the member inside? Should have no vested interest. Yes, we have a Medical Council to maintain the standard of school and profession. (Ratna)

Ratna identified that the absence of a Midwifery Council contributed to the inability to offer professional standards in midwifery education. She clearly stated that the Medical Council in her profession ensured how medical education and doctors would provide maximum medical care for the patient. She suggested that midwifery should have a Midwifery Council to enhance midwifery practice and education, and increase the ability to provide optimum midwifery care to women and families.

8.6 Summary of Chapter 8

This chapter discussed the theme 'structural and external factors' which emerged from participants voices in this study. Participants expressed the view that midwifery education could be strengthened in Indonesia if there was perception and agreement about the structure of the midwifery programmes. Participants discussed the need to create collaboration between midwifery schools, the government and clinical sites to make midwifery education stronger. The participants in this study also discussed how clinical sites should be integrated with midwifery schools. Ideally, midwifery lecturers or mentors would work alongside midwifery students and advocate for them to obtain the kind of clinical experience that they need. The participants also considered the accreditation process and the competency assessment as enablers and barriers to strengthening midwifery education in Indonesia. This theme of structural factors also

found that improvement of the competency assessment is needed to be considered to improve and facilitate the newly graduated midwives to implement their role. Better support for midwifery students and newly graduated midwives could be provided by the midwifery school, the Midwifery Association, stakeholders and other parties for improving the quality of fresh graduates. Participants in this study were mindful of the need for a Midwifery Act and Midwifery Council which provide the umbrella for the development of midwifery education in Indonesia. The next chapter will be an application of Bolman and Deal's Four Frames approach to the findings, which adds depth and a further layer of analysis.

Chapter 9.

Analysis with Bolman and Deal's Four Frames approach

9.1 Introduction

This chapter applies Bolman and Deal's (1997, 2003, 2008, 2017) Four Frames approach to the findings. The Four Frames: structural, political, human resource, and symbolic frames are utilised to explore and articulate the complexity and possible tensions that were identified in the research that impact on midwifery education in Indonesia. The application of the framework to the data adds depth and a further layer of analysis which is used in the following way:

1. Reading and digesting the data and reviewing it as informed by Bolman and Deal's Four Frames as the theoretical framework.
2. Applying the Four Frames and analysing the data.
3. Looking for the links, complexity, and tensions that emerge from the data when using the Four Frames.
4. Exploring the complexity that has been revealed by using the Four Frames to further inform what can strengthen midwifery education in Indonesia.
5. Using the complexity identified to articulate further points for discussion.

A summary of the data analysis mapped to Bolman and Deal's Four Frames is noted in the Appendix H. For this analysis, key findings were explored under each of the frames but always looking to how the frames are linked and connected, showing the fluid nature of these frames. The complex connections between these frames adds a layer of depth and complexity to what was already known about what will strengthen midwifery education in Indonesia.

In this study, the need for a Midwifery Act was endorsed by nearly all participants as a significant factor in enhancing midwifery education. A Midwifery Act was ratified during the submission process of this thesis. More in-depth analysis led to this becoming the fourth finding. It is essential to analyse this area further to obtain more understanding of this enabling factor that will strengthen midwifery education in Indonesia.

9.2 Key finding 1: Professional recognition by having the Midwifery Act 2019

9.2.1 The symbolic frame (key concepts: meaning, belief, culture, values)

Using Bolman and Deal's Four Frames, symbolic values were revealed in the data about the work over the last 15 years to lobby for a Midwifery Act 2019 in Indonesia (Ikatan Bidan Indonesia, 2016b, 2018). Lobbying for a Midwifery Act was primarily related to the fact that when a profession is recognised in legislation, it is given authority and status in a country. Ratification of the Midwifery Act in March 2019 gave the profession status and authority to both govern and regulate itself. Participants in this study, especially those from the Midwifery Association, speak about this as a driver for their work to obtain a Midwifery Act as midwives have lagged behind the other professions such as medicine and nursing. Alongside this driver, the participants spoke of values of equity, autonomy and collaboration as underpinning the need for a Midwifery Act. The achievement of the ratification of a Midwifery Act led to the legal recognition of midwifery as an autonomous profession within the scope of midwifery practice, and this brought midwives equity with other health professions in the regulated health care system in Indonesia.

There are many government documents about midwifery and the scope of midwifery practice. However, the Midwifery Act, which gives autonomy to the profession, is a powerful tool that enables midwives to govern midwifery practice, the registration of midwives and all matters related to midwifery in Indonesia. The Midwifery Act details the title of a midwife or '*bidan*'. The Act defines *bidan* or a midwife as a woman who has graduated from a midwifery education programme, within the country or abroad, and has fulfilled the requirements to perform midwifery practice. Bolman and Deal (2017) argued that the symbolic dimension of an object or action evokes meaning in people based on a shared understanding. For participants in this study, the Midwifery Act 2019 could be seen to symbolise the authority and professional recognition of midwives, which has a powerful meaning in Indonesia.

9.2.2 The structural frame (key concepts: organisational structure, rules, roles, goal, technology, and environment)

Participants in this study raised concerns regarding the framework of midwifery

education. Values of status and authority for midwives potentially could lead to structural changes such as a national midwifery framework for education in Indonesia. Equity and autonomy can lead to opportunities and structural changes in the establishment of a professional midwifery programme and recognition of this programme (Kementerian Sekretariat Negara Republik Indonesia, 2019). Nevertheless, before the ratification of a Midwifery Act 2019, the government had approved a professional midwifery programme in some midwifery schools. It is claimed that restructuring midwifery education in Indonesia would: increase the quality of midwifery education and practice; provide the protection and certainty of law to midwives and clients; and, according to Kementerian Sekretariat Negara Republik Indonesia (2019), potentially increase the health status of the society, primarily maternal, newborn, baby, toddler and pre-school health.

In time, having a Midwifery Council and setting up a new structure with the role of regulating midwives will in effect ensure that status, authority, autonomy, and equity, along with the collaboration with other health professionals on an equal footing. Having a Midwifery Act and a legal pathway to the formation of a Midwifery Council clarifies the system in regard to keeping the goal of producing competent midwives. However, it is not possible to discuss such things without acknowledging the political drivers and context in which this will happen.

9.2.3 The political frame (key concepts: power, conflict, bargaining, allocate resource, decision making)

Political lobbying by the Midwifery Association since 2004-2005 (Ikatan Bidan Indonesia, 2016b, 2018), and political action in terms of legislation by the Indonesian Government, has led to the ratification of the Midwifery Act in March 2019. The Act revealed the political commitment from the Indonesian Government to professional recognition of midwives with the development of a professional midwifery programme. The participants in the study spoke at length about this lobbying and how important it was for gaining a Midwifery Act. Bolman and Deal (2017) argued that decisions made emerge from an ongoing process of bargaining and negotiation among major interest groups. Fifteen years of lobbying process revealed the challenges that the Midwifery Association faced when making a political movement towards a

Midwifery Act. Conflict and compromise embody the struggles of the Midwifery Association towards a Midwifery Act. Undoubtedly, political action has resulted in the most robust document of midwifery legislation in Indonesia. Leadership by senior midwives from the Midwifery Association indicates how and what they did to maintain a strong direction for the midwifery profession.

From a political perspective, Bolman and Deal (2017) pointed out that political agents have their agendas, resources and strategies. In line with this, participants, especially obstetricians, raised the need for a Midwifery Council to maintain midwives' standards and the quality of midwifery education. Based on the Midwifery Act 2019, a Midwifery Council will be formed which will be an autonomous body that will have, as one of its foci, the standard of midwifery education (Kementerian Sekretariat Negara Republik Indonesia, 2019). Therefore, the Midwifery Association needs to keep lobbying the government for the formation of a Midwifery Council.

9.2.4 The human resource frame (key concepts: human needs, skill, limitations, relationships)

The frame of human resources provides us with an opportunity to explore what kind of midwife there will be in Indonesia in the future. The ratification of a Midwifery Act closes the debate concerning the autonomy and the scope of midwifery practice.

The ratification of a Midwifery Act has implications for the level of education of midwives in the future. In the future, the professional midwifery education programme will be the only way and route to becoming an independent midwife who will be able to get a midwifery licence to open a private midwifery practice. Uncertainty during the lobbying process by the Midwifery Association has implications for vocationally educated midwives who want to open a private midwifery practice. In the transition process, the Midwifery Act 2019 makes provision for diploma and advanced diploma midwifery graduates who are already in private midwifery practice to apply for recognition of prior learning to be registered as a professional midwife within seven years of the Midwifery Act being ratified (Kementerian Sekretariat Negara Republik Indonesia, 2019). Nonetheless, the recognition of prior learning still has to be developed and until this happens there is a potential for this to impact on the

midwifery workforce.

9.2.5 Synthesis of new learning from the application of Bolman and Deal's Four Frames to key finding 1 (Professional recognition by having the Midwifery Act 2019)

Analysing the Midwifery Act through Bolman and Deal's Four Frames approach (using the symbolic, structural, political, and human resource frames) provides significant insight into factors which will further strengthen midwifery education in Indonesia. Even though, in the sections above, each frame has been analysed individually, a diagram below (Figure 9.1) represents the interconnection of the Four Frames as applied to the key finding of the Midwifery Act. Through the symbolic frame, it can be seen that the values and meaning the participants associate with the Midwifery Act are that it will increase the status of the midwifery profession, give authority to the midwifery voice, and facilitate autonomy and equity with other health professions. The tensions, and connections and complexities identified through the analysis are as follows:

1. A national midwifery framework for education in Indonesia and structural changes in the establishment of a professional midwifery programme came about because of the action and lobbying of the Midwifery Association which resulted in the Midwifery Act 2019 being ratified by the Indonesian Parliament. This will, in time, result in professional midwifery graduates, which potentially means that they can practise autonomously as independent midwives.
2. Setting up the Midwifery Council is required by the Midwifery Act 2019. This will require ongoing political action by the Midwifery Association to make this a reality, as only in this way will education be standardised and graduates produced that are both competent and professional.

Description:

-  : under the structural frame
-  : under the political frame
-  : under the human resource frame

Through the application of Bolman and Deal's Four Frames approach, new insights were gained about the importance of the Midwifery Act 2019, as follows:

1. Chapter 8 describes a need for a Midwifery Act. The analysis using the Four Frames has shown how the Midwifery Act 2019 and the associated setting up of a Midwifery Council, with a standardised professional midwifery programme, will impact significantly on the quality of midwifery practice and education.
2. The contribution of the Midwifery Association is significant to the change process concerning the Midwifery Act 2019, and so is the commitment of the Indonesian Government to enhancing the quality of midwife-led care.

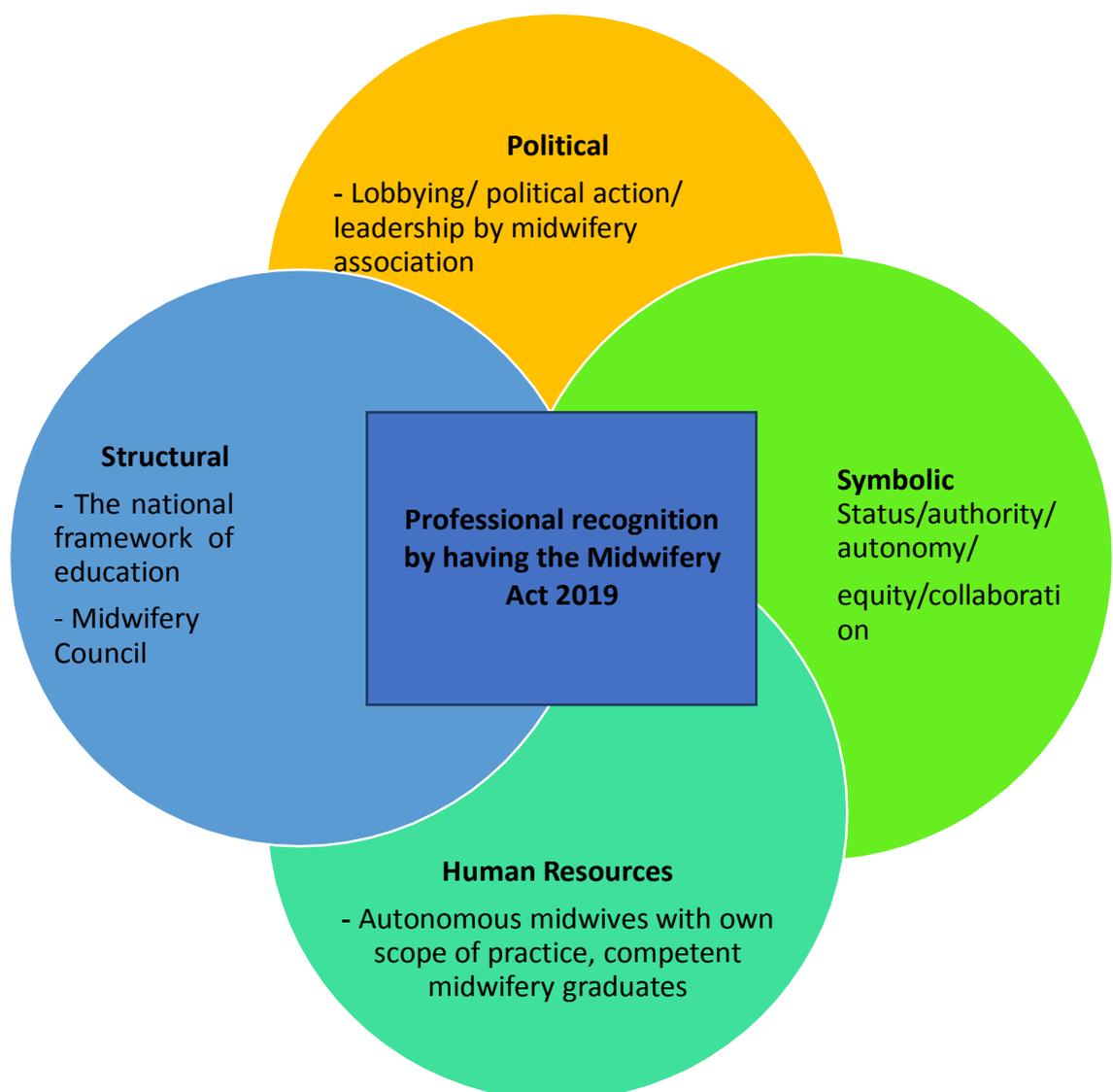


Figure 9.1 The application of Bolman and Deal's Four Frames to key finding 1 (Professional recognition by having the Midwifery Act 2019)

9.3 Key finding 2: Structural and external factors that impact on midwifery education

9.3.1 The symbolic frame (key concepts: meaning, belief, culture, values)

There was concern expressed by the participants about the different types of midwifery education programmes which led to the variability of midwifery education. The participants were clear that they valued consistency in the education of midwives and that every education programme should produce the same type of graduate who would graduate as a competent midwife, albeit at a beginning level. Furthermore, accreditation is considered significant for a midwifery education programme in Indonesia as accreditation aims to reduce variability in midwifery education programmes and can ensure consistent quality.

Midwifery in Indonesia is moving from vocational education programmes to academic and professional programmes. However, as yet there is no clear definition of what an academic or professional programme is, as this is yet to be developed. What is clear from the participants is that a standardised programme will ensure consistency between programmes. The professional programme aims to produce an autonomous midwifery graduate. Autonomy was seen by the participants as an essential attribute of a midwife.

In some midwifery circles, there appears to be a belief that new graduate midwives are not competent. This belief can be seen in structural requirements like the post-graduation competency training, which has been established by the Midwifery Association. This training was put in place by the association because new graduate midwives were not seen as work-ready or competent. The post-graduation competency training is seen by the midwifery schools and new midwives as a barrier which undervalues their education and skills. Participants suggested this will be addressed by ensuring consistency and quality of education. The passing of the Midwifery Act and the associated processes such as accreditation will hopefully make a big difference in this area and lead to a change both in the competence of and the meaning and beliefs about new midwives.

9.3.2 The structural frame (key concepts: organisational structure, rules, roles, goal, technology, and environment)

The Midwifery Act of 2019 will see a significant structural change in midwifery education as there is a transition from primarily vocational to academic and professional education programmes. From a structural frame perspective, Bolman and Deal (2017) discussed the idea that structures must be designed to fit the current circumstances. The professional programme has the potential to transform midwifery education and produce autonomous competent graduates. However, for this to happen, there are changes that need to be made. For example, the clinical sites (hospitals) need to be connected to the midwifery education programme as they play a critical role in midwifery student clinical experience. This would enable more clinical opportunities for midwifery students, lecturers, and midwives to work together in the teaching and learning processes. Integration between the hospital and midwifery education programmes would create a collaborative clinical environment to support the goals of midwifery education. The rules and policies which determine how these institutions operate need to be reviewed to break down barriers, and ensure collaborative decision-making, which in turn would improve student midwives learning.

There are two structural frameworks which relate to quality and competence in midwifery education. The first of these frameworks is the national competency test which, at the time of the research, students had to pass after they graduated. This test is in place primarily as midwifery graduates are not seen as competent and many fail this competency test. The passing of the Midwifery Act 2019 means that the national competency test will now be taken before graduation. The second framework is called the post-graduation competency training and is required by the Midwifery Association. The association carries out a competency assessment of the new midwife before registration and entry into the midwifery workforce. Through this training, the Midwifery Association aims to provide professional development for new midwives. The Midwifery Association sees this as supporting new graduates. Increasingly, as midwifery education is standardised and accredited, these tests and competency assessments may become redundant. Accreditation is a crucial external-structural framework that has the potential to impact significantly on and strengthen

midwifery education as it can ensure quality assurance of midwifery education that will lead to competent midwifery graduates. This one structural change would in effect address two of the issues raised by the participants, namely issues of quality and consistency.

9.3.3 The political frame (key concepts: power, conflict, bargaining, allocate resource, decision making)

Midwifery education is a complex system which has evolved and altered in response to research, new knowledge in midwifery, understanding women's expectations, and the political context in the country. Participants in this study spoke of politics as being a critical factor in determining midwifery education. Bolman and Deal (2017) discussed the idea that politics are "arenas hosting ongoing contests of individual and group interest" (p. 184); therefore, coalitions form because of interconnections among its members; and competing groups articulate preferences and mobilise power to get what they want. This can be clearly seen in the political action and policies led by the Midwifery Association and the government concerning the national competency test and the post-graduation competency training. The Midwifery Association has both the authority and power to act on their concerns regarding the competency of new graduates. The post-graduation competency training sits outside midwifery education and was seen by the schools to undermine their educational programmes, and made newly graduated midwives feel incompetent. This illustrates how, in Indonesia, there are different groups at times with competing interests who can politically influence what will happen in midwifery education and what 'competence' means for a new graduate midwife.

Furthermore, complexity is seen in the changing landscape of midwifery education with the passing of the Midwifery Act in 2019. This Act and the proposed national midwifery education framework mean that not all education programmes of midwives will continue. The Act indicates that the advanced diploma of midwifery programme is no longer considered fit for purpose. The political debate among decision-makers over the last 15 years meant that the advanced diploma of midwifery programme was established as a 'crash programme' to increase the numbers of midwives quickly in Indonesia. However, the advanced diploma has not supported the production of

'competent' graduates to provide quality midwifery services. This has in part been part of a complex picture which meant Indonesia did not meet the MDG 2015 target. The professional education programme will raise the level of education as based on Indonesia Qualification Framework (IQF), and this will, in turn, lead to midwifery having the status of an autonomous profession in Indonesia. It appears that a decision has been taken and policies formulated which privilege a professional midwifery programme over the advanced diploma of midwifery programme. This stance came about because of significant lobbying by the Midwifery Association together with decision-makers among universities and education institutions at the national level. This will impact significantly on midwifery education in Indonesia and potentially could address many of the concerns raised by the participants concerning quality and consistency.

Alongside this, the Midwifery Association and the education institutes need to decide how to formalise the integration between the hospital and midwifery schools as the hospitals play a critical role in students' learning. Therefore, politically active collaboration across many parties is required to influence the processes and procedures of the integration of the hospital and midwifery schools.

From a political perspective, requirements for accreditation are a primary driver to ensure quality and consistency. Accreditation processes will provide a setting in which to regulate the complex environment of midwifery education, as Bolman and Deal (2017) suggested "exercising power is a natural part of ongoing contests" (p. 199) and "politics can be a vehicle for achieving noble purposes" (p. 234). The position of accreditation as an external structure can potentially create a transparent process of teaching and learning to strengthen midwifery education.

9.3.4 The human resource frame (key concepts: human needs, skill, limitations, relationships)

The political decisions and structural changes under this key finding have impacted on midwives financially and in their career progression. Before the ratification of the Midwifery Act 2019, midwifery graduates from whatever midwifery programme obtained the same registration and could open a private midwifery practice. However,

since the Midwifery Act, the structural and political changes privilege professional midwifery programmes which means only graduates from these programmes will be able to work in private practice. Some allowance is being made for midwives from the diploma or advanced diploma who want to work in private practice, but there will be important processes which include recognition of prior learning for them to complete before being able to do this. There are a number of other human resource considerations which are impacted by structural and external factors. These include collaboration and dialogue across many parties to encourage: the integration between the hospital and midwifery schools; that the post-graduation competency training does not continue to be an obstacle to new graduates entering the workforce; the national competency test and accreditation which ensure consistent standards leading to a competent and work-ready midwifery workforce.

9.3.5 Synthesis of new learning from the application of Bolman and Deal's Four Frames to key finding 2 (Structural and external factors that impact on midwifery education)

The application of Bolman and Deal's Four Frames to the structural and external factors reveals the complexity of this key finding. While in the section above each frame has been explored separately, they are, in fact, interconnected and impact on and influence each other. They are each held together by what Bolman and Deal (2017) call the 'superglue' which is the symbolic frame (p. 242). The 'superglue', the values and beliefs presented by the participants that give meaning and direction to what should inform the structural and external factors are ensuring that variability was reduced and consistency achieved across all midwifery programmes, leading to quality programmes and competent midwifery graduates. The symbolic frame can be seen to inform and connect the tensions and interconnections identified in the analysis:

1. The transition from a vocational to a professional midwifery programme explored under the structural frame is impacted by political action which in turn affects the career and financial position of midwives.
2. The recognition that the hospitals and educational institutions need to be connected and work in an integrated way will only happen if there a change in the policy and the rules that govern student clinical placements as this will ensure competent graduates from the midwifery programme.

3. The significant change to the national competency test is impacted by political action as this will ensure consistent standard in assessing the competence of midwifery students before graduation.
4. The post-graduation competency training analysed under the structural frame decided by the government and the Midwifery Association as another assessment of competence process was seen as a disadvantage that limits the ability of new midwives to enter the midwifery workforce.
5. Accreditation will ensure quality assurance and will provide a framework to regulate the complex environment of midwifery education that will lead to competent midwifery graduates.

Description:

-  : under the structural frame
-  : under the political frame
-  : under the human resource frame

This analysis can be seen to be held together by the ‘superglue’ by the need to ensure consistency leading to quality education and competent graduates. If all of these things can come together in this way, midwifery education in Indonesia will be strengthened.

Part of the purpose of using the Four Frames to explore further and add depth to the findings was to articulate what new learning had taken place in applying this framework. The application of the frames to structural and external forces impacting on education provide new insight into:

1. The influence of political forces on changes in midwifery education and who decides what takes place in midwifery education.
2. What needs to happen for things to become a reality such as the national midwifery education framework, and the integration of hospitals and education providers.
3. Clearer articulation of the values and drivers and the players who are involved in ensuring a competent midwifery graduate

While Chapter 8 clearly describes what the participants said about the structural and external factors that impact the further analysis, using the Four Frames has shown the

connections between these factors, how one factor influences and impacts on the other, and thus provides some further insight into how change may take place to strengthen midwifery education in Indonesia.

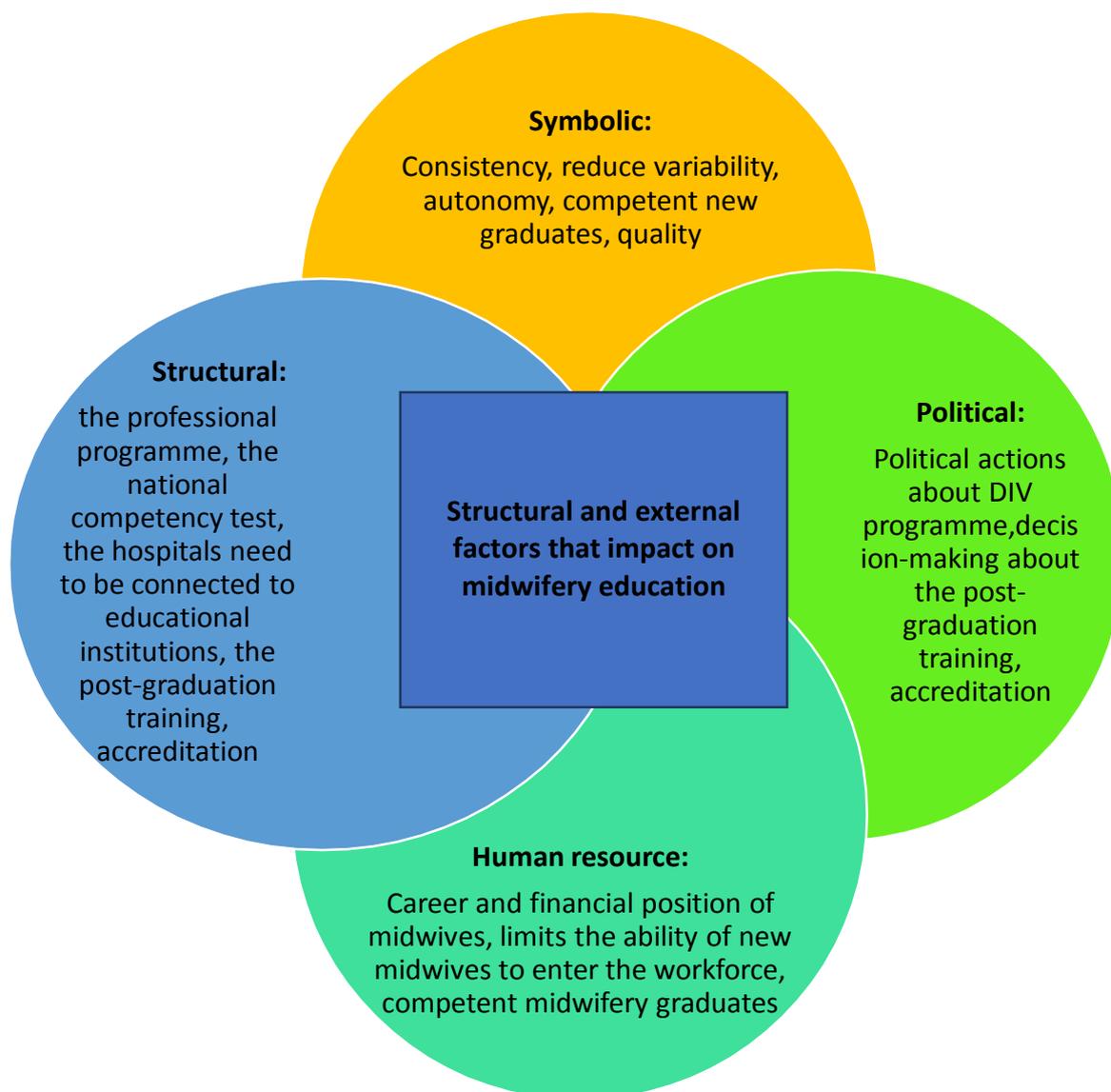


Figure 9.2 The application of Bolman and Deal's Four Frames to key finding 2 (Structural and external factors that impact on midwifery education)

9.4 Key finding 3: Clinical experience to become a competent midwife

9.4.1 The symbolic frame (key concepts: meaning, belief, culture, values)

There were some clear values that underpinned the participants' insistence that clinical experience was something that needs to be addressed to strengthen midwifery education. Participants valued 'hands-on' experience working with women as they believed this was when the best learning happened and potentially would ensure

midwives could make a difference to outcomes for women and babies. They described in detail the barriers to students becoming competent midwives without significant 'hands-on' experience. While 'hands-on' experience was valued, the way students did clinical practice was also brought into question by the participants. Participants saw women-centred care as being essential for providing the best service to women. Participants also spoke at length about clinical practice that was divided up, for example, with one student doing the 1st stage, another doing the 2nd stage and yet another doing the 3rd stage of labour, all for one woman. The concern was that a woman had too many students looking after her, which was not a woman-centred but student-centred approach, and even that could be debated, but it showed a lack of respect for the woman. The value of 'hands-on' experience and women-centred care informed the need for changes to clinical practice. One of the areas of particular concern for participants was that the students learnt to develop empathy which is essential in Indonesia. Midwives are expected to be empathic, and so this needs to translate through to working with women. Alongside women-centred care, the other significant value for students' clinical experience was that of relationship and the connection that happens through continuity of care. Continuity of care facilitates the student working in partnership with the woman and learning how to build trust and to communicate effectively. This is particularly important in Indonesia, where women often feel they are not in charge of their pregnancy. All of these things were valued highly by the participants in enabling students to become competent midwives who are able to work with women.

One of the critical factors identified in the research was the culture of teaching and learning in clinical practice. The midwifery mentor often leads the culture of the clinical placement, and they play a crucial role in student clinical learning. The mentors are often required to focus on the clinical targets the students need to meet, for example, a number of births that students need to get in clinical placement, as numbers and hours are seen to equal competence. This can get in the way of mentors being able to provide high-quality midwifery-led and women-centred care. If students are to become midwives who uphold and embody midwifery values by learning from the role modelling of their mentors, it is essential that the mentors are able to create a

midwifery learning space. It is only in this way that the values of midwifery will then be modelled and learnt in the clinical setting.

9.4.2 The structural frame (key concepts: organisational structure, rules, roles, goal, technology, and environment)

There are a number of structures, hospital and educational hierarchies that, along with the clinical environment, impact significantly on midwifery clinical experience for students. The primary concern is the type of clinical experience the student gets along with the quality of that experience in regard to teaching and learning. The system of clinical practice in Indonesia is that of fragmented care, as discussed under the symbolic frame, and this often means a number of midwifery students are in the one room or clinic all focused on one woman or baby. The organisation of clinical placements is controlled by the hospitals, and the midwifery mentors are appointed by the hospital and have multiple roles that they are trying to fulfil each day. Midwifery students follow the midwifery unit roster set by the clinical coordinator and mentor, and again, this means the hospital determines the type and quality of student placements. However, if the students cannot reach their clinical targets, they have to pay themselves for more clinical experience. Fees paid by midwifery students for additional clinical experience reflect a system that is not able to provide adequate and quality clinical experience and meet targeted requirements. It also demonstrates an environment that is not student-focused or friendly, as the student is the one who carries the responsibility for deficits in a system which cannot provide them with the clinical placements they require. Therefore, one of the structural changes suggested by the participants was that clinical placements are reviewed and those who have the authority to protect a woman, and also ensure the best clinical experience for midwifery students, should work to do so.

The structure and requirements of the midwifery curriculum and theory learning also impact on clinical practice in that what is taught does not always equate to what happens in clinical practice. There is sometimes a significant theory-practice gap, even though education providers work hard to make sure that there is no gap. Education providers have discussed their programmes with stakeholders and also ensured the ratio of theoretical to practical learning experiences meets international standards.

Standardised and regular review of the curriculum, as happens in the diploma of midwifery, is an effective system for both recognising this gap and taking steps to rectify any issues that arise.

There is a commitment by some midwifery schools to implement continuity of care. However, the implementation of this is difficult as there is often no logistical structure in place which could support student midwives in providing continuity of care for a woman. There needs to be significant work carried out at a number of levels, such as the Midwifery Association, hospitals and public health officials, as they need to ensure the necessary frameworks, policies and guidelines are put in place so that the continuity of care can be effectively and safely implemented.

9.4.3 The political frame (key concepts: power, conflict, bargaining, allocate resource, decision making)

Many of the participants in the research echoed the values that are set out in the Midwifery Act, as they also saw women-centred care as being at the heart of midwifery. There appears to be congruence between the political and legislative expectations of a midwife in practice and the values and beliefs of the midwives themselves.

Many government documents concerning midwifery and the scope of midwifery practice position midwives as the front-line providers of maternal-neonatal health outcomes in the health system in Indonesia (Keputusan Menteri Kesehatan Republik Indonesia, 2010; Menteri Kesehatan Republik Indonesia, 2007, 2017). The Midwifery Act 2019 sets out clearly the expectation that midwifery practice is based on humanity, science, ethics, professionalism, justice, protection and client safety, and it aims to increase maternal and neonatal health status. The government has also been strong in stating that midwifery care in Indonesia is women-centred (Menteri Kesehatan Republik Indonesia, 2007). Although political frames are often focused on power, Bolman and Deal (2017) stated that it is incorrect to assume that power only comes from the top down; instead, it exists at every level of an organisation.

In Indonesia, the Midwifery Association has been politically active and among other things has set the clinical targets for student midwives to ensure they get the practice they need to be competent midwives. This position has been divisive as midwifery schools can resist or resent the authority of the association over midwifery education. Bolman and Deal (2017) argued that it is possible to exercise coercive power in an organisation where coercive power rests on the ability to constrain, block, interfere, or punish. The setting of targets can be directly related to the Midwifery Association's concern about the competence of new graduate midwives. Midwifery targets are commonly used in various countries by regulators to ensure students have adequate clinical experience and maybe, when there is a Midwifery Council in Indonesia, the regulation of this space may help standardise and ensure the quality of these midwifery targets.

The authority of the hospitals in Indonesia means that they in effect regulate clinical placements as they mark it as their 'territory'. Participants in this study saw the power of the hospitals supported by their bureaucracy and resources giving them authority to determine the quality and quantity of student placements. In effect, the leaders, managers and decision-makers in the hospitals can be a barrier to the provision and organisation of midwifery students' clinical placements. There is a real need for education providers and hospitals to work closely together to ensure quality clinical placements as this serves the interest of both since these students are the future workforce of the hospital.

9.4.4 The human resources frame (key concepts: human needs, skill, limitations, relationships)

The values explored in the symbolic frame provide insight into the type of midwife the participants want to see in Indonesia. The midwife will have knowledge and skills built from hands-on experience, and it is crucial that their clinical experience is not primarily focused just on labour and birth but across the scope of midwifery practice. Midwifery students need to be supported to provide good midwifery care during pregnancy, labour, birth and postnatal time. They need to be able to both work in normal pregnancy and birth and deal with complications and emergencies, including neonatal resuscitation and immediate care of the newborn. As explored in the structural and

political frames, midwives will be the front-line workers making a difference to outcomes for women and babies. A key ingredient in developing such a competent midwife on graduation is the midwife mentor, and this is an essential human resource consideration in that significant investment needs to be made in supporting and developing midwifery mentors.

Support and development would enable the mentors to work in a way that they are not focused just on the targets required by the midwifery schools but can demonstrate competent high-quality midwifery practice for students to learn from. Having standardised criteria for midwife mentors to guide midwifery students would be valuable for clinical experience and would provide a level of equity between midwifery lecturers and mentors. Midwifery lecturers and mentors should have equal status and should work together in developing the competence of midwifery students. Providing high-quality clinical experience for midwifery students, will contribute toward a competent midwifery workforce providing quality care.

The financial costs, as discussed under the structural frame, impact also in the area of human resources as midwifery student progression through the midwifery programmes can be delayed significantly due to these additional clinical costs.

9.4.5 Synthesis of new learning from the application of Bolman and Deal's Four Frames to key finding 3 (Clinical experience to become a competent midwife)

The analysis carried out through the use of Bolman and Deal's Four Frames above provides some insight into the complexity of clinical experience and the issues that need to be addressed to develop the competency of midwifery students at clinical sites. The analysis of the data reveals the connection between each frame and the interrelated nature of the frames shows the challenges concerning the clinical experience. Through the symbolic frame, the values and beliefs of the participants, such as hands-on experience, women-centred care, empathy, and a culture of student-centred teaching and learning in clinical sites, offer some insight into how the structural and political frames need to build the competency of midwifery students. The complexities and tensions in the clinical experience, reveal the interconnections as follows:

1. The gap between what is taught and what happens in practice shows itself as a significant theory-practice gap and it is hoped that standardised and regular review of midwifery curriculum will close this gap and lead to midwifery students who are both knowledgeable and skilled in practice.
2. The hospital, educational hierarchies, and the clinical environment need to move into a collaborative relationship whereby they can work together to ensure that the students' clinical experience is women-centred and has significant hands-on experience so they can become competent midwives on graduation.
3. The clinical environment provides opportunities for midwifery students to develop their skills and this in turn impacts on their ability to meet the targets set by the Midwifery Association which are essential for developing competent midwives who deal with complications and emergencies.
4. The system of clinical practice to meet the targets set by the Midwifery Association impacts on the financial burden of midwifery students who need additional clinical experience.
5. At present, much of the students' clinical experience is of fragmented care and it is hoped that continuity of care with increasingly become the norm, but this will require changes to policy and guidelines and how workplaces are organised, and will require the hospital, public health officials and the Midwifery Association to work closely together.
6. The culture of teaching and learning in clinical practice is dependent on the mentors and the role they play. It is essential that the mentors are able to create a midwifery learning space. For this to happen, hospitals and educational institutes and, possibly, the Midwifery Association need to ensure that there are standardised criteria for midwife mentors and that they are remunerated appropriately. This will mean that midwifery students become highly skilled in clinical practice.

Description:

-  : under the structural frame
-  : under the political frame
-  : under the human resource frame

The application of Bolman and Deal's Four Frames to the key finding on clinical experience offered some new insights into how to strengthen midwifery education in Indonesia, as follows:

1. To develop the competency of midwifery students who will then become competent graduates, the decision-makers and educational leaders must go beyond the 'targets' and focus on providing quality clinical experience ensuring students become competent across the midwifery scope.
2. Education providers and midwifery mentors who guide the midwifery students at the clinical sites have to understand how important their position is and take a leadership role in ensuring students gain the quality clinical experience they need to be competent on graduation.

In Chapter 7 there was both a description and exploration of how the participants saw midwifery clinical experience. The further analysis through the Four Frames has shown how best to support the clinical experience, and so develop a competent midwife.

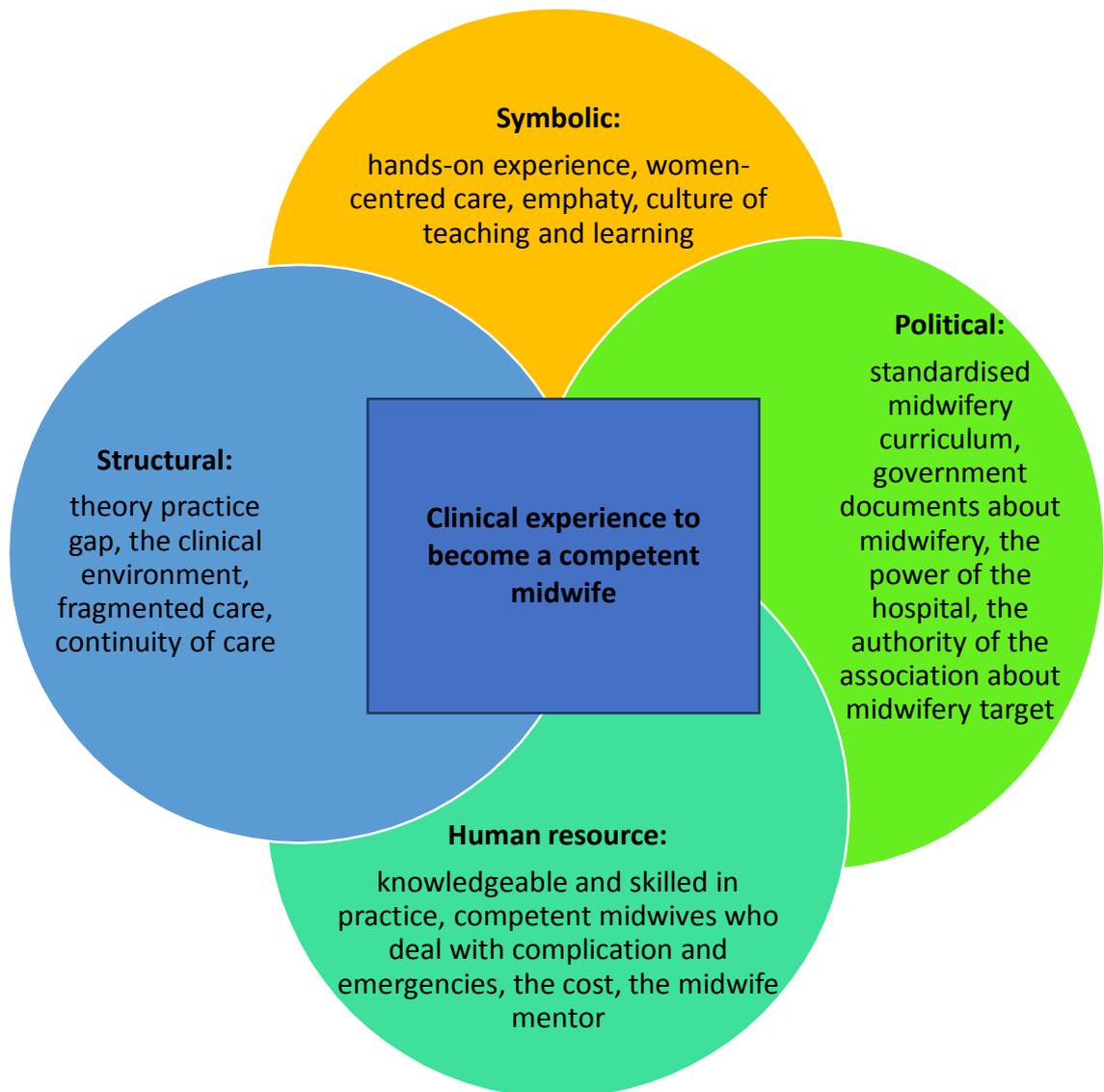


Figure 9.3 The application of Bolman and Deal's Four Frames to key finding 3 (Clinical experience to become a competent midwife)

9.5 Key finding 4: Effective teaching and learning of theory

9.5.1 The symbolic frame (key concepts: meaning, belief, culture, values)

The values that the participants identified as strengthening teaching and learning of theory processes were primarily around shifting from a teacher-based to student-centred teaching and learning. The meaning of this shift was captured in the suggestions the participants gave such as problem-based learning, the tutorial system and small group teaching and learning. This approach was seen to facilitate critical thinking and better learning, and required the teachers to be both creative and

innovative in their teaching. This was illustrated in the tutorial system, which was seen as promoting collaboration and connected both the teacher and the student to the teaching and learning process. In this key finding, a good midwifery lecturer was seen as inspirational as she had the ability to facilitate and foster teaching and learning. For instance, she could tell the 'stories' of practice which inform the teaching process and through this show the 'spirit' of midwifery. Bolman and Deal (2017, p. 276) stated that the 'spirit' of something (how someone feels about something and is connected to it) is essential to the meaning and value of work. In the data, it appears that if the midwifery lecturer was not connected to clinical practice, then there was something missing in the 'spirit' of her teaching.

One factor in the data that many participants spoke of as impacting significantly on effective teaching and learning of theory was that of the motivation of the student midwife. For many students, the values that motivated them were wanting to help the community, seeing midwifery as a respected, even a noble profession, and wanting to make a difference to women and their families. These students were more likely to engage with and in teaching and learning. In the data, it was clear that they were motivated to become highly-skilled midwives in the community and, for this to happen, they needed good knowledge and midwifery skills, and this motivated them to learn. Conversely, if the students had entered into midwifery because of family or other pressures, they were less likely to want to learn and to engage in teaching and learning. This is a complex issue and revealed some of the beliefs that inform the way of life in Indonesia. On the one hand, the religious belief, such as the concept of '*ikhlas*', explains the sincerity and kindness that support the student to want to become a competent midwife. On the other hand, the value of the parents knowing what is best meant the students obey them but this could create a barrier to them engaging in the teaching and learning processes if they did not really want to be a midwife. Bolman and Deal (2017) pointed out that values reflect a core ideology that shapes people. Values were identified as being a strong motivator which impacted on the midwifery teaching and learning processes for some positively and others negatively.

9.5.2 The structural frame (key concepts: organisational structure, rules, roles, goal, technology, and environment)

The midwifery teachers were committed to utilising different styles of teaching, such as storytelling and problem-based learning, to improve teaching and learning of theory. Even though problem-based learning was seen as challenging for both midwifery lecturers and midwifery students, it was seen as vital as it developed critical thinking. Bolman and Deal (2017) pointed out the significance of establishing organisational goals as the vehicle for moving the organisation forward. The goal of fostering better teaching and learning involved different styles of teaching which in turn required new strategies and a different learning environment. However, moving from a teacher-to a student-centred approach posed a number of challenges and one of them, as mentioned under the symbolic frame, was motivation. Student not engaging with the teaching and learning often meant that the lecturer would feel they had to move from tutorial/small group to more structured/didactic teaching. This created a disruption to effective teaching and learning of theory through the strategies outlined above.

There are a number of other formal structures and rules that impact on teaching and learning. The first of these is the requirement that English is taught as a subject in the midwifery programme. In Indonesia, English is seen as the language most commonly used in academic writing, research and educational resources. This creates a barrier for students' learning as many students are not fluent in English. The second factor that impacts on teaching learning is that obstetricians are part of teaching midwifery students and they also review the curriculum in some midwifery schools as they are the head of the midwifery department. The obstetricians are appointed to this role by the government because the medical profession is seen as being the most 'expert' in this field and so has the best credentials to lead a midwifery programme. Structurally, the involvement of obstetricians at this level in the midwifery programme raises the question of who controls midwifery education.

The structural factors that impact on effective teaching and learning of theory are the inadequate resources such as out-of-date textbooks, lack of mannequins, and unstable internet, all which were identified as barriers to effective teaching and learning of

theory. The exploration of midwifery lecturers needing to be clinically practising, as explored under the symbolic frame, poses a very real need to address the structure/environment that will enable midwifery teachers to both teach and practice clinically. This will need to be supported by new policy that will facilitate midwifery lecturers being connected to practise which will, in turn, enhance effective teaching and learning of theory.

9.5.3 The political frame (key concepts: power, conflict, bargaining, allocate resource, decision making)

There are a number of political factors that impact on effective teaching and learning of theory. One of these, as already mentioned, is the appointment by the government of obstetricians as heads of midwifery programmes. This means that obstetricians design midwifery education, decide how new graduates will be prepared for practice and also set strategic directions for midwifery education within their institutions. The government considers obstetricians to be experts in the field who would develop a shared leadership model and cultivate an academic environment. They see the obstetricians as ensuring high-quality midwifery education programmes using their expertise around complicated childbirth. The ICM, in their education standards, are clear that midwives need to be teaching midwives. The Midwifery Association is in the process of negotiating about midwives leading midwifery education programmes.

The other political factor that impacts on effective teaching and learning of theory is the decision by the authorities concerning teaching and learning processes. The Head of Schools has directed the midwifery schools to ensure that there are tutorials, small classes, and other learning approaches, including the English language as a subject (Fakultas Kedokteran Universitas Padjadjaran, 2015; Kementerian Kesehatan Republik Indonesia, 2011; Midwifery Undergraduate Degree Program Fakultas Kedokteran Universitas Brawijaya, 2016). The government also needs to ensure that the midwifery programmes support midwifery lecturers to practise clinically as this will strengthen teaching and learning. From a political perspective, the government has requirements for a registered midwifery lecturer, but this focuses primarily on teaching theory and not on the need to be practising clinically. It would be good to see this change as it would impact significantly on effective teaching and learning of theory.

Participants also spoke about how the decision-making process happens in allocating learning resources. This area needs considerable attention to ensure high-quality resources are available for all students. This was considered the responsibility of the heads of the midwifery schools.

9.5.4 The human resource frame (key concepts: human needs, skill, limitations, relationships)

One of the values explored in the symbolic frame was the motivation to be a midwife which can impact significantly on effective teaching and learning of theory as the participants shared how unmotivated students required extra time and energy from midwifery lecturers and midwife mentors.

Furthermore, the midwifery lecturers need time and education to learn how to use the tutorial system, facilitate small class learning and use different styles of teaching and learning, such as storytelling and problem-based learning. The changes in teaching and learning processes were directly linked to developing the knowledge and skills of midwifery students. This will ensure the midwifery students are well prepared for midwifery practice and work-ready for the role and responsibilities of being a midwife. The midwifery lecturers need to be resourced to support innovative teaching and also to practice clinically in a supportive clinical environment. A key human resource challenge for the future is to prepare midwives to lead midwifery programmes, as this will not only meet the ICM standards but will further strengthen midwifery education in Indonesia.

9.5.5 Synthesis of new learning from the application of Bolman and Deal's Four Frames to key finding 4 (Effective teaching and learning of theory)

The key findings analysed through the Four Frames add more understanding and reveal the complexity in effective teaching and learning of theory, specifically the role of the midwifery lecturer. The application of the symbolic frame showed that, for the participants, the values of student-centred learning, tutorial-based learning, small classes, problem-based learning, facilitating critical thinking and decision-making,

creative and innovative teaching, and motivation give the foundation on which to base effective teaching and learning of theory.

The application of the Four Frames informed by the symbolic values revealed the following interconnections between the frames:

1. **The changes in effective teaching and learning of theory** as decided by the educational leaders of the midwifery education programmes will facilitate critical thinking and further develop knowledge and skills leading to work-ready midwifery graduates.
2. **The inadequate learning resources** need considerable attention from the educational leaders to better support the teaching and learning processes, which in turn will promote better teaching and learning for midwifery students and midwifery lecturers.
3. **The structure/environment that will enable midwifery lecturers to both teach and practice clinically** requires the decision-makers to take the initiative to make the changes, so the midwifery lecturers are supported to practise clinically.
4. **The position of obstetricians in some midwifery schools as the heads of the midwifery departments, as decided by the government, needs to be explored to prepare midwives to lead midwifery programmes.**

Description:

-  : under the structural frame
-  : under the political frame
-  : under the human resource frame

The application of Bolman and Deal's Four Frames to the key finding on effective teaching and learning of theory provided some new insights into how to enhance midwifery education in Indonesia, as follows:

1. Effective teaching and learning of theory need to cultivate the motivation of those students who came to midwifery because of family or other pressures so they can stay in midwifery. Unmotivated participants can be shaped and influenced by midwifery lecturers and midwife mentors gain a passion and heart for midwifery.

2. There needs to be vision and commitment to supporting midwifery lecturers to be practising clinically. This will require collaboration across the sector with all parties (heads of midwifery, directors of hospitals, the Ministry of Health, the Midwifery Association) agreeing to this as important in providing quality midwifery education.
3. A supportive environment, both theoretical and clinical, that is student-centred needs to be created and maintained to build a system which will foster high-quality teaching and learning.

The analysis using Bolman and Deal's Four Frames reveals the complexity and tensions in effective teaching and learning of theory to enhance midwifery education programmes, which can then strengthen midwifery education in Indonesia.

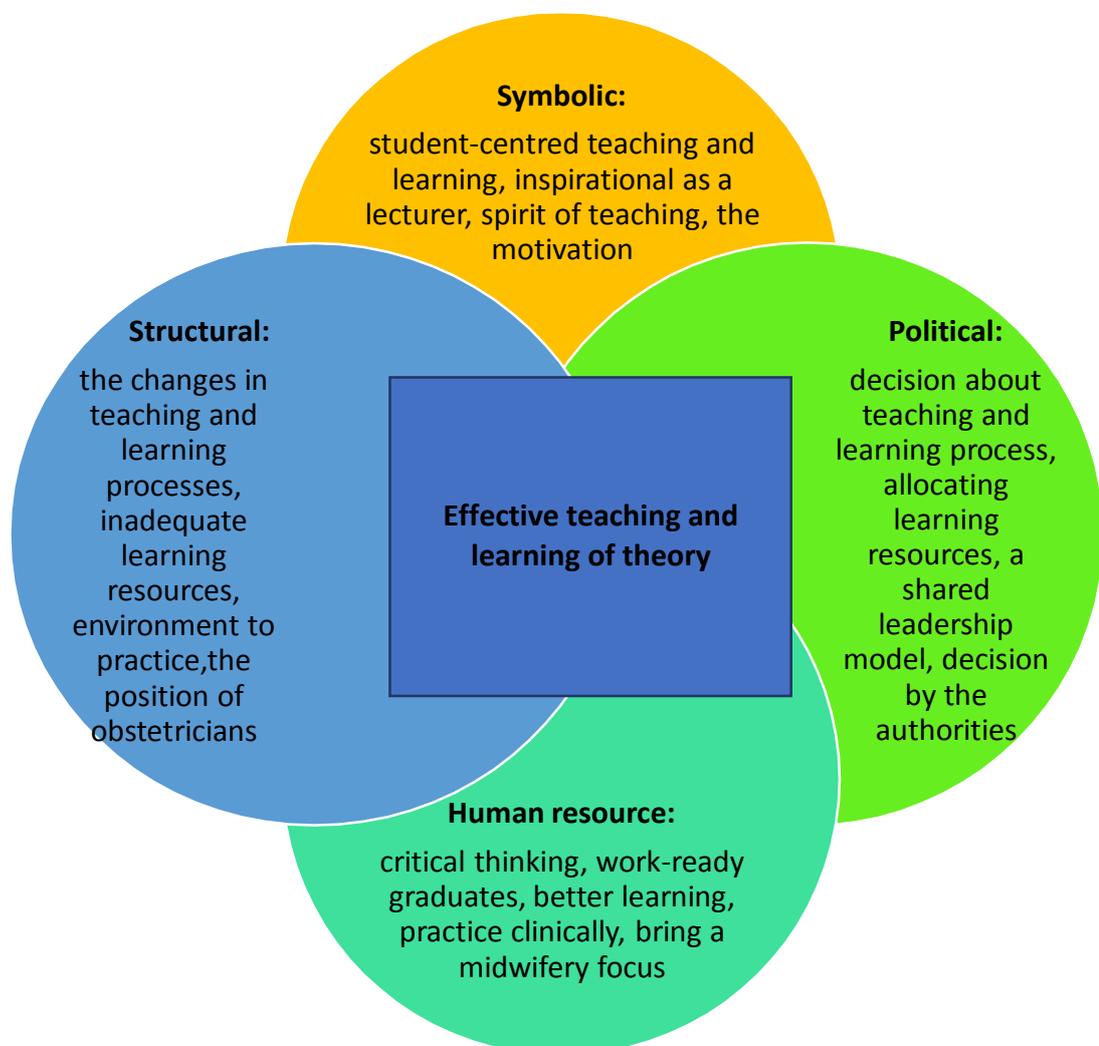


Figure 9.4 The application of Bolman and Deal's Four Frames to key finding 4 (Effective teaching and learning of theory)

9.6 Summary of Chapter 9

This chapter has explored the findings through the application of Bolman and Deal's Four Frames that sought to further deepen the analysis of the findings and provide new insights around what will strengthen midwifery education in Indonesia. The qualitative analysis found three findings (midwifery teaching and learning of theory, midwifery clinical experience, structural and external factors) and the application of Bolman and Deal's Four Frames revealed a fourth finding (the Midwifery Act 2019). The next chapter integrates the four key findings of this study, discusses them in the light of other contemporary literature, and makes recommendations for research, education, and practice.

Chapter 10.

Discussion and Conclusion

10.1 Introduction

This research has explored the experience of midwives, midwifery lecturers, midwifery students, newly graduated midwives, and obstetricians, with a view to uncovering what can be done to strengthen midwifery education in Indonesia. This chapter discusses the four key findings which emerged: midwifery teaching and learning of theory, midwifery clinical experience, structural and external factors, and the Midwifery Act 2019. The different levels (macro-, meso, and micro-levels) used to structure and organise the findings of this chapter. These levels of exploration are well known in the literature of sociology and social sciences (Collins, 1988; Li, 2012; Schillo, Fischer, & Klein, 2000; Serpa, & Ferreira, 2019; Turner, 2005), and they have been used in this discussion chapter in the following way:

1. The macro-level looks at the large systems and frameworks at the government, institutional national and global levels and the way they impact midwifery education.
2. The meso-level looks at the functions and roles of the organisations and systems (identified at the macro-level) and includes the relationships between institutions and workplaces.
3. The micro-level looks at the individual and the relationships between individuals and the environment.

This chapter articulates clearly the contribution of this study to the body of knowledge about midwifery in Indonesia and identifies its limitations. The key findings are explored in relation to other literature and research. Recommendations for practice, education and research are presented along with a conclusion.

10.2 Drawing the findings of the research together

The findings are organised using the different levels (macro-, meso-, and micro-levels) to make clear the complexity and interconnection of key factors which will strengthen midwifery education (see Table 10.1).

Table 10.1 Drawing the findings of the research together

Macro-level	Meso-level	Micro-level
<ol style="list-style-type: none"> 1. The Midwifery Act 2019, including ensuring a national midwifery framework of education and, in time, the establishment of the Midwifery Council 2. National accreditation standards under the new accreditation agency (LAMP-PTKes) which includes a midwifery section. 	<ol style="list-style-type: none"> 1. The requirement for post-graduation competency training 2. Having quality clinical experience: <ol style="list-style-type: none"> a. Effective hands-on experience a. The system in the clinical environment b. Developing continuity of care c. Collaboration across different institutions and organisations, including the integration of hospitals and education providers 	<ol style="list-style-type: none"> 1. Effective teaching and learning of theory, including learning resources 2. Motivation to study and stay in midwifery 3. Midwifery lecturer needs to be clinically current 4. Role of the mentor in practice

10.2.1 Macro-level

This study shows strengthening midwifery education in Indonesia will be influenced at the macro-level by:

1. The Midwifery Act 2019, including ensuring a national midwifery framework of education and, in time, the establishment of a Midwifery Council
2. The new accreditation agency (LAMP-PTKes) and in particular national accreditation standards

10.2.1.1 The Midwifery Act 2019, including ensuring a national midwifery framework of education and, in time, the establishment of the Midwifery Council

This research identified that the Midwifery Act 2019 is essential to provide a foundation that will strengthen midwifery education in Indonesia. The findings of this study reinforce what contemporary literature related to developing countries shows about the negative impact of an absence of midwifery regulation and, primarily, a Midwifery Act mean when there is no legislative framework to support the development of midwifery education (Bogren et al., 2013; Bogren et al., 2012; Dawson et al., 2016; Gross et al., 2011; Homer et al., 2017; McCarthy et al., 2013). However, a Midwifery Act is a powerful tool in all matters related to midwifery, including midwifery education, and this is clear from research on the experience of other countries such as Canada, Brunei Darussalam, New Zealand, the United Kingdom, and Australia (Bogossian, 1998; Gilkison et al., 2013; Massey, 1993; Mumin, 2015; Perez-Botella & Downe, 2006). The road to the 2019 Midwifery Act started 150 years ago with the establishment of midwifery education in Indonesia (Hesselink, 2011; Ikatan Bidan Indonesia, 2016; Indonesian Midwives Association, 2015; Kementerian Sekretariat Negara Republik Indonesia, 2019; Wiknjosastro, 1979). It is clear, then, that the ratification of the Midwifery Act 2019 is an important event providing an opportunity for midwives to claim autonomy, while also showing the commitment of the Indonesian Government to providing midwifery legislation which will significantly impact on the quality of midwifery practice and midwifery education.

1. Ensuring a national midwifery framework of education

The Midwifery Act is a vital ingredient in ensuring a national midwifery framework of education in Indonesia. Just as the passing of a Midwifery Act in a number of countries, such as New Zealand and Brunei, can be linked to the national midwifery framework for education (Mumin, 2015; Pairman, 2000, 2005, 2006), this has also been the case in Indonesia, where the 2019 Midwifery Act has established a national midwifery framework for education. This framework means that the professional midwifery programme is now the only route to becoming an independent midwife and to getting a midwifery licence to open a private midwifery practice. This will mean that midwives in Indonesia meet the ICM midwifery education standards and competencies for practice (ICM, 2012, 2013, 2017).

2. The establishment of the Midwifery Council

This study highlighted that the establishment of a Midwifery Council will strengthen midwifery education. Other countries, such as New Zealand and the United Kingdom, have ensured the professional standards of midwives and midwifery education by the establishment of a Midwifery Council (Gilkison et al., 2013; Midwifery Council of New Zealand, 2018; Nursing and Midwifery Council, 2016). Even though the ratification of the Midwifery Act 2019 enhances midwifery education, the establishment of a Midwifery Council is also required to standardise midwifery education, as such a council serves to ensure a high standard of midwifery education resulting in competent and confident new midwives who meet women's needs in the various maternity settings. There is a gap in the literature concerning the role of a Midwifery Council in developing countries as a body to standardise midwifery education (Bogren et al., 2013; Bogren et al., 2012; Gross et al., 2011; Homer et al., 2017; McCarthy et al., 2013). This study highlights that even though the autonomy and status of midwifery were strengthened through the 2019 Midwifery Act, the midwifery profession in Indonesia will not be fully self-regulating until a Midwifery Council is established. A combination of the Midwifery Act and a Midwifery Council are essential to enhancing midwifery education in Indonesia.

10.2.1.2 National accreditation standards under the new accreditation agency (LAMP-PTKes)

The national accreditation standards under the new accreditation agency were utilised to assess the extent to which midwifery education programmes in Indonesia meet the accreditation standards. The committee of the new accreditation agency has a section for each health profession, including medicine, midwifery, nursing, dentistry, and pharmacy. These sections formulate their own professional standards to ensure all health schools meet standards. The midwifery division, under the new accreditation agency, assesses all documents required to accredit the midwifery programmes. This study highlights that accreditation is a system that will strengthen midwifery education by regulating the complex environment of midwifery education. The findings support the report from the Ministry of Research, Technology and Higher Education Indonesia and the Midwifery Association about some ways to strengthen midwifery education in Indonesia, including a review of midwifery professional standards, midwifery

education programmes, an accreditation system, a certification system, publication, an annual scientific meeting, and training for lecturers (Director of Quality Assurance, Ministry of Research, Technology, and Higher Education Indonesia, 2018; Indonesian Midwives Association, 2018). Internationally, accreditation of standards has been developed to provide a mechanism for the quality assurance of programmes and alignment with international standards (Bogren et al., 2018; Fullerton et al., 2011; Leap, Brodie, & Tracy, 2017; McCarthy et al., 2017; Nove et al., 2018; Smith et al., 2008). However, the findings of this research show that, often, the accreditation processes, run by the midwifery division under the new accreditation agency (LAMP-PTKes) only assess documentation, administration and, sometimes, the equipment set out on the day. This seems to act as a constraint on the accreditation process in improving the quality of midwifery schools in Indonesia. Therefore, this research suggests that the accreditation process needs to assess more than documents. It should view all activities, including laboratory and clinical practice, and not just be 'a paper exercise'. The research findings also show that the accreditation status of a school strongly influences both the likelihood of new graduates finding employment and the midwifery school being chosen by new applicants.

In the Indonesian context, midwifery education is strongest where the accreditation status of the school is highest. Current practice for those applying for a job as a midwife, whether at a hospital, as contract employee, or in other settings, is the requirement to submit many documents and this includes the accreditation certificate of their school (Direktorat Jenderal Pelayanan Kesehatan RSUP Dr Sardjito, 2017; Kementerian Kesehatan Republik Indonesia, 2017). Different institutions receive different accreditation grading as A, B, or C (LAM-PTKes, 2019). This results in tension among newly graduated midwives, especially those from midwifery schools with an accreditation status C or schools that are non-accredited, as this impacts on their employability. While an accreditation system is an essential aspect of strengthening midwifery education, it is important that its processes result in quality education and there are strategies and opportunities provided to schools so they can improve their education programmes.

Thus, at the macro-level it is clear that, in addition to the Midwifery Act 2019, what is needed to strengthen midwifery education in Indonesia is: a national framework for midwifery education, the establishment of a Midwifery Council, and an accreditation process under a Midwifery Council.

However, this study shows that addressing these crucial factors at the macro-level alone is not sufficient. It is essential that critical factors at the meso-level are also addressed.

10.2.2 Meso-level

An exploration of the functions and roles of the organisations and systems (identified at the macro-level), including relationships between institutions and workplaces (the meso-level) has the potential to identify factors that could further strengthen education in Indonesia. These factors are:

1. The requirement for post-graduation competency training
2. Having quality clinical experience:
 - a. Effective hands-on experience
 - b. The system in the clinical environment
 - c. Developing continuity of care
 - d. Collaboration across different institutions and organisations, including the integration of hospitals and education providers

10.2.2.1 The requirement for post-graduation competency training

This study highlights that some participants were divided in their views about post-graduation competency training for midwives. This is another name for the continuing professional development (CPD) that qualified midwives do. Some viewed this training as supporting new midwives, while others saw it as a barrier which undervalues midwifery schools and new midwives' skills. The focus and purpose of this training at present is CPD and not a supportive new graduate programme. In this, it is very different from other new graduate programmes. In New Zealand, the Midwifery First Year of Practice (MFYP) programme is funded by the government and is a structured, supportive, collegial and compulsory national programme for all newly graduated midwives. This programme supports new midwives following graduation as

they transition to become autonomous professionals (Dixon et al., 2015; Pairman et al., 2015; Patterson, Maćznik, Miller, Kerkin, & Baddock, 2019). Similarly, in Indonesia, to assist newly graduated midwives in the transition process from midwifery school to full-time clinical practice, there needs to be collegial and constructive support offered which is different from the CPD for experienced qualified midwives. It will be interesting to see what role a Midwifery Council will have in ensuring midwives are competent and confident to work across the scope of midwifery practice on graduation. There have already been calls in Indonesia for a professional body of some sort which could standardise midwifery training and the licensing of providers, as it is recognised this is key to reducing maternal and neonatal mortality (The US National Academy of Sciences & the Indonesian Academy of Sciences, 2013). This is an important role the Midwifery Council of Indonesia could play in the future.

10.2.2.2 Having quality clinical experience

1. Having effective hands-on experience

One of the new accreditation agency's roles and responsibilities is to ensure quality clinical experience. This study has identified that, for some participants, quality clinical experience was seen as having effective hands-on experience, namely one midwifery student would care for one woman and give her all care. This effective hands-on experience would ensure a student-centred learning environment, as well as providing respectful midwifery care. Participants in this research spoke of the reality in practice being that students rarely got to do full practice but just 'parts' of the hands-on experience, for example, touching the head of the baby, perineum, and delivering the placenta, and this cannot be defined as effective hands-on experience. This finding is confirmed in other studies which found that midwifery students not be taught parts but rather be confident with the whole process of labour and birth (Ahmadi, Shahriari, Kohan, & Keyvanara, 2018; Bäck, Hildingsson, Sjöqvist, & Karlström, 2017; Bäck, Sharma, Karlström, Tunon, & Hildingsson, 2017). As long as midwifery students and newly graduated midwives' clinical experiences are limited to doing parts of the clinical experience and focused on birthing skills, they are unlikely to be able to meet the standard expected of competent and confident midwifery graduates.

An effective hands-on experience also meant that clinical experience must not be primarily focused on labour and birth but across the scope of midwifery practice. For some time in Indonesia there has been discussion about the reduction in maternal and neonatal mortality that could be expected if midwifery education prepared the workforce to work across the full scope of practice (The US National Academy of Sciences & the Indonesian Academy of Sciences, 2013).

The importance of hands-on experience is also clear in research from Pakistan, Jordan, Papua New Guinea, Ethiopia, and South Africa, which shows that hands-on practice enhances the quality of learning and so the competency of midwifery graduates (Dawson et al., 2016; Lakhani et al., 2018; Shaban et al., 2012; Vuso & James, 2017; Yigzaw et al., 2015). International studies support the findings of this research that quality clinical experience stimulates students' awareness enabling them to develop critical thinking and achieve competency while working with women and their families (women-centred care) (Bäck, Hildingsson, et al., 2017; Gilmour, McIntyre, McLelland, Hall, & Miles, 2013; Licqurish & Seibold, 2008; Rawnsion, 2011).

2. The system in the clinical environment

This research highlights the way the clinical environment influences the quality of clinical experience. A system which allows midwifery students to do parts of a woman's care results in midwifery care that is not appropriate or respectful. This finding is confirmed by other research in developing countries which also identifies concerns regarding disrespectful care during clinical placement (Binfa et al., 2011; Moyer et al., 2016). The current system often results in too many students in placement at the one time and means they do not get the opportunity to work across the scope of midwifery. This is compounded by the fact that midwifery students are not prioritised at clinical sites. The fees paid by midwifery students for additional clinical experience also reflect a system that is not able to provide adequate and quality clinical experience and meet targeted requirements. This research revealed that, too often, the focus was on skill numbers and midwifery targets instead of a focus on the quality of clinical experience across the scope of practice. One of the roles of the midwifery division of the new accreditation agency, will be to ensure this shift in focus happens.

Midwifery students in Indonesia have to do a minimum of 50 births prior to finishing their midwifery programme. This number is high compared to other countries such as Ethiopia (20 births), Pakistan (40 births) India (30 births), New Zealand (40 births) and the global standard (40 births) (Lakhani et al., 2018; Midwifery Council of New Zealand, 2018; Sharma et al., 2015; UNFPA et al., 2014a; Yigzaw et al., 2015). This study calls for an evaluation of the midwifery target, particularly the number of births.

3. Developing continuity of care experiences

The role of the midwifery division of the new accreditation agency is to ensure the quality of clinical experience. It will need to consider the place of continuity of care experiences which is the gold standard of midwifery care and involves students following a woman through antenatal, labour, birth and postnatal care. This research identifies that continuity of care experiences in some midwifery schools offers positive experiences and very effective learning. There is a significant body of research which shows that continuity of care experiences in midwifery education enhances the confidence and competence of midwifery students (Browne, Haora, Taylor, & Davis, 2014; Browne & Taylor, 2014; McKellar, Charlick, Warland, & Birbeck, 2014; Tickle, Sidebotham, Fenwick, & Gamble, 2015). This research is consistent with the study of continuity of care experiences from Norway (Aune, Dahlberg, & Ingebrigtsen, 2012) and Indonesia (Yanti et al., 2015), which reveal that this impacted positively on both midwifery students and women. The implementation of this finding will require changes to policy, guidelines, and the organisation of the workplace. There will also need to be collaboration on a number of levels along with a well-managed change process.

4. Collaboration across different institutions and organisations, including the integration of hospitals and education providers

Collaboration across different institutions and organisations, including hospitals and education providers, could be useful to facilitate how things are done at a structural and organisational level, and establish the quality of education that results in competent new midwives. One of the areas of collaboration that is needed urgently is supporting midwifery lecturers to practice clinically and to produce standardised

criteria for midwife mentors. There have been similar findings regarding collaboration in countries like Bangladesh, some African countries, and Australia. It was found that when key people from essential organisations and the government collaborated for the improvement of midwifery education and profession, there were significant results (Bogren, Berg, Edgren, van Teijlingen, & Wigert, 2016; Bogren et al., 2015; Leap et al., 2017; Middleton et al., 2014). The WHO (2017a) also called for collaboration between stakeholders to strengthen health education. The findings of this research complement previous studies and is a timely reminder that collaboration across different institutions and organisations is deemed critical to strengthening midwifery education in Indonesia.

Furthermore, the new accreditation agency states that a Memorandum of Understanding (MoU) between midwifery schools and clinical sites is required to ensure collaboration and the quality of clinical experience with the integration of hospitals and education providers. However, this research highlighted that the many layers of documents required, such as an MoU between schools and clinical sites, was unnecessarily time consuming. This finding was consistent with research from Ethiopia which showed that a lack of coordination between academic and clinical sites, including transport, inappropriate clinical rotation, and overcrowding, to name some factors, impacted significantly on the quality of clinical education (Kibwana et al., 2017). In the Indonesian context, institutional factors are constrained by hierarchical and organisational systems which make the process of gaining appropriate clinical sites for students' clinical placement challenging. This research found that collaboration across relevant parties might assist in ensuring the students' clinical experience is women-centred and has significant hands-on experience so they can become competent midwives on graduation. Also, this collaboration would enable midwifery lecturers to teach and practice clinically while also supporting midwifery mentors in the hospital.

The discussion at the meso-level revealed the role and responsibility of the midwifery division of the new accreditation agency to ensure ongoing effective midwifery programmes in Indonesia. The Midwifery Act 2019 does raise a question about what the role and responsibility of the yet-to-be formed a Midwifery Council will be in

relation to midwifery education. In a number of other countries, Midwifery Councils not only set the standards for education but they also accredit midwifery schools to make sure that midwifery graduates are well-prepared for practice (Gilkison et al., 2013; Midwifery Council of New Zealand, 2018; Nursing and Midwifery Council, 2016). When the Midwifery Council is formed in Indonesia, it will be interesting to see what its relationship is to the new accreditation agency and what role the Council will see it needs to play. This is an important discussion because the quality of midwifery education has the potential to increase the health status of the society, primarily maternal and neonatal health in Indonesia, and the Midwifery Council's role in this could be significant.

10.2.3 Micro-level

On the micro-level (individuals, and the relationship between individuals and the environment), factors which are associated with quality clinical experiences and will lead to strengthening midwifery education are explored. These factors are:

1. Effective teaching and learning of theory, including learning resources
2. Motivation to study and stay in midwifery
3. Midwifery lecturer needs to be clinically current
4. Role of the mentor in practice

10.2.3.1 Effective teaching and learning of theory, including learning resources

This study highlighted that fostering theoretical teaching and learning processes in the classroom and laboratory were directly linked to developing the knowledge and skills of midwifery students. These processes would ensure the midwifery students were well prepared for the transition process from the classroom and laboratory into clinical sites. The findings of this research revealed that teaching and learning strategies, such as a small group tutorial system rather than a didactic lecture approach, and the use of practice stories, facilitated critical thinking. The knowledge and skills of student midwives were developed when teaching and learning was supported by learning resources such as mannequins, a stable internet, and midwifery textbooks. The literature on education shows that the intellectual capabilities of students are developed during teaching and learning processes, such as small group tutorials, problem-based learning, and storytelling (Flanagan, 2015; Fry, Ketteridge, & Marshall,

2008; Kozulin, Ageyev, Gindis, & Miller, 2003). However, a number of participants, including midwifery lecturers and students, initially felt challenged by the paradigm shift from teacher-based learning to student-based learning. This echoes the findings of other studies, including in education (Barangard, Afshari, & Abedi, 2016; Fry et al., 2008; Rowan, McCourt, & Beake, 2008; Sangestani & Khatiban, 2013). For example, a tutorial system posed challenges to lecturers as they had to be creative and innovative when facilitating group discussions, and had to ensure all students participated actively in all steps of learning. Once again this is also acknowledged in other studies, including in education literature (Fry et al., 2008; Rankin & Brown, 2016; Rowan, McCourt, Bick, & Beake, 2007).

This study showed the perception that storytelling in the form of sharing practice experiences or stories can foster and nurture the motivation and learning of midwifery students. Others recognised this was problematic, as not all lecturers were practising storytelling. These creative teaching methods were described by participants as a meaningful way of learning that helped to develop and facilitate critical thinking, communication skills, and how to become a midwife. Research in other countries revealed that sharing practice stories provided a deeper understanding of midwifery and enhanced the learning process (Gilkison, Giddings, & Smythe, 2016; Hunter & Hunter, 2006; Rankin & Brown, 2016; Weston, 2012). Further, midwifery students in other countries wished to be involved in interactive learning instead of a didactic model (Carolan-Olah & Kruger, 2014; Lake & McInnes, 2012; Lobb & Butler, 2009; Phipps, Whitney, Meddings, & Evans, 2015; Rankin & Brown, 2016; Rowan, McCourt, & Beake, 2009). This research reaffirms and complements the use of multiple midwifery teaching strategies.

Commonly, midwifery textbooks and journals are written in English and the findings of this study reflect concerns about the way the use of the English language impacts on teaching and learning strategies. In Indonesia, English is taught as a subject in the midwifery curriculum. The participants in this research noted that fluency in English should be improved to reduce difficulties when reading educational resources in English. Studies conducted in Pakistan by Lakhani et al. (2018) and in Bangladesh by Erlandsson et al. (2018) also raised this concern. This current study found that

improving students' comfort and ease with English would enable participants to read and understand current midwifery research evidence. In an era of globalisation where English is one of the primary languages used by academics, this research is a reminder of the importance of students and lecturers being proficient in English.

The findings of this research suggest that students' confidence and competence in a clinical setting will be strengthened through learning skills in a safe, simulated environment supported with adequate resources and followed by appropriate assessment. Other studies, especially those in education, have shown that when done to a high standard, simulation and competence assessment prepares students well for clinical practice (Baloyi & Mtshali, 2018a; Fry et al., 2008; Fullerton, Johnson, et al., 2011; Kolb, & Kolb, 2005; Morgan, Green, & Blair, 2018). However, this research indicated that limited access to learning resources such as mannequins was a constraint on student learning in the laboratory. Learning resources such as a stable internet, midwifery textbooks, and other equipment are necessary to improve the teaching and learning of theory at midwifery schools. This finding is consistent with the report that a lack of learning resources and infrastructure become a barrier in teaching and learning processes in developing countries (UNFPA et al., 2014; UNFPA, UNICEF, WHO, ICM, 2019). The issue of adequate resources for teaching and learning needs to be addressed urgently. It is hoped the new Midwifery Council along with the Midwifery Association will be strong advocates for ensuring the midwifery schools have the teaching and learning resources they require.

10.2.3.2 Motivation to study and stay in midwifery

This study highlighted some of the individual variables associated with midwifery education. Motivation was identified as significant in relation to midwifery education and participants spoke of students being motivated by a range of things including personal interest, family reasons, religious beliefs, and professional development. The influence of family was strong and, even for mature students, the transition from pleasing their family to having a true calling to become midwives was genuinely challenging. This finding was supported by other research which explores factors that influence midwifery students' attitude towards the profession in Jordan (Al Hadid, Al-Rajabi, AlBarmawi, Yousef Sayyah, & Toqan, 2018). It is important to place motivation

in the context of Indonesia, where typically a daughter lives in the same house with her parents and depends on them throughout higher education until she is married or able to move out (Samarakoon & Parinduri, 2015; Trommsdorff & Schwarz, 2007). This provides a backdrop to why the influence of family may be so powerful for some student midwives.

Motivation was identified as impacting significantly on students' receptivity to being taught and lecturers often found it difficult to teach unmotivated midwifery students. When midwifery students do not wish to be midwives, it can be seen as a barrier and detrimental in the long term because it leads to a focus on nurturing the motivation of students instead of a focus on teaching midwifery knowledge and skills. A robust selection process could be an effective way to select potential midwifery students and reduce the difficulties presented by those who do not want to be a midwife.

However, participants pointed out the inspirational and motivating influence of midwifery lecturers and midwife mentors whose passion was sometimes contagious and could help students to gain a passion for midwifery and the heart of a midwife. Engaging in small group tutorial systems, learning from midwifery stories and interacting with women and family during their clinical experience could motivate students to study midwifery. This finding is consistent with psychology and educational literature which explores motivational theory. Fry et al. (2008) and Ryan and Deci (2000) have found that intrinsic and external factors can motivate individuals in their actions. Unmotivated students do not know why they are at university, they think they are incompetent, and feel that they have little control over what happens to them (Fry et al., 2008; Ryan, & Deci, 2000). Creative teaching methods and quality clinical experience are strategies by which students can be motivated to engage and gain a passion for the profession they are studying.

This research highlighted that nearly all participants were Muslim and, as such, the blessing of Allah was vital to them. The Muslim participants believed that knowledge and knowledgeable persons will bring them closer to their creator (Allah) and that they were motivated to perform good things by taking care of women and their families in the community. Further research is needed for a better understanding concerning

non-Muslim Indonesians. In psychology research concerning religious belief and motivational mechanisms, it was stated that religious belief motivates individuals to achieve noble purposes and maintain effective action (Kay, Gaucher, McGregor, & Nash, 2010; Smither, & Walker, 2015). These psychology studies support the finding of this study that religious belief has triggered positive values, which were in turn influencing participants to study and stay in midwifery and to provide excellent midwifery care.

This research also highlighted that some participants became midwives because of the status of midwives in the community, and they were passionate about midwifery and the fulfilment of women's needs. This finding is in line with studies by Lakhani et al. (2018) in Pakistan, and Carolan (2011), and Carolan and Kruger (2011) in Australia, which showed that to be a good midwife one had to have passion about midwifery. In contrast, in Jordan where the midwife's status has been devalued, and midwifery is seen as a lower profession to nursing and other health professions, the motivation to be a midwife is not strong (Shaban et al., 2012). Motivation to become and remain a midwife is multifactorial with influences such as being proud to be a midwife, job satisfaction, positive role models as a midwife, and wanting to make a difference to maternal and neonatal mortality and morbidity, all playing a part (Al Hadid et al., 2018; Carolan & Kruger, 2011; Cullen, Sidebotham, Gamble, & Fenwick, 2016; Moores et al., 2015; Sullivan, Lock, & Homer, 2011).

10.2.3.3 Midwifery lecturer needs to be clinically current

This study found that having a background of clinical experience, as well as an ability to continue midwifery practice, was seen as an important functional attribute of a midwifery lecturer. Being close to clinical work is essential in developing the knowledge and midwifery skills of students as well as the 'spirit' of midwifery. This finding is consistent with studies in many countries in which the qualification to become a midwifery lecturer is not solely because of educational background (e.g., having a master's degree), but interlinked with practice experience and clinical skills (Abou-Malham et al., 2015; Albarran & Rosser, 2014; Dawson et al., 2016; Erlandsson et al., 2018; Fullerton, Johnson, et al., 2011; Gilkison, Pairman, McAra-Couper,

Kensington, & James, 2016; Nyoni & Botma, 2018; Rankin & Brown, 2016; Thompson et al., 2011; Vuso & James, 2017; Yigzaw et al., 2015).

While the Ministry of Research, Technology and Higher Education in Indonesia identified the need to improve the quality and quantity of midwifery lecturers in Indonesia (Director of Quality Assurance, Ministry of Research, Technology and Higher Education, 2018), participants in this study spoke of the qualities that make a good midwifery lecturer. It was acknowledged by most of the participants that just because midwifery lecturers held a master's degree, it did not mean they were effective midwifery lecturers. This research found that having midwifery lecturers skilled in midwifery rather than just academic study was one way to enhance the quality of midwifery education. The impact that midwifery lecturers' clinical experience and ability to do midwifery practice had on midwifery students' knowledge and skill was thought to be profound. Midwifery lecturers who have clinical experience and current clinical practice would be able to share practice stories more with midwifery students. Being closely connected to practice also means that the lecturers are skilled in teaching midwifery skills. These things build the knowledge and skills of midwifery students.

The findings of this study clearly showed that the ideal midwifery lecturer is highly motivated, has effective teaching skills, clinical experience and the ability to maintain these skills, as well as a clear grasp of midwifery philosophy, and so can deliver quality midwifery education. The midwifery educator core competencies identified by the WHO (2013) can be utilised to identify the national criteria for midwifery lecturers in Indonesia. The WHO (2017b) also stated the critical need for competent lecturers to implement a midwifery curriculum that is in line with the country's needs. When midwifery lecturers do not have adequate clinical background or supported clinical practice, they are more likely to transfer knowledge and midwifery science from the textbook and less likely to inspire midwifery students through storytelling and other teaching and learning strategies.

10.2.3.4 Role of the mentor in practice

This research identified midwife mentors at clinical sites as being an essential element in ensuring the quality of clinical experience, and thus contributing to the quality of

midwifery education programmes. The midwife mentors became role models in the clinical sites developing the competency and confidence of midwifery students. This research identifies the significance of midwife mentors in clinical practice and echoes the findings of studies reviewed in Chapter 3 (Bogren et al., 2013; Dawson et al., 2016; Erlandsson et al., 2018; Lakhani et al., 2018; Moores et al., 2016; Shaban et al., 2012; Turkmani et al., 2013; Vuso & James, 2017). There was often a misconception between midwifery lecturers and midwife mentors about clinical performance and the appropriate evaluation of students in the clinical sites. The existence of a theory-practice gap, which was portrayed in this research, highlights that midwifery theory should not be separated from clinical practice. Midwife mentors and midwifery lecturers working side by side at clinical sites would help midwifery students to retain knowledge and midwifery skills. There were, however, concerns raised in this research about the negative relationship with mentors, and the high workload of mentors due to there being too many students in one room. The negative behaviour of some unsupportive mentors resulted in poor role modelling for midwifery students and newly graduated midwives, and limited their exposure to midwifery skills in clinical sites. Having a clearer understanding of the mentor's job description and an appropriate ratio of mentors to students in clinical sites may help to ensure adequate support for midwifery students' learning objectives. The findings highlighted the guidance of supportive mentors in clinical practice as a contributing factor to improving midwifery education.

In the Indonesian context, there are no specific criteria for midwife mentors for midwifery students in clinical sites. It could be argued that core competencies for midwife mentors should be defined and considered by the new Midwifery Council. A mentorship programme or workshops in the hospitals for midwives who wish to become mentors would be beneficial in strengthening midwifery education, as has been shown in countries such as the United Kingdom and New Zealand. These countries have robust, formal mentorship and clinical supervision programmes for midwives who become mentors for midwifery students and newly graduated midwives (New Zealand College of Midwives, 2018; NHS Education for Scotland & The Scottish Government, 2007; Nursing and Midwifery Council, 2008).

10.3 Contributions of this study

This study explores how midwifery education in Indonesia can be strengthened and in doing so makes a meaningful contribution to the body of knowledge about midwifery education in Indonesia. The literature review found there was only one study from Indonesia relevant to this research, and that study concentrated on students' understanding of women-centred care philosophy through the continuity of care learning model (Yanti et al., 2015). This research is the first study done on midwifery education in Indonesia and for that reason alone its contribution is unique and significant. However, this research set out to investigate what would strengthen midwifery education in Indonesia and so its findings provide insight into the present education of midwives along with what will strengthen midwifery education. The contribution of the research is that first and foremost it brings rich insight into the experiences of midwifery students, newly graduated midwives, midwives, midwifery lecturers, and obstetricians, and uncovers the enablers and barriers as they experience them. The research then explores the multiple factors that impact on midwifery education in Indonesia, identifying the different structural, political, human resources, and symbolic factors that will need to be addressed to strengthen midwifery education. This is the first time the experiences of those involved in midwifery education have been articulated along with the factors which significantly impact on it.

The findings draw attention to things that can strengthen midwifery education and support the new graduate midwife, for example the need for a Midwifery Council and a supportive and collegial new graduate programme. The references to midwifery regulation and legislation in these findings make an important contribution to knowledge because of the significant gaps in the global literature about midwifery regulation and legislation in developing countries (Bogren et al., 2013; Bogren et al., 2012; Castro Lopes et al., 2016; Dawson et al., 2016; Gross et al., 2011; Homer et al., 2017; McCarthy et al., 2013). The many factors identified in this research offer important information that decision-makers, politicians, and people with an interest in midwifery education must take into account to enhance midwifery education in Indonesia. This research also has the potential to inform midwifery education globally, primarily for developing countries, to improve the outcomes for women and babies. This research is in line with an international report about a framework for

strengthening quality midwifery education. The three strategies it identifies are similar to what this research uncovers; for example, the report discussed the importance of collaboration between education providers, health providers and stakeholders (UNFPA, UNICEF, WHO, ICM, 2019). The purpose of this research was only ever focused on making a difference to maternal and neonatal health outcomes. If midwifery education in Indonesia is strengthened in line with the recommendations, this will have a direct impact on these outcomes as midwives are the primary maternity care givers in the community.

10.4 Limitations and strengths of this study

One of the limitations of this research is that it is confined to the Indonesian context; that is to say, to one of the developing countries in South-Eastern Asia. The research was conducted in 12 midwifery schools (there are 733 midwifery schools) and the Midwifery Association which is situated in eight cities and six provinces in Indonesia. The research settings were purposely chosen as representative of midwifery schools in Indonesia. I believe that each midwifery school has its context, which may not be generalised to another context. Further, the timeline to conduct this research (six months) and with only myself as the single researcher to gather the data in Indonesia, could be seen as a limitation of this study. A research assistant would have helped for all the administrative processes.

Some scholars have said that qualitative descriptive is the least theoretical of all the qualitative approaches (Sandelowski, 2000, 2010). While qualitative descriptive is a methodology fit for the purpose of this research, a theoretical framework through Bolman and Deal's Four Frames was also employed in this study to further explore and strengthen the findings, so that the substantial contribution to knowledge was clear to all. A strength of this research is the 37 participants who were interviewed in depth. The rich data gathered from midwifery students, newly graduated midwives, midwifery lecturers, midwives, and obstetricians provided data for in-depth analysis. This research did not include government officials' views as decision-makers about midwifery education in Indonesia. These participants could be included in another study as a critical factor to provide the government's perspective concerning midwifery education in Indonesia. Also, this study did not capture the stories from the

women and families who received midwifery care. However, qualitative descriptive methodology with an interpretive paradigm and Bolman and Deal's Four Frames as a theoretical framework offers a comprehensive understanding of participants' experiences in everyday life. The experience of participants from multiple perspectives in a broad range of research settings provides rich information about midwifery education in Indonesia, which can inform and provide insights for other researchers in Indonesia.

Another limitation is associated with the cross-language nature of the research. Data were gathered in Bahasa Indonesia, translated verbatim into English, and analysed in English. Even though I checked and re-checked the translation files to avoid losing the meaning, still, I felt that increased sensitivity of the translation process was required for additional verification. However, the cross-language nature of this research can also be seen as a strength, as participants spoke in their language. The following poem by the Indian poet Sujata Bhatt speaks of my reflection regarding the translation process. In this point, the poem title '*My Tongue*' captures my thinking on the essential aspect when conducting the cross-language research of the struggle to authentically capture the nuances and depth of meaning in the participants' stories when rendering that meaning in another language.

Search for My Tongue by Sujata Bhatt (1994)

You ask me what I mean
By saying I have lost my tongue
I ask you, what would you do
If you had two tongues in your mouth,
And lost the first one, the mother tongue,
And could not really know the other,
The foreign tongue.
You could not use them both together
even if you thought that way.
And if you lived in a place you had to speak a foreign tongue,
Your mother tongue would rot,
Rot and die in your mouth
Until you had to spit it out.
I thought I spit it out
But overnight while I dream,
It grows back, a stump of shoot
Grows longer, grows moist, grows strong veins,
It ties the other tongue in knots,
The bud opens, the bud opens in my mouth, It pushes the other tongue aside.

Every time I think I've forgotten,
I think I've lost the mother tongue,
It blossoms out of my mouth.

10.5 Recommendations arising from the research

Recommendations from this research are focussed on ways to ensure that midwifery education in Indonesia is strengthened.

10.5.1 Recommendations for policy

1. This research could be used to facilitate a conversation and change in policy with the education and clinical providers ensuring quality clinical experience, so that the practice of midwifery students paying fees for additional clinical experience can stop.
2. This research could be used to advocate to the decision-makers that the structure/ clinical environment and policy are changed to support midwifery lecturers to practice clinically.
3. This research suggests that hospitals should integrate with midwifery schools to enable collaborative practice. In some settings, the experience of midwifery students exposed to the universities' hospitals needs further research.
4. This research could be used to advocate for the regulatory board to evaluate the process of accreditation and national standards of accreditation. Midwifery schools need to recognise that the high-quality of their schools was not only on paper. Therefore, standards of accreditation assessment should include, how the accreditation process would be run, when and how long the accreditation process would take, who assess the midwifery schools, and what hinders the accreditation process from improving the quality of accreditation and midwifery schools. Improving the accreditation process might actively contribute to changing all parties' professional behaviour, not merely "ticking boxes" of accreditation criteria to provide a record.
5. The Indonesian Midwives Association and the Indonesian Midwifery Education Association define and standardise the continuing professional development for midwives and structured support services for new midwives. The Midwifery Association should make a difference to training for registered midwives and new midwives, which will ensure the best support for the transition process for a new

midwife into the workplace.

6. One significant recommendation of this research is the formation of a Midwifery Council. A professional regulatory board such as a Midwifery Council would ensure midwives meet and maintain professional standards of midwifery education, including accreditation of midwifery programmes in the future and high-performance of midwives throughout their years of practice.

10.5.2 Recommendations for education

1. Midwifery programmes need to have better selection processes which pay careful attention to the motivation of potential midwifery students.
2. Learning and teaching strategies which promote problem-solving and critical thinking need to be supported with resources and faculty development.
3. Problem-based or inquiry-based learning as opposed to didactic teaching needs to be implemented.
4. Action needs to be taken to improve English language competency. This will give midwifery students and lecturers additional skills when working with learning and teaching resources.
5. There needs to be a commitment to increasing the number of midwifery faculty, supporting their professional development, and enabling them to keep up their clinical practice. There is a need for midwifery faculty to include both the academic and the clinically expert midwife as this will ensure the best educational experience for students.
6. It is essential to consider at what stage of their career a midwife can become a midwifery lecturer, as some are teaching soon after graduation. In many countries, midwives have to have had five years in practice before they can teach in an undergraduate programme. There needs to be a structured support programme for midwifery lecturers to do clinical practice, primarily for the newly graduated midwives who directly become midwifery lecturers.
7. Ensure all requirements of midwifery students are met before graduation; this includes the standardisation of assessment and the number of midwifery skills to ensure the competency of midwifery students across the midwifery programme. Continuity of care experiences should be implemented and integrated into the midwifery curriculum. At this point, significant logistical challenges to the

implementation of continuity of care need to be considered.

10.5.3 Recommendations for practice

1. More support from clinical sites is required to provide more opportunities for midwifery students to have quality clinical experience.
2. As midwifery theory can not be separated from clinical practice, midwife mentors and midwifery lecturers should work side by side at clinical sites. This would help midwifery students to retain knowledge and midwifery skills.
3. The position of a mentor on clinical placement to guide midwifery students and newly graduated midwives should be reviewed and, where possible, mentors should be provided for students. This will require the core competencies of mentors to be defined and considered, as well as professional development for the mentors to ensure they have skills to work with students.
4. Establishment of a well-structured support programme for new graduate midwives as they transition into working as a registered midwife.
5. Effective procedures and administration processes to support midwifery students to undertake a clinical placement. Effective communication between the Midwifery Association, midwifery programmes, public health officials, and the midwifery department in maternity services is needed to provide an effective approach for clinical sites.

10.5.4 Recommendations for further research

1. A more extensive study across the country to explore the experiences of a broad range of participants in developed and less developed islands, especially in an area that is not predominantly Muslim, would contribute to a greater understanding of the needs of midwifery education in Indonesia. In particular, the motivational factors in midwifery related to religious belief, as found in this study, need further research.
2. Research regarding the views of women, their families, and stakeholders about midwives and midwifery care, including the continuity of care model in private and public maternity services, would inform midwifery education, as to what aspects should be added.
3. Research into a collaboration between the government, the Midwifery Association,

educational institutions, stakeholders, and other parties could be explored to provide insight into how decisions, in particular, midwifery regulation and midwifery education, are managed. This in turn would inform the ongoing development of midwifery education in Indonesia.

4. The system of assessing student competency at the midwifery school and the clinical site needs further research.
5. The significant alteration of the national competency test requires further research and would inform policy-makers on some aspects of the national competency test.
6. As a national midwifery framework for education is established, comparing midwifery students and newly graduated midwives from diploma and professional of midwifery programmes could be explored to provide new insights across the programmes. This study could also be used to facilitate research concerning the complexity of organisational change for registered midwives as a result of the passing of the Midwifery Act 2019.
7. Hermeneutic phenomenology could be utilised to capture lived experiences of specific participants to offer more in-depth understanding concerning their stories in the midwifery world.

10.6 Final thoughts

The findings of this research offer meaningful insight into and valuable understandings of midwifery education in Indonesia. They reveal critical factors that need to be addressed to strengthen midwifery education and produce competent and confident new midwives. The journey of this research started with concerns around the lack of competence and confidence of new midwives in the country. Evidence indicated that there were low numbers of new midwives passing the national competency test. There was public discussion about both the quality of new midwives and the quality of midwifery education in the country. This concern led to a question about the quality of newly graduated midwives and this in turn led to the formulation of the research question, “How can midwifery education in Indonesia be strengthened?”. This research set out to explore the experience of midwifery lecturers, midwifery students, newly graduated midwives, midwives, and obstetricians regarding midwifery education in Indonesia. It also aimed to identify the barriers and enablers to strengthen Indonesian midwifery education leading to competent and confident midwifery graduates. Using

Bolman and Deal's Four Frames as a lens, the findings reveal the complexity and tensions which are involved in efforts to improve midwifery education in Indonesia. This study demonstrates it is not just the responsibility of midwifery lecturers and midwife mentors to strengthen midwifery education with a view to producing competent and confident newly graduated midwives, who can be expected to make a positive difference to maternal and neonatal health outcomes. It is also the responsibility of politicians, decision-makers at the hospital and maternity settings, leaders at the midwifery associations, academic leaders at the midwifery programmes, and the individual midwifery student. This study is the first piece of research regarding strengthening midwifery education in Indonesia. Indonesia did not meet the MDGs 2015 target; therefore, it is hoped the findings of this study will go some way to helping Indonesia achieve the SDGs by 2030.

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Appendices

Appendix A: Midwifery curriculum from different kinds of programmes in Indonesia

Table A1 Curriculum structure Diploma of Midwifery

Semester	Course	Semester Credit system (SCS)	Theory	Practice	Clinic
1	Religion	3	2	1	
	Civil Education	3	2	1	
	Indonesian	3	2	1	
	Basic Biology and the Development of Biology	4	2	2	
	Basic Midwifery Skill I	3	1	2	
	Midwifery Concept	4	2	2	
	Social Sciences and Basic Culture	3	2	1	
		23	13	10	
2	Communication in Midwifery Practice	3	1	2	
	Basic Midwifery Skill II	3	1	2	
	Reproductive Health and Family Planning	4	2	2	
	Legal Ethics in Midwifery Practice	2	1	1	
	Community Health	4	2	2	
	Quality Midwifery Service and Health Policy	3	2	1	
		19	9	10	
3	Midwifery Care in Pregnancy	5	3	2	
	Midwifery Care in Delivery and Newborn	5	3	2	
	Midwifery Care in Postpartum and Breastfeeding	3	3	1	
	Midwifery Care in Neonates, Baby, Child, and Pre-School	5	3	2	
		18	11	7	
4	Midwifery Care in Maternal and Neonatal Emergency	4	2	2	
	Midwifery Care in Community	4	2	2	
	Research Methodology and Basic Statistics	3	1	2	
		11	5	6	
5	Midwifery Practice I (Pregnancy, Delivery, Postpartum, Family Planning, Neonates, Newborn, Child, and Pre-School)	6			6

	Midwifery (Midwifery Community, Health and Emergency)	Practice Care Reproductive Maternal Neonatal	II	6			6
				12			12
6	Midwifery (Comprehensive Practice)	Practice	II	8			8
	Final Scientific Paper			3			3
				11			11
	TOTAL			96	39	57	

Source: Kementerian Kesehatan Republik Indonesia (2011)

Based on the structured programme of the midwifery diploma, the midwifery students have to attend a minimum of 96 credits and the local midwifery curriculum (total 110-120 credits), divided into 39 credit hours in theory, 34 credit hours of laboratory sessions, and 23 credit hours in clinical practice (Kementerian Kesehatan Republik Indonesia, 2011).

1 credit hour in theory = 1 contact hour/week (16-19 effective weeks), plus 1-2 hours structured activity and 1-2 hours independent = 16 contact hours

1 credit hour in laboratory session = 2 contact hours/week, plus 1-2 hours structured activity and 1-2 hours independent = 32 contact hours

1 credit hour in clinical practice = 4 contact hours/week, plus 1-2 hours of structured activity and 1-2 hours independent = 64 contact hours

Total hours in theory (effective weeks:16-19 weeks) 39 credits = 624 contact hours (40%)

Total hours in practice (34 laboratory & 23 clinical) = 57 credits = 2560 contact hours (60%)

Total = 96 credits = 3184 contact hours (100%)

To become a midwife, the midwifery student in the diploma of midwifery programme is expected to acquire the following midwifery skills at the end of midwifery education:

- a. Attending a minimum of 100 antenatal visits, including interpretation of laboratory tests such as blood tests, urine tests.
- b. Attending a minimum of five high-risk pregnancies and/or with complications.
- c. Opportunity to gain competence that includes appropriate referring to the hospital.
- d. Being with a minimum of 50 women giving birth as a primary care-giver, through labour and the immediate period following birth. This may include partograph.

- e. Opportunity to gain competence in breech deliveries.
- f. Opportunity to gain competence on a vacuum, antepartum bleeding, placenta manual, emergency cases and complication during birthing.
- g. Appropriate attending a minimum of five women having an intrauterine device (IUD), Norplant visits include counselling about family planning.
- h. Attending a minimum of 50 newborn and baby examinations.
- i. Attending a minimum of 10 home visits for postpartum and neonatal.
- j. Opportunity to gain competence in antenatal screening investigations.
- k. Opportunity to gain competence in examination in a special care baby unit.
- l. Attending a minimum of 50 immunisations.
- m. Appropriate identification for cancer, myoma uteri that includes sex education.

Upon completion of the diploma of midwifery programme, the graduates will be expected to have the following competencies (Kementerian Kesehatan Republik Indonesia, 2011):

Competency 1: able to behave professionally, ethically and morally and be responsive to socio-cultural values in midwifery practice.

Competency 2: able to communicate effectively with women, family, community, colleagues and other professions to improve maternal and child health status in midwifery services.

Competency 3: able to provide care of midwifery effectively, safely and holistically by taking into account cultural aspects of pregnant women, childbirth, breastfeeding, newborns, toddlers and reproductive health under normal conditions based on standard practice midwifery and professional codes of ethics.

Competency 4: able to provide emergency treatment by her authority.

Competency 5: able to make promotion, preventive, early detection and community empowerment efforts in midwifery services.

Competency 6: can manage entrepreneurship in the midwifery service that becomes her responsibility.

Table A2 Curriculum structure Advanced Diploma of Midwifery

Semester	Course	Semester system (SCS)	credit
1	Introduction of midwifery profession	4T, 1C	
	Humanities I	4T	
	Basic Communication Skills	1T, 1P	
	Basic Sciences for Midwifery Skill 1	5T, 5P	
2	Basic Science for Midwifery Skill 2	6T, 3P, 1C	
	Ante Natal Care	6T, 4P, 1C	
3	Intra Natal Care	3T, 3P, 2C	
	New Born and Child Care	4T, 4P	
4	Post Natal Care	3T, 3P	
	Reproduction Health and Family Planning	5T, 4P	
	Midwifery Care Practice 1	6C	
5	Maternal-Neonatal Pathology Care	6T, 3P	
	Management Leadership and Entrepreneurship	2T, 2P	
	Applied Research	3T, 3P	
6	The Community Care and Enhancing Midwife as a Midwifery Educator	5T, 2P, 2C	
	Midwifery Care Practice 2	6C	
7	Midwifery Care Practice 3	8C	
	Advanced Clinical Learning*	1T, 1P, 2C	
	Internship 1	8C	
8	<i>Humanities II</i>	3C	
	<i>Midwifery Final Report</i>	3C	
	Internship 2	10C	
	Amount: 149 SCS	58T, 38P, 53C	

Source: Fakultas Kedokteran Universitas Padjadjaran (2015)

T = Theory

C = Clinic

P = Practice

Table A3 Curriculum structure Bachelor of Midwifery

Semester	Course
1	Humanities contains: English Religion Civil Education The Concept of Midwifery Bioscience I, contains: Biomolecular and Basics of Biochemistry Basic Anatomy Basic Physiology
2	Bioscience II, contains: Microbiology Parasitology Basic Pharmacology

	Indonesian Pancasila Legal Ethics and Patient Safety Basic Communication Methodology I Midwifery Care I: Adolescence and Premarital Skill Midwifery Care 1: Adolescence and Premarital
3	Midwifery Care 2: Preconception Skill Midwifery Care 2: Preconception Midwifery Care 3: Normal Pregnancy Skill Midwifery Care 3: Normal Pregnancy
4	Midwifery Care 4: Early Detection of Pathological Pregnancy Skill Midwifery Care 4: Early Detection of Pathological Pregnancy Midwifery Care 5: Normal Delivery Skill Midwifery Care: Normal Delivery Methodology II
5	Midwifery Care 6: Early Detection of Pathological Childbirth Skill Midwifery Care 6: Early Detection of Pathological Childbirth Midwifery Care 7: Postpartum Period and Breastfeeding Skill Midwifery Care 7: Postpartum and Breastfeeding Methodology III
6	Midwifery Care 8: Neonates Skill Midwifery Care 8: Neonates Midwifery Care 8: Infants and Toddlers Skill Midwifery Care 8: Infants and Toddlers
7	Midwifery Care 9: Menopause and Women's Reproductive Disorders Skill Midwifery Care 9: Menopause and Women's Reproductive Disorders Midwifery Care 10: Community Midwife Skill Midwifery Care 10: Community Midwife
8	Management and Leadership Skill Management and Leadership PKNM Thesis
	Total: 146
9	Clinical Rotation based on Ward: 36
10	
	TOTAL Semester credit system (SCS): 182

Source: Midwifery Undergraduate Degree Programme Fakultas Kedokteran Universitas Brawijaya (2016)*

* This reference is no longer accessible as it is now password protected

Appendix B: Ethics approval

1. Ethics approval from Auckland University of Technology Ethics Committee (AUTEC)



AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 521 9999 ext. 8416
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

19 July 2016

Judith McAra Cooper
Faculty of Health and Environmental Sciences

Dear Judith,

Re Ethics Application: **15/259 How can midwifery education in Indonesia be strengthened? A hermeneutic study.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 19 July 2019.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 19 July 2019;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 19 July 2019 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research.



Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Qorinah.Adnani_boninichostinin@yahoo.co.id

2. Ethics approval from The Health Research Ethics Committee, Faculty of Medicine, University of Padjadjaran, Bandung, Indonesia



KEMENTERIAN RISET, TEKNOLOGI DAN PENDIDIKAN TINGGI
UNIVERSITAS PADJADJARAN FAKULTAS KEDOKTERAN
KOMISI ETIK PENELITIAN KESEHATAN
HEALTH RESEARCH ETHICS COMMITTEE

Jl. Prof. Setiabudi No. 26 Bandung 40132
 Telp & Fax: 022-25343997 Email: kek.fk.unpad@gmail.com

No. Reg.: 0515000870

PERSETUJUAN ETIK
ETHICAL APPROVAL

No: 953/JN6.C1.E.2/KEPK/PN/2016

Komisi Etik Penelitian Kesehatan Fakultas Kedokteran Universitas Padjadjaran Bandung, dalam upaya melindungi hak asasi dan kesejahteraan subjek penelitian kesehatan dan menjamin bahwa penelitian yang menggunakan formulir survei/registrasi/surveilans/Epidemiologi/Humaniora/Sosial Budaya/Bahan Biologi Tersimpan/Gel Punca dan non klinis lainnya berjalan dengan memperhatikan implikasi etik, hukum, sosial dan non klinis lainnya yang berlaku, telah mengkaji dengan teliti proposal penelitian berjudul:

The Health Research Ethics Committee Faculty of Medicine Universitas Padjadjaran Bandung, in order to protect the rights and welfare of the health research subject, and to guaranty that the research using survey questionnaire/registry/surveillance/epidemiology/humaniora/social-cultural/archived biological materials/system belvoher non clinical materials, will carried out according in ethical, legal, social implications and other applicable regulations, has been thoughtly reviewed the proposal entitled:

"HOW CAN MIDWIFERY EDUCATION IN INDONESIA BE STRENGTHENED? A HERMENEUTIC STUDY"

Nama Peneliti Utama : *Principal Researcher* : Qurinah Estiningtyaz Sakilah Adnan, SST, M.Keb.

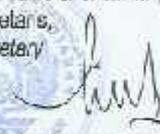
Pemimbing/Peneliti Lain : *Supervisor/Other Researcher* : Associate Professor Judith McAra-Cooper
Dr. Andrea Gilkison

Nama Institusi : *Institution* : Auckland University of Technology (A/IT)
Auckland New Zealand

proposal tersebut dapat disetujui pelaksanaannya.
hereby declare that the proposal is approved.

Ditetapkan di : Bandung
 Issued in :
 Tanggal : 07 - 10 - 2016
 Date :

s.n. Ketua,
 in the name of Chairman,
 Sekretaris,
 Secretary



Dr. Meta Dhamayanti, dr., SpA(K), M.Kes
 NIP. 196305191987122001

Pelengkapan berkas:
 File etik ini berlaku selama satu tahun sejak tanggal ditetapkan.
 This ethical clearance is effective for one year from the due date.
 Pada akhir penelitian, laporan pelaksanaan penelitian harus diserahkan ke Komisi Etik Penelitian Kesehatan.
 In the end of the research, progress and final summary report should be submitted to the Health Research Ethics Committee.
 Jika ada perubahan atau perlu perubahan protokol dan/atau perpanjangan penelitian, harus mengajukan kembali permohonan kejian etik penelitian.
 If there be any protocol modification or duration and/or extension of the study, the Principal Investigator is required to resubmit the protocol for approval.
 Jika ada laporan donas yang tidak diinginkan (KTD) harus segera dilaporkan ke Komisi Etik Penelitian Kesehatan.
 If there are serious Adverse Events (SAE), should be immediately reported to the Health Research Ethics Committee.

Appendix C: Approval letter from midwifery associations and midwifery schools

1. Cover letter from Midwifery Education Association of Indonesia to some midwifery schools



ASOSIASI PENDIDIKAN KEBIDANAN INDONESIA (AIPKIND)

Jl. Pondok No.21E Kampung Ambon
Kef. Kayu Putih Kec. Pulogadung, Jak-Tim 13210

Telepon : 021 - 295 74896
Fax : 021 - 295 74896
Email : aipkindpsiat@gmail.com

No : 296/SP/AIPKIND/IX/2016
Lampiran : 1 Berkas
Perihal : Ijin wawancara penelitian

Jakarta, 2 September 2016

Kepada Ysb,

Dekan Fakultas Kedokteran Universitas Brawijaya Malang

Di-

Tempat

Dengan Hormat

Sehubungan dengan adanya permohonan penelitian Sdri. Qorinah Estiningtyas Sakilah Adnani, Mahasiswa Pasca Sarjana/S3 Kebidanan Aucland University New Zealand, bersama ini kami mohon bantuan kiranya Bapak dapat membantu ybs untuk melakukan wawancara dengan beberapa orang Dosen Bidan, 2 orang Obgyn yang mengelola dan mengajar, pembimbing klinik, mahasiswa serta beberapa Alumni.

Prosedur persyaratan perijinan dari institusi yang bersangkutan / Aucland University terlampir

Bantuan dan ijin yang Bapak berikan sangat diharapkan dan mudah-mudahan ybs dapat menyelesaikan pendidikannya dalam waktu yang tidak terlalu lama.

Demikian, atas bantuan yang Bapak berikan kami ucapkan terima kasih.

**Pengurus Asosiasi Pendidikan Kebidanan Indonesia
(AIPKIND)**

Dr. Jumiarni Ilyas, M.Kes : Yetty Leoni M. Irawan, Msc
Ketua : Sekretaris

Tembusan

1. Ketua Program Studi S1 dan S2 Kebidanan
2. Peninggal

2. Approval letter from Health of Polytechnic Majapahit, Mojokerto, East Java



YAYASAN KESEJAHTERAAN WARGA KESEHATAN KAB. MOJOKERTO
POLITEKNIK KESEHATAN MAJAPAHIT

Program Studi • D-III Keperawatan (Terakreditasi LAM-PTKes)
• D-III Kebidanan (Terakreditasi BAN-PT)

Jl. Raya Gayaman Km. 02 Mojoanyar Telp. 0321-329915 Fax. 0321-331736 Mojokerto 61364
E-mail : majapahitmojokerto.poltekkes@gmail.com Website : poltekkesmajapahit.ac.id

Mojokerto, 25 Agustus 2016

Nomor : 551/IVD/ PKM / 2016
Perihal : Persetujuan penelitian
Lampiran :-

Kepada Yth.
Qorinah Estiningtyas Sakilah Adnani, SST, M.Keb
PhD Candidate in Midwifery
Di Auckland, New Zealand

Dengan hormat,

Berdasarkan surat saudara tanggal 18 Agustus 2016 tentang permohonan ijin penelitian berjudul "*How can midwifery education in Indonesia be strengthened? A hermeneutic study*" yang akan dilaksanakan di Politeknik Kesehatan Majapahit Mojokerto, pada dasarnya kami tidak keberatan dan memberikan ijin untuk melakukan penelitian di Politeknik Kesehatan Majapahit Mojokerto.

Demikian surat ini kami buat dan atas kerjasamanya kami sampaikan terimakasih

Direktur,

dr. Rahmi Syarifatun Abidah
082 20 250 088

3. Approval letter from Polytechnic of Health, Ministry of Health, Yogyakarta, Central Java

LEMBAR DISPOSISI

Tanggal : 02 September 2016
Jam : 13.30 WIB

No. Agenda Surat	1030	Tgl. Agenda	<input type="checkbox"/> RAHASIA
No. Agenda TU	:	Tgl. Agenda TU	<input type="checkbox"/> PENTING
			<input type="checkbox"/> BIASA
			<input type="checkbox"/> SEGERA

Nomor Surat	DM. 01.04 / 1.1 / 4814 / 2016	Tgl Surat	: 1 September 2016
Asal Surat	Direkturat		
Isi Ringkas	Permohonan Ijin Penelitian A/N Qorinah Estinngtyas Sakilah Adnani M. Keb Judul : How can Midwifery Education.		

DITERUSKAN KEPADA :	INSTRUKSI/INFORMASI
<input type="checkbox"/> Kaprodi D-3	<input type="checkbox"/> Teliti & Pendapat/ Telaahan
<input type="checkbox"/> Kaprodi D4	<input type="checkbox"/> Untuk Diketahui/ Simpan
<input type="checkbox"/>	<input type="checkbox"/> Selesaikan/ Tindak Lanjut
<input type="checkbox"/>	<input type="checkbox"/> Monitor/Lapor
<input type="checkbox"/>	<input type="checkbox"/> Hadir/Wakilkan
	<input type="checkbox"/> Bicarakan dengan saya
	<input type="checkbox"/> Edarkan/ Teruskan Jawab/ Setuju/ Tolak
	<input checked="" type="checkbox"/> Jadwalkan Koordinasikan
	<input type="checkbox"/>

CATATAN PIMPINAN
<p>Segepa : y dikombinasikan dg su ppm f 7/9 2016</p> <p>Wakilkan NIKEN : untuk di tindak lanjuti</p> <p style="text-align: right;">2/9 2016 A</p>

4. Approval letter from Polytechnic of Health, Ministry of Health, Yogyakarta, Central Java

 **KEMENTERIAN KESEHATAN R.I.**
BADAN PENGEMBANGAN DAN PEMBERDAYAAN
SUMBER DAYA MANUSIA KESEHATAN
POLITEKNIK KESEHATAN KEMENKES YOGYAKARTA
Jl. Tabanuri No. 3, Banyuwadèn, Gamping, Sleman, D.I. Yogyakarta Telp./Fax. (0274) 617601
http://www.poltekkesjogja.ac.id e-mail : poltekkes.depkes.yogya@gnresf.com

Nomor : DM.01.04/1/1/4874 /2016
Lamp : 1 (satu) set
Perihal : Permohonan Ijin Penelitian

1 September 2016

Kepada Yth.
Qorinah Estiningtyas Sakilah Adnani, SST, M.Keb
Di Tempat

Dengan hormat,

Menjawab surat dari Saudari Qorinah Estiningtyas Sakilah Adnani, SST, M.Keb, tanggal 20 Agustus 2016 perihal permohonan izin untuk penelitian tersebut dibawah ini:

Nama : Qorinah Estiningtyas Sakilah Adnani, SST, M.Keb
Nomor Identitas Mahasiswa : 14831683
Judul : How can midwifery education in Indonesia be strengthened? A hermeneutic study
Lokasi : Poltekkes Kemenkes Yogyakarta Jurusan Kebidanan
Waktu Penelitian : September - Oktober 2016

Pada prinsipnya kami tidak keberatan untuk dilakukan penelitian di lokasi tersebut. Dengan ketentuan:

1. Dalam melaksanakan penelitian tersebut harus selalu berkoordinasi dengan penanggung jawab di lokasi;
2. Wajib menjaga ketertiban dan mematuhi peraturan Poltekkes Kemenkes Yogyakarta;
3. Izin hanya digunakan untuk kegiatan sesuai izin yang diberikan;
4. Setelah selesai kegiatan wajib melaporkan pelaksanaan kegiatan dalam bentuk *softcopy* (CD) dan *hardcopy* kepada Poltekkes Kemenkes Yogyakarta;
5. Izin dapat dibatalkan sewaktu-waktu apabila tidak memenuhi ketentuan tersebut diatas;

Demikian, atas perhatian dan kerjasamanya diucapkan terima kasih.


Direktur,
Abdillah Mulyid, SKM., MS
NIP. 195606061981111001

Tembusan :
1. Ketua Jurusan Kebidanan
2. Yang Bersangkutan
3. Arsip

5. Approval letter from the Midwifery Education Association of Indonesia, Jakarta Special Capital Region



ASOSIASI PENDIDIKAN KEBIDANAN INDONESIA (AIPKIND)

Jl. Pondok No.21E Kampung Ambon
Kel. Kayu Putih Kec. Pulogadung, Jak-Tim 13210

Telepon : 021 – 293 74896
Fax : 021 – 293 74896
Email : aipkindpuset@gmail.com

No : 278/SP/AIPKIND/IX/2016

Jakarta, 2 September 2016

Lampiran : 1 Berkas

Perihal : Ijin wawancara penelitian

Kepada Yth

Sdri. Qorinah Estiningtyas Sakilah Adnani

Di-

Tempat

Dengan hormat,

Memperhatikan surat Saudari tentang permohonan bantuan fasilitasi untuk mendapatkan ijin / melaksanakan penelitian, bersama ini kami beritahukan bahwa pada prinsipnya kami mendukung dan akan memfasilitasi **Sdri. Qorinah Estiningtyas Sakilah Adnani** mengambil data penelitian pada responden terpilih. Untuk pelaksanaannya Sdr menghubungi langsung Dosen Bidan & Bidan praktek yang diinginkan.

Demikianlah, atas perhatiannya diucapkan terima kasih.

**Pengurus Asosiasi Pendidikan Kebidanan Indonesia
(AIPKIND)**

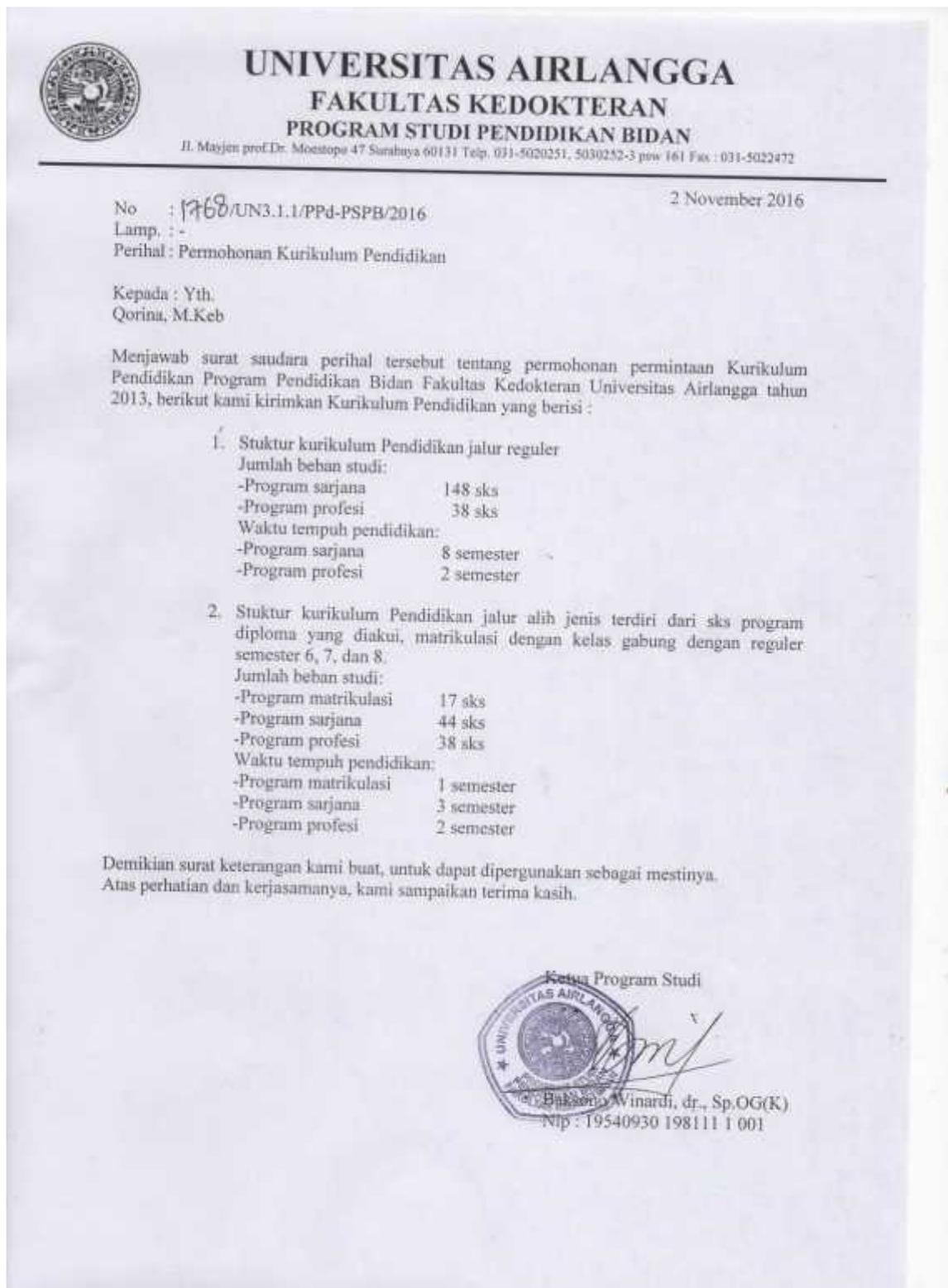
Dra. Murniarni Ilyas, M.Kes
Ketua

Yetti Leani M. Irawan, Msc
Sekretaris

Tembusan

1. Pettinggal

6. Cover letter from Midwifery Programme, Medical Faculty, Airlangga University, Surabaya, East Java



7. Approval letter from Midwifery Programme, Medical Faculty, Airlangga University, Surabaya, East Java

**UNIVERSITAS AIRLANGGA**
FAKULTAS KEDOKTERAN
PROGRAM STUDI PENDIDIKAN BIDAN
Jl. Mayjen prof.Dr. Moestopo 47 Surabaya 60131 Telp. 031-5020251, 5030252-3 psw 161 Fax : 031-5022472

SURAT IJIN
MELAKUKAN SURVEY / PENELITIAN
Nomor: 1344 /UN3.1.1/PPd-PSPB/2016

Memperhatikan Surat
Dari : Qorinah Estiningtyas Sakilah Adnani
Tanggal : 04 Agustus 2016
Hal : Ijin Survey / Penelitian

Dengan ini menyatakan tidak keberatan dilakukan survey / penelitian oleh:
Nama : Qorinah Estiningtyas Sakilah Adnani
Pekerjaan : Dosen Kebidanan STIKES Karya Husada Kediri
Menempuh Program: Mahasiswa di Auckland University of Technology
(Program PhD Midwifery)
Tujuan : Melaksanakan Penelitian
Tema Penelitian : "How Can midwifery education in Indonesia be strengthened?
A hermeneutic study"
Daerah / Tempat : Program Studi Pendidikan Bidan FK Universitas Airlangga
Penelitian : Surabaya

Dengan Syarat – syarat / ketentuan sebagai berikut:

1. Yang bersangkutan harus mentaati ketentuan – ketentuan / peraturan yang berlaku dimana dilakukannya kegiatan penelitian.
2. Dilarang menggunakan kuesioner diluar design yang telah ditentukan.
3. Yang bersangkutan sebelum dan sesudah melakukan survey / penelitian harap melaporkan pelaksanaan dan hasilnya kepada Program Studi Pendidikan Bidan FK Universitas Airlangga Surabaya.
4. Surat ijin ini akan dicabut / tidak berlaku apabila yang bersangkutan tidak memenuhi syarat – syarat serta ketentuan seperti diatas.

Demikian Surat Izin Melaksanakan Survey / Penelitian diberikan kepada yang bersangkutan untuk dipergunakan oleh yang berkepentingan seperlunya.

Surabaya, 02 September 2016
Koordinator Program Studi

Baksono Winardi, dr., Sp. OG(K)
NIP : 19540930 198111 1001

8. Approval letter from Institute of Health Science Dharma Husada, Bandung, West Java

 **STIKes Dharma Husada**
Sekolah Tinggi Ilmu Kesehatan Dharma Husada Bandung
Jl. Terusan Jakarta No.75 Telp/Fax.022-7204803 Antapani Bandung

Nomor : 188/SDHBI/TU/IX/2016
Lampiran : -
Perihal : **Permohonan Izin Penelitian**

Bandung, 05 September 2016

Kepada yang terhormat,
Qorinah Estiningtyas Sakilah Adnani
di-
Tempat

Memperhatikan surat dari saudara , tanggal 12 Agustus 2016 , perihal permohonan izin penelitian, dengan ini disampaikan bahwa pada prinsipnya kami dapat memberikan izin kepada saudara, untuk melaksanakan kegiatan penelitian tentang **"How can midwifery education in Indonesia be strengthened? A hermeneutic study"**.

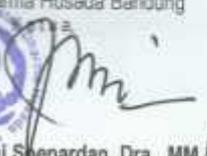
Kegiatan tersebut dapat dilaksanakan dengan ketentuan sebagai berikut :

1. Tidak mengganggu pelayanan di STIKes Dharma Husada Bandung.
2. Mematuhi ketentuan/prosedur yang telah ditentukan STIKes Dharma Husada Bandung.
3. Hasil dari kegiatan hanya untuk tujuan akademik, apabila akan dipublikasikan harus mendapat persetujuan dari STIKes Dharma Husada Bandung.
4. Menyerahkan laporan hasil kegiatan ke Bagian Akademik STIKes Dharma Husada Bandung.
5. Kegiatan tersebut dimulai pada tanggal 13 September s.d. 12 Nopember 2016.
6. Untuk pelaksanaannya dilaksanakan berdasarkan kesepakatan Saudara dengan unit terkait.
7. Bersedia mempresentasikan hasil penelitian (apabila diperlukan oleh STIKes Dharma Husada Bandung).

Untuk memperoleh keterangan lebih lanjut sebelum melaksanakan kegiatan, kami harap yang bersangkutan dapat menghubungi Bagian Akademik STIKes Dharma Husada Bandung.

Demikian kami sampaikan, atas perhatiannya kami ucapkan terima kasih.

STIKes Dharma Husada Bandung


Dr. Hj. Suryani Sibepardan, Dra., MM

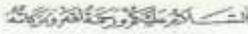
Tembusan : Kepada yang terhormat,
1. Ketua Yayasan Purna Dharma Husada di Bandung
2. Wakil Ketua I, II STIKes STIKes Dharma Husada Bandung
3. Yang bersangkutan

9. Approval letter from Health Science Faculty, Aisyiyah University, Yogyakarta, Central Java

 UNIVERSITAS 'AISYIYAH YOGYAKARTA
FAKULTAS ILMU KESEHATAN (FIKES)
Kepmenristek & Dikti No: 100/KPT/1/2016 Tanggal 10 Maret 2016 

Nomor : 272/UNISA/Ad/IX/2016
Hal : Ijin Penelitian

Kepada Yth.
Qorinah Estinigtyas Sakilah Adnani, SST., M.Keb
PhD candidates in Midwifery
di Tempat



Puji syukur kita panjatkan ke hadirat Allah SWT atas limpahan rahmat dan karunia Nya, tidak lupa sholawat semoga tetap tercurah kepada junjungan kita Nabi Muhammad SAW beserta keluarga dan sahabat-sahabatnya. Amin.

Berdasarkan surat Ibu tanggal 23 Agustus 2016 tentang Permohonan Ijin Penelitian atas nama:

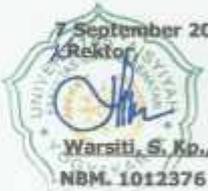
Nama	: Qorinah Estinigtyas Sakilah Adnani, S.ST., M.Keb
NIM	: 14831683
Perguruan Tinggi	: Aucland University of Technology (AUT)
Supervisor	: 1. Associate Professor Judith McAra-Couper 2. Dr. Andrea Gilkison
Tujuan	: Untuk melaksanakan penelitian di Fakultas Ilmu Kesehatan, Universitas 'Aisyiyah Yogyakarta dalam rangka menyusun disertasi dengan judul " How can midwifery education in Indonesia be strengthened? A hermeneutic study "

Pada prinsipnya **dijinkan**, dengan ketentuan :

1. Mematuhi peraturan yang berlaku di Universitas 'Aisyiyah Yogyakarta dan tidak mengganggu kegiatan di Universitas 'Aisyiyah Yogyakarta.
2. Menyerahkan dan mempresentasikan hasil penelitian secara langsung/teleconference kepada Rektor Universitas 'Aisyiyah Yogyakarta.
3. Membayar biaya administrasi Rp. 750.000 (Tujuh ratus lima puluh ribu rupiah) kepada bagian administrasi keuangan Universitas 'Aisyiyah Yogyakarta.

Demikian atas perhatian dan kerjasama yang baik diucapkan terima kasih.




7 September 2016
Rektor
Warsiti, S. Kp., M. Kep., Sp. Mat
NBM. 1012376

Tembusan :

1. Yang bersangkutan
2. Ketua LPPM
3. Administrasi Keuangan
4. Arsip

10. Approval letter from the Public Health Office, Padang, West Sumatera



**PEMERINTAH KOTA PADANG
DINAS KESEHATAN**

Jl. Dy Patis Km 15 Padang *Telp (0751) 462619*

Nomor : *070/36-37 /SDM /DKK/IX/2016* Padang, 5 September 2016
Lamp : -
Perihal : Izin Penelitian

Kepada Yth :
Qorinah Estiningtyas Sakilah Adnani
di
Tempat

Sehubungan dengan surat Saudara tanggal 23 Agustus 2016 perihal yang sama pada pokok surat di atas pada prinsipnya kami tidak keberatan memberikan izin kepada Saudara melakukan penelitian di lingkungan Dinas Kesehatan Kota Padang.

NO	ID	Judul
1	1310418106047	How can Midwifery Education in Indonesia be Strengthened? A Hermeneutic Study

Dengan ketentuan sebagai berikut :

1. Tidak menyimpang dari kerangka acuan penelitian.
2. Mematuhi semua peraturan yang berlaku.

Demikian disampaikan, atas perhatiannya kami ucapkan terima kasih.


Kepala DKK Padang
Kand. PSDM
[Signature]
Desmita Wiguna, SKM
Nip. 19660225 198903 1 005

Tembusan : disampaikan kepada Yth :

1. Ka. Bid. DKK Padang
2. Ka. Pusk. Kota Padang
3. Arsip

11. Approval letter from Medical Faculty, University of Andalas, The Ministry of Research Technology and Higher Education, Padang, West Sumatera

The Ministry of Research, Technology and Higher Education University of Andalas Medical Faculty		Kementerian Riset, Teknologi dan Pendidikan Tinggi Universitas Andalas Fakultas Kedokteran
<small>J. Perintis Kemerdekaan No. 94, PO BOX 49 Padang 25127 West Sumatra - Indonesia Phone : +62 751 31746 Fax : +62 751 32838, Dean : +62 751 39844 website : http://fk.unand.ac.id e-mail : dekanat@fk.unand.ac.id</small>		<small>J. Perintis Kemerdekaan No. 94, PO BOX 49 Padang 25127 Sumatera Barat - Indonesia Telpon : +62 751 31746 Fax : +62 751 32838, Dekan : +62 751 39844 website : http://fk.unand.ac.id e-mail : dekanat@fk.unand.ac.id</small>

Nomor: *969* /UN16.2/TU/2016 9 September 2016
Hal : Persetujuan untuk Pengambilan Data.

Yth.Sdr.Qorinah Estiningtyas Sakilah Adnani,SST,M.KebPhD
School of Clinical Sciences, Departement of Health Care Practice
Faculty Health and Environmental Sciences
Auckland University of Tecnology (AUT)
Auckland, New Zealand

Membalas surat Saudara tanggal 23 Agustus 2016, tentang izin untuk pengambilan data untuk penelitian, dengan Judul Penelitian " Haw can midwifery education in Indonesia be strengthened ? A hermeneutic study " **pada prinsipnya dapat disetujui**, dengan catatan :

1. Semata-mata untuk kepentingan Pendidikan
2. Memberikan laporan dari hasil penelitian

Demikian disampaikan, atas perhatian Saudara diucapkan terima kasih.


Dr. dr. H. Masrul, MSc, SpGK
NIP. 19561226 198710 1 001

Tembusan :

1. Ka.Prodi S2 Kebidanan FK.Unand
2. Ka.Prodi S1 Kebidanan FK.Unand
3. Arsip

12. Approval letter from Polytechnic of Health, Ministry of Health, Padang, West Sumatera

 **KEMENTERIAN KESEHATAN RI**
BADAN PENGEMBANGAN DAN PEMBERDAYAAN
SUMBERDAYA MANUSIA KESEHATAN
POLITEKNIK KESEHATAN KEMENKES PADANG 

Jl. SIMPANG PONDOK KOPI NANGGALO TELP. (0751)7051300 FAX: (0751)7058128 PADANG 25146
Website: <http://www.poltekes-pdg.ac.id>
Telp. Jurusan Keperawatan (0751)7051848, Prodi Keperawatan Solok (0755)20445, Jurusan Kesehatan Lingkungan (0751)7051817-56608
Jurusan Gizi (0751)7051769, Jurusan Kebidanan (0751)443120, Prodi Kebidanan Bukittinggi (0752)32474, Jurusan Keperawatan Gigi (0752)23085-21075

Nomor : DM.02.04/ 3766/2016 09 September 2016
Lamp : 1 (satu) lembar
Perihal : Izin Penelitian

Kepada Yth.
Qorinah Estiningtyas Sakilah Adnani
di
Tempat

Sehubungan dengan surat Saudara tanggal 23 Agustus 2016 perihal yang sama pada pokok surat di atas pada prinsipnya kami tidak keberatan memberikan izin kepada Saudara melakukan penelitian di lingkungan Poltekkes Kemenkes Padang.

NO	ID	Judul
	14831683	How can Midwifery Education in Indonesia be Strengthened A hermeneutic Study

Dengan ketentuan sebagai berikut:

1. Tidak menyimpang dari kerangka acuan penelitian
2. Mematuhi semua peraturan yang berlaku
3. Mengisi formulir permintaan informasi publik

Demikian disampaikan, atas perhatiannya kami ucapkan terimakasih.


Direktor
H. Sunardi, SKM, M.Kes
NIP.1959082911982101001

Tembusan : disampaikan kepada Yth

1. Pudir I, II, dan III
2. Ka. UPT Penelitian
3. Ka. Subbag ADAK
4. Ka. Subbag ADUM
5. Arsip

13. Approval letter from Midwifery Programme, Medical Faculty, Brawijaya University, Malang, East Java

	<p style="text-align: center;">KEMENTERIAN RISET, TEKNOLOGI, DAN PENDIDIKAN TINGGI UNIVERSITAS BRAWIJAYA FAKULTAS KEDOKTERAN</p> <p style="text-align: center;">Jalan Veteran Malang - 65145, Jawa Timur - Indonesia Telp. (62) (0341) 551611 Ext. 213.214; 569117; 567192 - Fax. (62) (0341) 564755 http://www.fk.ub.ac.id e-mail : sekr.fk@ub.ac.id</p>
<hr/>	
Nomor : 10218 /UN10.7/ S1Keb/2016	27 SEP 2016
Lampiran : 1 (Satu) Lembar	
Hal : Tanggapan Ijin Wawancara Penelitian An. Qoriyah Estiningtyas Sakilah Adnani	
<p>Yth. Ketua AIPKIND di Jakarta</p> <p>Menindaklanjuti surat dari Ketua Asosiasi Pendidikan Kebidanan Indonesia (AIPKIND) Jakarta Nomor: 296/SP/AIPKIND/IX/2016 tertanggal 02 September 2016 tentang Ijin wawancara penelitian mahasiswa <i>University of Technology (AUT), Auckland, New Zealand</i> atas nama Qorinah Estiningtyas Adnani, PhD candidate in Midwifery dengan judul penelitian: "<i>How Can Midwifery Education in Indonesia be Strengthened? A Hermeneutic Study</i>", dengan ini kami sampaikan bahwa pada prinsipnya kami dapat menerima permohonan ijin wawancara penelitian Saudara di Fakultas Kedokteran Universitas Brawijaya. Berikut terlampir form kesediaan sebagai responden.</p> <p>Demikian atas perhatian dan kerjasamanya, kami sampaikan terima kasih.</p>	
	 Dekan
Tembusan :	Dr. dr. Sri Andarini, M. Kes NIP. 19580414 198701 2 001
1. KPS S1 Kebidanan FKUB	
2. Ybs	
<p style="text-align: center;">D:/SUSI/SSK/AK-S1KEB/2016</p>	

14. Approval letter from Polytechnic of Health, Ministry of Health Jakarta III, Jakarta Special Capital Region



**KEMENTERIAN KESEHATAN REPUBLIK INDONESIA
BADAN PENGEMBANGAN DAN PEMBERDAYAAN
SUMBER DAYA MANUSIA KESEHATAN
POLITEKNIK KESEHATAN JAKARTA III**

Jl.Arteri JORR Jatiwarna Kec.Pondok Melati - Bekasi 17415

Tel. (021) 84978693 Fax. (021) 84978696

Website : www.poltekkesjakarta3.ac.id, Email : sekretariat@poltekkesjakarta3.ac.id



Nomor : DM.02.02/ L.05 / 5905 / 2016
Lampiran : -
Perihal : **Balasan permohonan Ijin Penelitian.**

30 September 2016

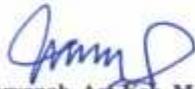
Kepada Yth,
Ketua
Asosiasi Pendidikan Kebidanan Indonesia (AIPKIND)
Jl. Pondasi No. 21E Kampung Ambon
Kel. Kayu Putih Kec. Pulogadung

di -
Jakarta Timur

Menjawab surat No. 287/SP/AIPKIND/IX/2016 tertanggal 2 September 2016 perihal Izin wawancara penelitian. Bersama ini kami sampaikan bahwa pada prinsipnya kami mengizinkan untuk melakukan wawancara penelitian dengan sebelumnya melampirkan ethical aproval dari Auckland University of Technology Ethics Committee sesuai dengan Prosedur Komisi Etik Penelitian di Poltekkes Kemenkes Jakarta III.

Untuk selanjutnya untuk teknisnya dapat berkoordinasi kepada Ketua Jurusan Kebidanan Poltekkes Kemenkes Jakarta III untuk perizinan lebih lanjut.

Demikian, atas perhatiannya kami ucapkan terima kasih.

Direktur, 

Dra. Maryanah, Am.Keb, M.Kes
NIP. 195905201979122001

Tembusan.

1. Pudir I
2. Ka. Subbag ADAK dan Persin
3. Ketua Komisi Etik

15. Approval letter from Indonesian Midwives Association, Jakarta Special Capital Region



16. Approval letter from Health Science Faculty, Muhammadiyah University, Purwokerto, Central Java



UNIVERSITAS MUHAMMADIYAH PURWOKERTO
FAKULTAS ILMU KESEHATAN

Kampus II : Jl. Letjen. Soepardjo Roestam Km 7 PO. Box 229 Purwokerto 53181
Telp. (0281) 6844252, Fax. (0281) 6844253

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

Nomor : A17.II/17331 S.Pb/FIKES/X/2016
Lamp. : -
Hal : Ijin Penelitian untuk Penulisan Disertasi

23 Muharram 1438 H
24 Oktober 2016 M

Kepada : Yth. Sdr. Qorinah Estinilingtyas Sakilah Adnani, S.ST., M.Keb., PhD Candidate in Midwifery
School of Clinical Sciences, Department of Health Care Practice,
Faculty Health and Environmental AUT, Auckland, New Zealand

Assalamu'alaikum wr. wb.,

Menjawab surat Saudara tertanggal 18 Agustus 2016 perihal seperti tersebut pada pokok surat, dengan hormat kami beritahukan bahwa kami tidak keberatan Saudara melakukan penelitian dengan judul "How can midwifery education in Indonesia be strengthened ? A hermeneutic study" di Fakultas Ilmu Kesehatan Universitas Muhammadiyah Purwokerto terhitung mulai akhir bulan Oktober sampai dengan selesai.

Untuk keperluan dokumentasi serta menambah koleksi pustaka Fakultas Ilmu Kesehatan Universitas Muhammadiyah Purwokerto, mohon hasil penelitiannya dapat dialokasikan 1 eksemplar Fakultas Ilmu Kesehatan Universitas Muhammadiyah Purwokerto.

Demikian pemberitahuan ini untuk diketahui dan guna seperlunya. Atas perhatian Saudara kami ucapkan terima kasih.

Wassalamu'alaikum wr. wb.,



Bekas,

Drs. H. Ikhsan Mujahid, M.Si.
HP. 1965039 199403 1 002

Tembusan Yth.
Rektor, sebagai laporan.

17. Approval letter from the Faculty of Medicine, Padjadjaran University, Bandung, West Java

**KEMENTERIAN RISET, TEKNOLOGI DAN PENDIDIKAN TINGGI**
UNIVERSITAS PADJADJARAN
FAKULTAS KEDOKTERAN
PROGRAM D.IV KEBIDANAN
Jl. Raya Bandung-Sumedang KM. 21 Telp. (022) 7795594 & (022) 7796373 Fax. (022) 7795595 Email - 48bid@unpad.ac.id

Nomor : 273/UN6.C1.SBA/TU/2016 21 November 2016
Lampiran : -
Hal : Ijin Penelitian

Kepada :
Yth. Sdr. Qorinah Estiningtyas Sakilah Adnani
Di Tempat

Menindaklanjuti surat permohonan Saudari mengenai ijin untuk melaksanakan penelitian di Prodi D.IV Kebidanan FK.Unpad, pada prinsipnya kami mengizinkan Saudari untuk melakukan penelitian tersebut, agar penelitian berjalan lancar, silahkan untuk menghubungi Sekretaris Prodi dalam mengatur waktu pengambilan data di Prodi.

Demikian surat balasan kami, untuk dapat dipergunakan sebagaimana mestinya. Atas perhatiannya kami ucapkan terima kasih.


an Ketua
Sekretaris,
Seti Aryuni Nirmala, SST.,M.Keb

Tembusan :
Yth. Ketua Program Studi Diploma IV Kebidanan (sebagai laporan)

Appendix D: Tools for data collection

1. Participant Invitation (Email)



Participant Invitation (Email)

Dear potential participant,

My midwifery colleague will do the research in Indonesia. Her name is Qorinah Estiningtyas Sakilah Adnani and a Doctor of Philosophy (PhD) student in Midwifery, Auckland University of Technology (AUT) Auckland, New Zealand. She would like to invite you to participate in her research study. This study is a fulfilled requirement towards her doctoral degree. She will be the primary researcher of this study and her study under supervision of Associate Professor Judith Mc-Ara Couper and Dr Andrea Gilkison. She is a registered midwifery lecturer on leave from Institute of Health Sciences Karya Husada, Kediri, East Java.

Her study describe that midwives are the frontline of maternal and neonatal care and play a pivotal role to enhance maternal, and infant health outcomes, and midwifery education is one of the three pillars to strengthen midwives globally. The study will explore how midwifery education in Indonesia can be strengthened. This study aims to:

1. explore the experience of midwifery educators, midwifery students, newly graduated midwives, and the view of key informants about what may strengthen midwifery education.
2. identify the barriers and enablers to strengthen midwifery education.
3. determine how midwifery education may be strengthened in Indonesia leading to competent and confident midwifery graduates.

This study will contribute to her PhD degree and sponsored by the Ministry of Research, Technology and Higher Education of Indonesia. The results of this study will be disseminated as a written report. It is anticipated that conference presentations and journal articles will be generated from the research findings from this research.

She is interested in hearing your experience regarding this study. Any information you provide will be kept confidential. Further information about this study can be found in the attached Participants Information Sheet. You are invited to take part in a face to face in-depth interview.

Attached to this invitation is a Participant Information Sheet. This will provide you with further information about the interview and who to contact if you have any questions. If you are happy to participate after reading this information please contact the researcher: Qorinah Estiningtyas Sakilah Adnani on following address: qorinahestiningtyas@yahoo.co.id, Mobile +81357053522, Facebook Messenger: Qorin Prasetyo, WhatsApp +62 8992246896

She will value your feedback and we hope that you will consider sharing your experience so that we can strengthening midwifery education in Indonesia

Yours sincerely,

Ita Eko Suparni, SSIT, M.Keb

Approved by the Auckland University of Technology Ethics Committee on 19 July 2016, AUTEC Reference number 16/259.

2. Advertisement at Midwifery Schools

The logo for Auckland University of Technology (AUT) is located in the top right corner. It consists of the letters 'AUT' in a bold, white, sans-serif font on a black rectangular background. Below the letters, there is a smaller line of text in Indonesian: 'TEKNOLOGI, MANAJEMEN, HUMANISASI'.

An invitation to participate in important
midwifery research

How can midwifery education in Indonesia be strengthened? A hermeneutic study

My name is Qorinah Estiningtyas Sakilah Adnani. I am a Doctor of Philosophy (PhD) student in Midwifery at Auckland University of Technology (AUT), Auckland, New Zealand.

- If you are:
1. **midwifery educators** (Have the experience with at least five years to guide and teach midwifery students),
 2. **obstetricians** (Have the experience to lead or teach midwifery students at least five years),
 3. **midwifery students** (Age 18 years old upwards, Final year of studies),
 4. **newly graduated midwives** (Graduated within the last year),

I would like to invite you to participate in my study. This study will contribute towards my PhD qualification.

For further information, please contact me: Qorinah Estiningtyas sakilah Adnani. Email: qorinah.estiningtyas@aut.ac.nz
qorinahestiningtyas@yahoo.co.id or WhatsApp +62 8992246896, telp 082112271804

Approved by the Auckland University of Technology Ethics Committee on 19 July 2016, AUTEK Reference number 16/259.

3. Advertisement at the Midwifery Association



An invitation to participate in important midwifery research

How can midwifery education in Indonesia be strengthened? A hermeneutic study

My name is Qorinah Estiningtyas Sakilah Adnani. I am a Doctor of Philosophy (PhD) student in Midwifery at Auckland University of Technology (AUT), Auckland, New Zealand.

If you are: - registered midwives and
- have the experience to supervise midwifery students and/or newly graduated midwives with at least five years experience,

I would like to invite you to participate in my study. This study will contribute towards my PhD qualification.

For further information, please contact me: Qorinah Estiningtyas Sakilah Adnani
Email: qorinah.estiningtyas@aut.ac.nz,
qorinahestiningtyas@yahoo.co.id or Facebook Messenger: Qorin Prasetyo or WhatsApp +62 8992246896

Approved by the Auckland University of Technology Ethics Committee on 19 July 2016, AUTEK Reference number 16/259.

4. Participant Information Sheet in Bahasa Indonesia



Lembar Informasi untuk Responden
(Wawancara Mendalam)

Bahasa: salinan untuk lembar informasi ini tersedia dalam bahasa Inggris dan bahasa Indonesia

Tanggal Lembar Informasi Dikeluarkan:
4 Agustus 2016

Judul Penelitian
Bagaimana pendidikan kebidanan di Indonesia lebih diperkuat? Sebuah studi dengan hermeneutik

Sebuah undangan

Selamat datang. Nama saya Qorinah Estiningtyas Sakillah Adnani dan peneliti mahasiswa Pascasarjana (S3) Kebidanan di Auckland University of Technology (AUT) Auckland, New Zealand. Saya ingin mengajak anda untuk berpartisipasi dalam penelitian saya. Penelitian ini merupakan persyaratan untuk memenuhi pendidikan PhD saya. Partisipasi dalam penelitian ini bersifat sukarela dan responden diperbolehkan menarik diri berpartisipasi dalam penelitian ini kapan saja sampai balas akhir pengumpulan data. Saya akan menjadi peneliti utama dalam penelitian ini dan studi saya di bawah pengawasan Profesor Judith McAra-Couper dan Andrea Gilkison, PhD. Saya adalah seorang dosen kebidanan dari STIKES Karya Husada Kediri, Jawa Timur yang sedang tugas belajar melanjutkan studi

Apa tujuan dari penelitian ini?
Bidan adalah garis terdepan dalam perawatan ibu dan bayi dan memainkan peranan penting untuk meningkatkan kesehatan ibu dan bayi, dan pendidikan kebidanan merupakan salah satu dari tiga pilar untuk memperkuat bidan secara internasional. Penelitian ini akan mengeksplorasi bagaimana pendidikan kebidanan di Indonesia dapat lebih diperkuat. Penelitian ini bertujuan untuk:

1. mengeksplorasi pengalaman pendidik kebidanan, mahasiswa kebidanan, bidan yang baru lulus dan pandangan kunci informan tentang apa yang mungkin memperkuat pendidikan kebidanan
2. mengidentifikasi hambatan dan pendukung untuk memperkuat pendidikan kebidanan
3. menentukan bagaimana pendidikan kebidanan dapat diperkuat di Indonesia mengarah ke lulusan kebidanan yang kompeten dan percaya diri

Bagaimana aku diidentifikasi dan mengapa saudara diundang untuk berpartisipasi dalam penelitian ini

Saya meminta anda untuk mengambil bagian karena anda telah merespon iklan dan email saya. Pengalaman, persepsi dan perspektif anda sangat berharga untuk penelitian ini dan akan menguntungkan program pendidikan Indonesia hari ini dan untuk pendidikan kebidanan secara global di masa depan.

Bagaimana saya menyetujui untuk berpartisipasi dalam penelitian ini

Anda akan diminta untuk membaca dan menandatangani formulir persetujuan yang tersedia pada saat wawancara. Anda perlu membaca untuk memastikan bahwa anda mengerti tentang penelitian ini, serta hak-hak anda termasuk perlindungan privasi dan kerahasiaan

Apa yang akan terjadi dalam penelitian ini

Setelah anda menerima undangan saya untuk berpartisipasi dalam penelitian ini, saya akan meminta anda untuk mengambil bagian dalam wawancara mendalam. Dalam wawancara anda akan ditanya tentang pengalaman anda tentang pendidikan kebidanan. Anda akan diminta untuk berbicara tentang hal-hal yang membuat sulit atau mudah untuk melakukan perbaikan dalam pendidikan kebidanan seperti "Tolong ceritakan tentang pengalaman anda saat anda sedang belajar di sekolah kebidanan sebagai lulusan bidan?". Wawancara akan diadakan di tempat yang pribadi dan nyaman untuk anda. Anda dapat mengundang orang lain untuk bersama anda selama wawancara. Selama wawancara anda dapat menolak untuk menjawab pertanyaan.

Wawancara akan direkam dan kemudian ditranskrip. Rekaman dan transkrip tetap rahasia untuk supervisor penelitian saya dan saya sendiri. Sebuah nama samaran atau nama palsu akan digunakan pada semua rekaman, transkrip dan laporan untuk melindungi identitas anda. Saya akan menuliskan percakapan kita dan emilikinya untuk dikirim kepada anda untuk memeriksa keakuratannya. Laporan akhir penelitian akan dikirim kepada anda jika anda memerlukan

Apa ketidaknyamanan dan risiko

Saya tidak mengantisipasi risiko untuk anda dalam penelitian ini. Namun, wawancara kadang-kadang seperti dimana anda berbagi pikiran dan emosi dapat membuat seseorang merasa tidak nyaman

Bagaimana agar ketidaknyamanan dan risiko bisa dikurangi

Anda akan mengendalikan seberapa banyak informasi yang anda ingin berbagi. Anda tidak harus menjawab semua pertanyaan dan anda dapat menghentikan wawancara setiap saat. Tidak ada informasi akan dilaporkan dalam penelitian yang dapat mengidentifikasi setiap orang tanpa izin dari orang tersebut.

Apakah manfaat

Manfaat mengambil bagian dalam studi ini adalah bahwa anda akan menjadi bagian dari penelitian yang memiliki potensi untuk memberikan keuntungan terhadap perempuan dan keluarga melalui penguatan pendidikan kebidanan. Penelitian ini akan menawarkan tempat yang ramah yang anda dapat berbagi pengalaman anda, persepsi dan perspektif mengenai pendidikan kebidanan. Informasi yang anda sampaikan akan memberikan keuntungan untuk pembuat kebijakan di Indonesia dalam meningkatkan pendidikan kebidanan sebagai kualitas lulusan adalah salah satu elemen untuk perawatan wanita. Penelitian ini juga dapat membantu saya dalam memperoleh kualifikasi PhD.

Bagaimana agar kerahasiaan data saya terjaga

Kerahasiaan anda akan terjaga. Setiap wawancara akan direkam dan ditranskrip. Untuk menjamin kerahasiaan dan perlindungan data identitas anda tidak akan diungkapkan kepada siapa pun. Sebuah nama samaran atau nama palsu akan digunakan pada semua kaset rekaman, transkrip dan laporan untuk melindungi identitas anda. Semua informasi yang berkaitan dengan anda akan disimpan dengan aman selama enam tahun dan peneliti akan bertanggung jawab untuk menghancurkan data dan tidak ada yang mengidentifikasi anda karena semua akan disimpan.

Apa pembiayaan untuk berpartisipasi dalam penelitian ini

Berpartisipasi dalam penelitian ini akan memakan waktu untuk melakukan wawancara, waktu untuk membaca transkrip dan mengembalikan transkrip. Wawancara diantisipasi sekitar 60-90 menit. Meninjau transkrip diantisipasi sekitar satu jam.

Apa kesempatan yang saya miliki untuk mempertimbangkan undangan ini

Jika anda ingin berpartisipasi dalam penelitian ini saya akan menghargai mendengar dari anda dalam waktu dua minggu. Jika anda ingin berpartisipasi dalam studi saya anda perlu menghubungi saya baik menggunakan nomor telepon atau alamat email di bawah ini. Kemudian kita akan menyepakati waktu dan tempat untuk wawancara berlangsung.

Apakah saya akan menerima umpan balik dari penelitian ini

Ringkasan hasil penelitian akan ditawarkan kepada seluruh responden penelitian ini. Temuan juga dapat disajikan pada konferensi dan seminar. Identitas anda tidak akan terungkap dalam konteks ini. Juga akan ada publikasi dari studi dalam bentuk jurnal.

Apakah yang saya lakukan jika saya memiliki kekhawatiran tentang penelitian ini

Segala sesuatu tentang sifat penelitian ini bisa disampaikan pertama kali ke Pimpinan penelitian ini Profesor Judith McAra-Couper, email: jmcaraco@aul.ac.nz, Telepon: +64 9921 9999 ext 7193.

Perhatian terkait pelaksanaan penelitian ini bisa disampaikan kepada Sekretaris Eksekutif AUTEK, Kate O'Connor, ethics@aul.ac.nz, Phone: +64 9921 9999 ext 6038.

Siapakah yang saya hubungi untuk informasi lebih lanjut tentang penelitian ini

Detail kontak peneliti:

Qorinah Estiningtyas Sakilah Adnani (mahasiswa PhD)
Auckland University of Technology (AUT), Auckland, New Zealand
qorinah.estiningtyas@aut.ac.nz qorinahestiningtyas@vahoo.co.id or
Facebook account: Qorin Prasetyo, or WhatsApp +62 8992246896

Detail kontak pembimbing:

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Dr Andrea Gilkison

Centre for Midwifery & Women's Health Research,
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Approved by the Auckland University of Technology Ethics Committee on *19 July 2016*, AUTEK Reference number *16/259*

5. Participant Information Sheet in an English version



Participant Information Sheet

Participant Information Sheet (In-depth Interviews)

Languages: copies of this information sheet are in English and Indonesian

Date Information Sheet Produced:

4th August 2016

Project Title

How can midwifery education in Indonesia be strengthened? A hermeneutic study

An Invitation

Selamat datang. My name is Qorinah Estiningtyas Sakilah Adnani, and I am a Doctor of Philosophy (PhD) student in Midwifery, Auckland University of Technology (AUT) Auckland, New Zealand. I would like to invite you to participate in my research study. This study is a fulfilled requirement towards my doctoral degree. Participation in this research is voluntary, and the participants may withdraw their involvement in this study at any time up until the end of data collection. I will be the primary researcher of this study and my study under the supervision of Associate Professor Judith Mc-Ara Couper and Dr Andrea Gilkison. I am a registered midwifery lecturer on leave from Institute of Health Sciences Karya Husada, Kediri, East Java.

What is the purpose of this research?

Midwives are the frontline of maternal and neonatal care and play a pivotal role to enhance maternal, and infant health outcomes and midwifery education is one of the three pillars to strengthen midwives globally. The study will explore how midwifery education in Indonesia can be strengthened. This study aims to:

1. explore the experience of midwifery educators, midwifery students, newly graduated midwives, and the view of key informants about what may strengthen midwifery education.
2. identify the barriers and enablers to strengthen midwifery education.
3. determine how midwifery education may be strengthened in Indonesia leading to competent and confident midwifery graduates.

This study will contribute to my PhD degree and sponsored by the Ministry of Research, Technology and Higher Education of Indonesia.

The results of this study will be disseminated as a written report. It is anticipated that conference presentations and journal articles will be generated from the research findings from this research.

How was I identified and why am I being invited to participate in this research?

I am asking you to take part because you have responded to an advertisement and an email. Your experiences, perceptions, and perspectives are precious for this study and will benefit Indonesia midwifery education programme today and for future midwifery education globally.

How do I agree to participate in this research?

You will be required to read and sign a consent form that will be available at the time of the interview. You need to sign it to make sure that you understand about this research, as well as your rights including the protection of your privacy and confidentiality.

What will happen in this research?

After you accept my invitation to participated in my study, I will ask you to take part in an in-depth interview. In the interview, you will be asked about your experience regarding midwifery education. You will be invited to talk about the things that make it difficult or easy to make improvement in midwifery education such as "Please tell me about your experience while you were studying in midwifery school, as a new graduate midwife after your graduation?". The interview will be held at a place that is private and convenient for you. You can invite a support person to be with you during the interview. During the interview, you can refuse to answer any questions.

The interview will be audiotaped and later transcribed. These tapes and transcripts remain confidential to my research supervisors and me. A pseudonym or false name will be used on all the tapes, transcripts and reports to protect your identity. I will transcribe our conversation and have it sent to you for checking its accuracy. The final report of the study will be forwarded to you if you require.

What are the discomforts and risks?

I do not anticipate any risks to you from this study. However, sometimes such interviews in which you share your thoughts and emotions can make a person feel uncomfortable.

How will these discomforts and risks be alleviated?

You will be control of how much information you share. You do not have to answer all the questions, and you can stop the interview at any time. No information will be reported in the research that could identify any person without the express permission of the individual.

What are the benefits?

The benefits of taking part in this study are that you will be part of the research that has the potential to help women and families through strengthening midwifery education. This study will offer a friendly place that you can share your experiences, perceptions, and perspectives regarding midwifery education. Your information will benefit for the Indonesian policy makers in enhancing midwifery education as the quality of graduates is one of the elements for childbearing women. The study may also assist me in obtaining a PhD qualification.

6. Consent Form in Bahasa Indonesia



Formulir Kesediaan

Digunakan untuk keperluan wawancara

Judul penelitian: Bagaimana cara pendidikan kebidanan di Indonesia lebih dikuatkan? Studi dengan hermeneutik

Pembimbing Penelitian: Associate Professor Judith McAra-Couper, Dr Andrea Gillison

Peneliti: Qorinah Estiningtyas Sakilah Adnani

- Saya telah membaca dan memahami informasi yang disediakan tentang penelitian ini seperti yang tertuang dalam lembar informasi yang dikeluarkan pada tanggal 4 Agustus 2016
- Saya memiliki kesempatan untuk menanyakan pertanyaan dan diberikan jawaban
- Saya memahami bahwa catatan akan diambil selama wawancara dan peneliti juga akan merekam dan menulis kembali seluruh wawancara dalam bentuk transkrip
- Saya memahami bahwa partisipasi saya dalam penelitian ini bersifat sukarela (pilihan saya sendiri) dan kemungkinan bisa mengundurkan diri setiap saat atau jika terdapat informasi yang saya sediakan untuk penelitian selama proses pengumpulan data tanpa ada keuntungan apa pun yang saya rasakan
- Saya memahami bahwa jika saya mengundurkan diri dari penelitian ini, saya akan diberikan tawaran tentang pilihan antara memiliki data tentang semua informasi yang berkaitan termasuk rekaman dan catatan wawancara atau bagian dari itu semua akan dimusnahkan atau diijinkan untuk digunakan. Bagaimanapun juga, sekali hasil penelitian telah dikeluarkan, pemusnahan data saya kemungkinan tidak mungkin dilakukan.
- Saya setuju untuk berpartisipasi dalam penelitian ini
- Saya berharap bisa menerima salinan laporan dari penelitian ini (pilih salah satu) : Ya Tidak

Tanda tangan responden:

Nama responden:

Alamat dan kontak responden (jika diperlukan):

.....
.....
.....
.....

Hari dan tanggal:

Approved by the Auckland University of Technology Ethics Committee on 19 July 2016 AUTEC Reference number 16/259

Note: The Participant should retain a copy of this form.

7. Prompt Questions for In-depth Interview

Indicative Questions for In-depth Interview

1. Introduction

- 1.1. My name is Qorinah, a Ph.D. student in Midwifery at the Auckland University of Technology, Auckland, New Zealand.
- 1.2. I would like to ask you to share your views about how can midwifery education in Indonesia be strengthened
- 1.3. I hope to use the conversation we share here beneficial to enhance midwifery education
- 1.4. We will spend around 60 minutes in conversation
- 1.5. Before having a conversation, the information sheet and consent form to read and sign. It is important to tell you that if you feel uncomfortable to share here, please feel free to withdraw

2. Body

- 2.1. I will start to talk about my background as a midwifery lecturer and as a midwife
- 2.2. Indicative Questions for Interviews to be used as prompts guide
 - a. Newly graduated midwives
 - Please tell me about your experience while you were studying in midwifery school, as a new graduate midwife, after your graduation?
 - What is your experience of being prepared to be a midwife and what do you think could be improved to make the new graduates feel even better prepared?
 - What would you identify as being the most important thing that you have experienced whilst studying midwifery?
 - Tell me about a time you cared for a women (pregnant woman, birthing, etc) while you were in midwifery school which prepared you for your current position?
 - What things can you identify to improve the midwifery program to help students become more confident?
 - What do you feel most proud about and what were the areas that you felt the least comfortable with?
 - What would you identify as being the most important thing to enhance midwifery education now and how can it work?
 - What would you identify as being the barriers and enablers when you do this? Can you suggest ways that can help reduce these barriers?
 - Has the midwifery education program made a difference for the women in your coverage area? Did it have any impact on others as well?

b. Midwifery students

- What were the key subjects of the education program that you participated in? Were there any major changes in the program while you were a student?
- What is your experience of being prepared to be a midwife?
- What would you identify as being the most important learning that you have received during your midwifery studies?
- What would you identify as being important things to improve midwifery education?
- If you were advising midwifery schools and governing bodies, what issues would you identify to help improve the midwifery school and curriculum?
- What would you identify as being the barriers and enablers within midwifery education? Can you suggest ways that can help reduce these barriers?

c. Midwifery educators/Obstetrician who teach/work in midwifery school

- Please tell me about your experience as educators. How do you organise and manage a successful course of study?
- What changes have you made over the time that you have been lecturing as a midwifery educator?
- What do you enjoy about teaching midwifery students?
- Please tell me about a time or times when you might have felt that it was “too hard” and what sustained you and helped you keep teaching during that time
- If you were advising midwifery education, what would you identify to offer as advice to midwifery schools?
- What would you identify as being the important most thing to strengthen midwifery education now and how can it work?
- If you were advising a new model of midwifery education, what advice would you give to your institution and government?
- What would you identify as being the barriers and enablers when you put your idea to a midwifery school? Can you suggest ways that can help reduce these barriers?
- Has the midwifery education program made a difference for the women in your coverage area? Did it have any impact on others as well?

d. Midwives from Indonesian Midwives Association and Indonesian Midwifery Education Association

- Please tell me about your view of the midwifery programme, how it is organised and managed and what makes it work
- What role does the association play in midwifery education?

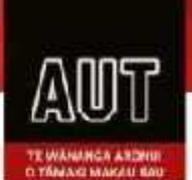
- If you were advising a midwifery school, what advice would you give on how to strengthen midwifery education?
- What do you think could be done better in relation to midwifery education?
- What would you identify as being the most important thing to strengthen midwifery education now and how can it work?
- What would you identify as being the barriers and enablers when you put your ideas to the midwifery association? Can you suggest ways that can help reduce these barriers?
- If you were advising a new model of midwifery education, what advice would you give to your institution/organisation and government
- Do you think the midwifery education program has made a difference to outcomes for women and babies in Indonesia?

3. Conclusion

3.1 I appreciate the time and the ideas from the participant

3.2 We will have refreshments together and I will give a souvenir for their time

8. Confidentiality Agreement in English



AUT
TE WHANAKA AROHU
O TĀHĀKI MĀKAU ĀRU

Confidentiality Agreement

For someone transcribing data, e.g. audio tapes of interviews.

Project title: How can midwifery education in Indonesia be strengthened? A hermeneutic study

Project Supervisor: Associate Professor Judith McAra-Couper, Dr Andrea Gilkison

Researcher: Qorinah Estiningtyas Sakilah Adnani

I understand that all the material I will be asked to transcribe is confidential.

I understand that the contents of the tapes or recordings can only be discussed with the researchers.

I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature:

Transcriber's name:

Transcriber's Contact Details (if appropriate):
.....
.....
.....
.....

Date:

Project Supervisor's Contact Details (if appropriate):
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.....
.....

Approved by the Auckland University of Technology Ethics Committee on 19 July 2016 AUTEK Reference number 16/259

Note: The Transcriber should retain a copy of this form

2 July 2015 page 1 of 3 This version was last edited in July 2015

Appendix E: Summary of Data

Table E1 Summary of Data

Newly graduated midwives	Midwifery students	Midwifery lecturers	Midwives	Obstetricians
Butterfly (8 pages; 51 minutes; 3,301 words)	Syifa Khoirunnisa (10 pages; 51 minutes; 3,597 words)	Ummi (51 pages; 51 minutes; 7,305 words)	(20 Bilbina (64 pages; 7,305 minutes; 3,980 words)	(9 Atmojo (67 pages; 3,370 minutes; 3,370 words)
Yuni (6 pages; 2,861 minutes; 4,097 words)	Joule (10 pages; 50 minutes; 4,097 words)	Dhendra (4 pages; 45 minutes; 1,454 words)	Happy (45 pages; 1,454 minutes; 4,746 words)	(13 Husni (9 pages; 60 49 minutes; 2,978 words)
Cici (17 pages; 7,337 minutes; 9,189 words)	Lisa (9 pages; 57 minutes; 4,432 words)	Dib (22 pages; 64 minutes; 9,189 words)	Arum (9 pages; 90 minutes; 3,091 words)	Sony (24 pages; 51 minutes; 7,877 words)
Okta (20 pages; 52 minutes; 6,168 words)	Dyah (20 pages; 61 minutes; 5,105 words)	Ana (13 pages; 45 minutes; 5,607 words)	Shinta (8 pages; 50 minutes; 2,950 words)	Agha (6 pages; 45 minutes; 2,250 words)
Rully (12 pages; 65 minutes; 5,464 words)	Ismi (16 pages; 57 minutes; 5,928 words)	Juju (10 pages; 55 minutes; 5,061 words)	Widya (21 pages; 64 minutes; 5,946 words)	Alim (3 pages; 40 minutes; 842 words)
Rin (5 pages; 2,598 minutes; 4,242 words)	Aura (14 pages; 75 minutes; 4,242 words)	Ina (7 pages; 55 minutes; 3,454 words)	Evi (10 pages; 61 minutes; 4,780 words)	Ratna (13 pages; 50 minutes; 5,011 words)
Far (18 pages; 8,969 minutes; 9,777 words)	Sas (17 pages; 56 minutes; 5,357 words)	Suri (24 pages; 69 minutes; 9,777 words)		
Ani (12 pages; 69 minutes; 5,624 words)	Lembayung Mawar (3 pages; 50 minutes; 1,645 words)			
Siti (13 pages; 50 minutes; 4,623 words)	Al Syifa (8 pages; 55 minutes; 3,385 words)			

111 pages; 592 107 pages; 562 110 pages; 581 70 pages; 392 66 pages; 412
minutes; 46,945 minutes; 37,788 minutes; 46,914 minutes; 25,493 minutes; 22,328
words words words words words

464 pages; 2,539 minutes; 179,468 words

Appendix F: Example of a portion of coding development process

Transcript

Keywords and concept

Q: Firstly, thank you so much Miss for your time and willingness to become one of my research respondents. Okay, the first thing I want to ask you, please tell me about your experience when you attended your study at the Midwifery program, after graduation as a new midwife?

A: I was in D IV Midwifery program, and it was during a transition time, changes of academic title. Initially D IV learning focus is to prepare us as midwifery teacher, shifted into clinical midwifery. The clinical midwifery criteria is still in the process of formulation. So for me, that was a time of uncertainty, because most D IV students stationed on the field, because the change to clinical midwifery, we also given less material to learn, incomplete. Not like educational midwifery which given a lot material before teaching their students. We mostly practising on the field because we are focused to become field (clinical) midwives. And after graduation, as it was the transition time, most institutions which about to accept me asked, why a D IV graduated like me not teaching? They don't know there is a new regulation so we practice more at the clinics, at hospitals. All they know D IV midwifery supposedly to be teaching. So we find it difficult, we cannot find a job as teacher, as hard as accepted in the field, because if we work in the field we will be equated with D III graduates. It was confusing and hard to find a job.

Q: So your experience in the training process is you are prepared as a midwife, what it is like to be a clinical midwife in the field? So, what was your feeling about the training process while you were in it, and after graduation, do you feel like 'this is it, I am a clinical midwife'. So on graduation were you well ready for the job?

A: About what I felt, I felt kind of puzzled. The training mostly on learning the material, focus to become midwife at the village. So I was more ready for work at a village. On a clinic, specially villages clinic. So I was uncertain and confused by myself.

Transitioning time – midwifery degree – the journey from midwifery school to workplace
 Expected to be prepared to be a midwifery teacher, but wasn't, was clinical midwifery – DIFFERENT EXPECTATION OF EDUCATION
 Feeling uncertain
 Lack of resources, lack of materials
 Practice at clinics and hospitals
 Cannot finding a job – qualification not accepted
 Confused

Appendix G: Example of a portion of work of searching for themes

Coding Tree midwifery lecturers – May 2017

NO	CODE	CATEGORY – SUB-THEMES IDENTIFIED	POSSIBLE THEMES
1.	1. Step by step to becomes a midwifery educator	Core midwifery educators – competency of midwifery teacher	Maintaining relationship with student and mentor
	2. Three pillars of higher education: teaching, research and community service - obligation of a midwifery teacher		
	3. Leading discussion, teaching, tutorials, guiding at laboratory and field practice	Talking about relationships with students	Labeling the group of students
	4. Coordinator of the subject		Defining her role as a good teacher
	5. Knowledge and skill		
	6. Clinical experience – without clinical experience what would happen to midwifery student		Setting criteria for clinical practice and mentor
	7. Maintaining relationship with student and mentor	Feel responsible for students learning	Life calling
	8. Interaction with students		
	9. Lecture competency		
	10. Self-reflection on how to spend their time to prepare, implement and evaluate the learning and teaching process		
	11. Responsibility of midwifery teacher		
	12. Unforgettable experience in the hospital – working at the hospital before becoming midwifery teacher	Woman-centred care	
	13. Educate midwifery students not only helping to assist the birth, check pregnancy		
	14. Appropriateness of clinical practice and clinical placement – student only seeing the process of labour		
	15. How to emphasise that midwifery students have an opportunity to check the real patient one by one	Not easy to	

16. Nurture the concept to becoming a midwife, midwife's task not only pregnancy but also woman's life circle transfer the soul of the midwife
17. Opportunity to do continuity of care
18. How students have professional skills and spirit to pursue their study and dream
19. Soul as a midwife – understand women mentally, socially, spiritually
20. Qualified lecturer has to have good grades – understand the theory but also experiences in the field too
21. Minimum requirement – hold master degree
22. Understand role as a lecturer – at least have clinical experiences in the field – know the real life of midwife – essential role to transfer knowledge and skill – not easy thing to transfer the soul of midwife Suggesting midwifery-led clinic
23. Working with passion – do it for Allah, for helping people, everything becomes interesting – the foundation is Allah, not because forced to do something that they do not like –sincerity because of Allah – good deed will spread Importance of culture and religion
24. Have to be brave in making decision
25. Allah always knows to make everything come true
26. Working as a team with midwifery colleagues
27. Clinical experience as reinforcement for student
28. How to encourage creativity, courage, giving a voice, positive feeling – winner at some conferences at Paris, Australia, Japan; my experience at school afraid of senior, giving a voice – culture of learning – don't want to be like that to her student

29. Teaching professionalism
30. Quality assurance at faculty – quality management
31. Midwifery teacher to teach concept of normality – strong identity as midwifery teacher
32. Clinic for midwifery practice? As a model for midwifery care
33. How to trigger student to learning from journal
34. Self-commitment – active learning
35. Increasing interest of midwifery student – most of forced by their parents
36. Purpose of being midwifery teacher – Islamic class/ religious session – to get blessing of Allah, value of faith, what is the purpose of life and all the activities – nature of human being – nature of women – God creates us
37. Passionate
38. Back to core document from ICM which is midwifery educator
39. Working and learning together with all parties to reach learning outcome – not only about good grade
40. Essentials of workshop of midwifery curriculum
41. Long career journey to become midwifery educator
42. Guidance from senior lecturer to become a good midwifery lecturer – qualified educational background minimum master degree and sufficient clinical experience
43. Building a communication with another lecturer
44. Ideal midwifery lecturer
45. Key of learning process is midwifery lecturer – facilitate the students well – become a good role model and give a good example – direct example
46. Big challenges – has to escort

- students during transition process from midwifery student to become a midwife
- 47. Technological support and English language
- 48. Have to have good capacity and read a lot of references, making of audiovisual media

- 2
- 1. Syllabus
 - 2. Lesson plan
 - 3. Create learning contract with students
 - 4. How learning objectives achieved
 - 5. Spending a great deal of time and effort preparing to teach
 - 6. Preparation a module for a guideline to study – divided students into small groups – facilitated learning easier, easier to guide at a laboratory, preparation of a video
 - 7. Should have clinical experience to give soul of theory
 - 8. Midwifery curriculum – anatomy physiology, biology, research methodology, continuity of care 2, final report
 - 9. Practice guidelines
 - 10. Compile the questions for the written test
 - 11. Evaluation system
 - 12. Constructing learning method
 - 13. Preparing for evaluation
 - 14. Planning to plan
 - 15. Constructing an evaluation plan
 - 16. Teaching methodology
- Teaching preparation, learning objectives
- Need time to prepare

Appendix H: Example of a portion of analysis with Bolman and Deal's Four Frames

A framework was used subsequent to the research process as means of exploring and articulating the complexity and at times, the complex tensions that were identified in the research that impact on midwifery education in Indonesia. **The framework added depth to the findings and a further layer of analysis to the findings and informed the discussion chapter.**

Structural	Human resource	Political	Symbolic
Organisational structure, rules, roles, goal, technology and environment	Human needs, skill, limitations, relationships	Power, conflict, bargaining, allocate resource, decision making	Meaning & belief, culture, values
The structural frame is defined as the formal structures that impact on midwifery education in Indonesia. Included are systems, hierarchies, goals, and roles.	The human resource frame focuses on interpersonal relationships between people as individuals, groups and parts of organisations who are involved in midwifery education in Indonesia	The political frame is defined as the way that decisions are made, goals, are set, policies and resources are allocated. This involves an ongoing process of bargaining and negotiation among various interest groups found both within and outside midwifery education programmes.	The symbolic frame is defined as the meaning, beliefs, assumptions, and core values that were revealed in the data as strengthening midwifery education in Indonesia
To be a good midwifery lecturer in Indonesia you need to have mastery of the English language. Government policy is that all University Lecturers pass the English test. (Combination structural, and political) Presents a challenge/barrier is a struggle for midwifery students and lecturers (HR)			
1. The structures of the tutorial and small class sizes provide better learning,	3. Lecturers felt limited through lack of clinical skill	5. The policy that determines that midwifery lecturers must	Core values that underpin the motivation to be a midwife: Motivated to be a midwife because wanted to
	4.		

<p>2. student-centred learning Tensions between large class and small class</p>	<p>have a master's degree in contrast to the need for lecturers to have recent practice. No masters in midwifery at that time</p>	<p>is make family proud, want to be valued and respected, to make a difference to their community, women, religious belief</p>
		<p>6. Storytelling transfers value to become a midwife 7. teaching is inspirational, related to midwifery practice.</p>
	<p>8. Negotiate between decision-makers at midwifery school to address learning resources</p>	

To be a competent midwife you need to be able to assist women in delivering the baby as the essential competencies for basic midwifery practice (combination structural, human resource, political and symbolic/ cultural)

Human resource

- different qualifications led to same registration
- different quals can hurt students in career and financially
- Quals confusing for employers
- Students not prepared to pass competency test
- Association post grad competency training
- mixed feeling about the future of her job

Structural and external factors barriers and enablers

Symbolic/cultural

- there is valued placed on you as a student and midwife depending on what qualifications you are doing/have can lead to some students demeaning and humiliating others
- unified, standardized programme
- programme based on Midwifery with teachers skilled in midwifery
- Graduates are expected to make a difference to Maternal and Newborn outcomes
- Accreditation process
- The meaning of the accreditation for the school and students
- The association does not believe midwifery education develops competent midwives

Political

- Different qualifications have been approved for midwifery
- Everyone meets same competencies at end of programme
- National Midwifery Education framework
- Maintaining programmes not fit for purpose and not designed to be in place long term D4
- Vocational/academic education – need agreement where midwifery sits
- Who provides the guidelines/education standards for midwifery curriculum IBI OR govt
- Accreditation
- Association post grad competency training

Structural

- 4 different types of midwifery programmes have different requirements
- Wish for a unified, standardised midwifery educational programme
- Different programmes led to different competencies
- National Midwifery Education framework needed
- Lack of knowledge why programmes established and short term programmes not intended to be in place long term still in place.
- D4 in place to increase numbers of midwives quickly
- D4 should be discontinued
- Need well managed education system
- Important balance between association education and hospitals maybe more connected – hospital critical role in students teaching and learning
- Accreditation
- Association post grad competency training

Possible Tensions in data	
Different quals	How midwives are judged/seen because of their qualifications Different quals can hurt students in career and financially Confusing for employers
Vocational/academic programme	Where does midwifery fit D4 should be discontinued
Different school different programmes meeting even different competencies	Standardised National education framework
Competency based curriculum	Students felt not prepared to pass competency test
Schools educating student midwives to be competent midwives and expected to make a difference to maternal and newborn outcomes	Association running the post graduate competence training – mixed feeling about the future of a new midwife
Association running the post graduate competence training	The association does not believe midwifery education develops competent midwives
Accreditation process	The meaning of the accreditation for the school and students
Integration between school, association and hospital	Important balance between association education and hospitals maybe more connected – hospital critical role in

O39

The many faces of midwifery: Australian midwives' views, beliefs and attitudes on Complementary and Alternative Medicines (CAM)

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Introduction: Complementary and Alternative Medicines (CAM) have increasingly been used by pregnant women. There has also been a steady rise in interest in this field by midwives however literature describing Australian midwives' personal views and beliefs towards CAM is sparse.

Aim: This study aimed to investigate Australian midwives' views, attitudes and beliefs towards CAM.

Methods: A national survey of Australian College of Midwives (ACM) registered midwife members ($n=3,552$) was undertaken at the National ACM conference (October 2015) and via ACM e-bulletins (November 2015–March 2016). The self-administered survey included questions on midwives' personal views of CAM, perceived organisational support of CAM, and the validated CAM Health Belief Questionnaire (CHBQ). The survey findings were compared with the two previous midwifery studies using the CHBQ.

Results: A total of 571 midwives completed the survey (16.0%). Demographics reflected Australian midwives and ACM membership on age, years as a midwife and state of residence. Most midwives have a positive view of CAM; believe women should have the right to choose CAM strategies (93.3%); is natural and effective in stimulating the body's natural healing power (71%); and do not view CAM as a threat to public health (91.7%). The majority (91.4%) believed that CAM options should be included in the undergraduate curriculum. Nearly half (49.5%) of respondents believed that their hospital/service did not have guidelines/procedures on the use of CAM to support or guide midwifery clinical practice; however, at the same time, nearly all respondents discussed (91.1%) and recommended (88.4%) CAM/self-help options to pregnant women.

Conclusion and implications: The majority of midwife respondents strongly agreed with the fundamental philosophical statements of CAM and woman-centred care. This study has implications for inclusion of CAM in undergraduate and postgraduate curricula for midwives and the development of a national guideline on CAM and midwifery practice.

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O40

Women requesting a caesarean birth in an otherwise healthy first pregnancy

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Introduction: The Many faces of Midwifery – The midwife researcher investigating the meanings women who request and have a caesarean section in a healthy first pregnancy attach to labour and vaginal birth and to caesarean, and when in life they decide to have a caesarean section. Now, more than ever before, there is an imperative for us to undertake research that enables

us to understand the life-worlds of the women we journey with as midwives, to make sure that women's voices are well and truly heard, and to ensure that women are represented as faithfully as possible in research that is about them.

Approach: This mixed method research uses in-depth face to face interviewing and participant created visual data to investigate the meanings women requested, and had a caesarean section in a normal first pregnancy, attach to labour and vaginal birth, and to caesarean section. It explores how those meanings came to be made, and when in life these women made their decision to have a caesarean section. To the knowledge of the researcher, this mixed methods approach has not been previously used to investigate healthy women having their first baby who request a caesarean section.

Implications for practice: The benefits of the use of participant created visual data as an adjunct to face to face in-depth interviewing are discussed and the preliminary findings are presented in this session.

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Partnerships to strengthen midwifery education: findings from a qualitative study in Indonesia

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Background: Midwifery education plays a pivotal role in producing qualified graduate midwives who, if well resourced, can potentially make a difference in maternal and newborn mortality. Although Indonesia has produced a large number of midwives, the maternal and infant mortality rates remain high. There is recent evidence that having more midwives, and better quality of midwives through the investment in midwifery education would enhance women's access to midwifery services and quality maternal and newborn care in low-middle-income countries, of which Indonesia is one. While the government and professional organisation in Indonesia have implemented the quality assurance processes for the accreditation of midwifery programmes, there have been no studies to evaluate whether they have strengthened midwifery education in Indonesia.

Aim: This presentation reports preliminary findings of the study on how midwifery education can be strengthened in Indonesia. This study aimed to explore the experience of those involved in midwifery education (midwifery students, newly graduated midwives, midwifery educators, midwives, and obstetricians) and what the barriers and enablers are to strengthen midwifery education leading to competent and confident midwifery graduates.

Methods: A qualitative descriptive method was used. Data were collected from thirty-seven participants through purposeful and snowballing techniques including Indonesian midwives, midwifery educators, midwifery students, newly graduated midwives, and obstetricians. The participants were recruited from twelve different midwifery schools in eight cities which situated in six provinces in Indonesia. Thematic analysis was undertaken to analyse the data from face-to-face in-depth interviews in regards to views of midwifery education.

Findings: There were three themes identified, that is: midwifery teaching and learning; midwifery clinical experience and structural

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