A Rapid Assessment Tool for affirming good practice in midwifery education programming

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A B S T R A C T
Objective: to design a criterion-referenced assessment tool that could be used globally in a rapid assessment of good practices and bottlenecks in midwifery education programs.

Design: a standard tool development process was followed, to generate standards and reference criteria; followed by external review and field testing to document psychometric properties.

Setting: review of standards and scoring criteria were conducted by stakeholders around the globe. Field testing of the tool was conducted in Myanmar.

Participants: eleven of Myanmar’s 22 midwifery education programs participated in the assessment.

Findings: the clinimetric tool was demonstrated to have content validity and high inter-rater reliability in use.

Key conclusions: a globally validated tool, and accompanying user guide and handbook are now available for conducting rapid assessments of compliance with good practice criteria in midwifery education programming.

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Introduction

Background

Skilled birth attendance has been cited as one of a very few interventions that have made a proven contribution to the promotion of safe motherhood (UNFPA, 2012). Skilled birth attendance, both independently, and in concert with packages of integrated reproductive health services, emerges as a critical strategy in sub-national, national and global analyses of factors contributing to reductions in maternal mortality (Adegoke and van den Broek, 2009; Liljestrand and Sambath, 2012; Carvalho et al., 2013; Montoya et al., 2014; Holmer et al., 2015). The degree of access to skilled birth attendance remains prominent in analyses of wealth-related inequalities in health status (Zere et al., 2013). A 2012 U.N. resolution (UN, 2012) urged governments to move toward providing all people with access to affordable, quality care. The way forward is dependent on reforms towards universal health coverage (UHC) that prioritise access to essential, quality health services (Hill et al., 2014, Lomazzi et al., 2014; Ruano et al., 2014).

Bergevin et al. (2015) hypothesise that an end to preventable maternal deaths could be achieved by 2035 in nearly all countries if a package of strategically integrated actions would be followed. These actions include emphasis on UHC and a massive scaling-up and skilling up of human resources for maternal health. The governance and management of a skilled and fit for purpose health workforce is central to any country’s response to the challenges of achieving universal coverage and health equity (Crowe et al., 2012; Campbell et al., 2014; Hammonds and Ooms, 2014; Germain et al., 2015).
The recent global analysis conducted by the UNFPA concluded that midwives, when educated and regulated to international standards (WHO, 2009; ICM, 2010a; ICM, 2011a; WHO, 2013), have the competencies (ICM, 2010b) to deliver 87% of the 46 essential reproductive maternal and newborn health services needed by women and newborns (UNFPA, 2014). The analysis indicated, however, that professional midwives made up only 36% of the reported midwifery workforce.

The response of governments has, all too often, and regrettably, been to focus on shorter-term solutions that aim to increase the numbers of providers (Mumtaz et al., 2015), or task-shifting/task sharing combined with community-based interventions to address regional shortages (Bhunnain and McCarthy, 2015), rather than a focus on competencies (Frenk et al., 2010). A strong political will and substantial financial commitment are fundamental to scaling up access to a skilled midwifery workforce (Frenk et al., 2014; Rosskam et al., 2014; Turkmani et al., 2014).

Midwifery education systems in low and middle income countries face a myriad of challenges (UNFPA, 2014). Insufficient numbers of schools are often under-funded and positioned in locations inaccessible to students most likely to be absorbed or retained in the communities where they are needed. Existing schools lack skills labs, computer and library resources needed for an evidence- and competency-based education. Many teachers have not been prepared for the role of educator and lack opportunities for continuing professional development to maintain or enhance their clinical and educational skills. Midwifery students may have few opportunities for hands-on clinical practice and may graduate having only indirectly experienced midwifery practice through observation. Students graduating from current education systems may feel under prepared, and may need a longer period of supervised practice after deployment, and/or rapidly leave the workforce. In spite of the challenges and the intuitive recognition for the need for change, procuring investments in educational improvement has proven to be equally challenging. Donors, concerned with difficulties impacting on complex educational systems and the long interval between inputs into system improvement and graduate impact on health are often more likely to opt for shorter term in-service training interventions. Clearly presented and logically articulated measures of pre-service education improvement are essential in reversing this trend.

**Aim of the study**

A number of non-governmental and private sector organisations are engaged in work with governments to strengthen midwifery education policy and programming, in order to achieve public health impact. Jhpiego, Baltimore Maryland, USA, has been providing this type of assistance for almost four decades. Jhpiego's approach in countries includes direct support to schools aimed to improve teaching, increase access to evidence-based resources and promote competency-based learning through development of skills labs and improved clinical education. Emphasis is always placed on ensuring sustainable quality through support of regulatory processes like accreditation and certification at the national level.

Jhpiego developed a Rapid Assessment Tool designed to provide an overview of the present-day situation of midwifery education programs. This tool is intended for use with programmes presently in the planning stages, or in anticipation of up-scaling and reform. The tool focuses at the micro- (the local and school) level, in the context of macro-level country-based policies and practices for health manpower planning and accreditation of educational programmes, and within the framework of global standards for best practices in health professions education.

The tool is framed around the assessment of five evidence-based educational inputs and influencing factors that are each directly related to creation of the contextual environment that facilitates and/or enables student achievement of competency prior to entry into the workforce (Fig. 1).

This article describes the steps taken to develop the tool; assess and to affirm its content validity and usability. The tool is discussed in the context of its fit for purpose within the framework of education workforce planning and educational quality assessment strategies.

**Methods**

**Conceptual model**

Development and testing of the Rapid Assessment Tool began with the derivation of a conceptual model for pre-service education (Johnson et al. 2013). This framework (Fig. 1) provided the overview of the domains that would reflect quality educational programming, and links those domains to the intended outcomes of health workforce development. The model was widely shared with global implementing and policy partners that also worked in the education sphere, such as the International Confederation of Midwives, International Council of Nurses, UNFPA, and the World Health Organisation Health Workforce department who provided feedback concerning the comprehensive nature of the model, its coherence, and its relevance.

**Criteria for assessment: standards of ’good practice’ in educational programming**

The next step in tool development was the selection of indicators of good practice based on externally verifiable and measurable criteria for each element of the model. An initial effort was made to determine whether information drawn from the 73-country survey that generated data for development of the State of the World’s Midwifery 2014 (SOWMy, UNFPA, 2014) could be used in the assessment of good practice. It was determined that the SOWMy survey did not contain sufficient information across all domains of the pre-service education conceptual framework to obtain good practice indicators.

The good practice criteria were drawn from several sources. These included the published literature, global consensus statements of education policy and practice, and standards and guidelines published by international organisations representing health workforce cadres that shared responsibilities for clinical services in reproductive and newborn health (WHO, 2009; ICM, 2010a; WFME, 2012; WHO, 2013).

In the cases when objective standards could not be identified, a minimum standard was established based on Jhpiego's global experience. Directions for use of the tool clearly indicate that where country-level standards exceed the minimum standard established by Jhpiego, the higher level should be substituted.

**Internal and external review**

The Rapid Assessment Tool underwent two rounds of review to ensure validity and applicability. The review process began with internal circulation of the tool to receive feedback on the relevance, coherence and comprehensiveness of the overall instrument, and specifically, to deliberate and debate all standards and criteria. A survey was used to collect the respondents’ agreement or disagreement with a set standard or criteria, (keep or delete), with a 70% agreement posed as the minimum level of agreement required to retain any single item. The survey also requested that
respondents provide commentary and specific contextual examples from their own professional and country-based midwifery education experiences, so that the authors could assess the applicability of the tool on a global level.

Feedback was received from informed respondents (midwifery educators, regulators, clinicians, administrators of education programmes; members of the professional association) in 13 countries in which Jhpiego conducts midwifery education, capacity building, and health systems strengthening. A total of 24 individual or group respondents provided a total of 368 comments. Each of the comments was individually reviewed by at least two of the tool’s authors, who made final decisions about modifications to the tool, based on the criterion level of consensus, and on an informed opinion about the relevance of every single item to the integrity of the conceptual model. This step in the review process was taken in the interest of affirming the content validity of the tool, the assessment criteria and the reference standards.

The tool was then sent to global partner organisations for external review. These partners held a common interest in midwifery education policy and advocacy. Six individuals and one group of seven respondents, offered feedback; a small number of suggestions for content revision were offered by these reviewers, and incorporated into the tool by its authors. The reviewers were also asked to comment on the place of the Rapid Assessment Tool within the context of the set of documents already in use for similar or allied assessments (e.g., country-level health workforce planning tools, accreditation standards). All reviewers noted their agreement that this tool had a unique and useful niche at the country level.

Table 1 outlines the framework of the tool, derived from the conceptual model, and the topical content within each of the six areas. A total of 30 criteria are presented in the full instrument which is freely available from the organisation (Jhpiego, 2015).

**Determination of a scoring rubric**

The intentional purpose of the tool underpinned the decisions made about development of a scoring rubric. It was clear to the authors that the tool would be most useful in the efforts to help countries who were newly or recently engaged in the design of midwifery educational policy and programming, and countries that had an interest in re-visioning their existing educational pathways. Therefore, a simple ‘yes’ or ‘no’ score was selected as an indicator of whether or not a current midwifery education plan or

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**Table 1**

Framework and abbreviated content of the Midwifery Rapid Assessment Tool.

<table>
<thead>
<tr>
<th>Infrastructure and management</th>
<th>Clinical practice sites</th>
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</thead>
<tbody>
<tr>
<td>1.1. Sufficient schools to produce the number of midwives needed in the workplace</td>
<td>4.1. Sufficient clinical sites needed to prepare students to competency in accord with ICM guidelines</td>
</tr>
<tr>
<td>1.2. Leadership by a midwife with experience</td>
<td>4.2. Clinical practice sites are accessible to students and teachers</td>
</tr>
<tr>
<td>1.3. Sufficient space needed to facilitate theoretical learning</td>
<td>4.3. Clinical practice site has sufficient medical supplies and other resources needed to train students to competency</td>
</tr>
<tr>
<td>1.4. Textbooks, journals, other library resources</td>
<td>4.4. Clinical practice site models practice that is consistent with evidence-based best practices</td>
</tr>
<tr>
<td>1.5. Functional clinical skills lab for practice and simulation.</td>
<td><strong>Curriculum</strong></td>
</tr>
<tr>
<td>1.6. Computer lab with teaching/support staff</td>
<td>5.1. Curriculum is aligned with national health priorities, and has been endorsed by relevant regulatory and professional bodies</td>
</tr>
</tbody>
</table>

**Students**

<table>
<thead>
<tr>
<th>Teachers, tutors and preceptors</th>
<th><strong>Influencing factors</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1. Sufficient midwives and others to educate existing students in the academic/theory components of the curriculum</td>
<td>6.1. Quality standards for midwifery education, congruent with ICM educational standards are in place</td>
</tr>
<tr>
<td>2.2. Teachers have completed a course preparing them for their teaching role</td>
<td>6.2. A midwifery education accreditation system reviews and documents educational quality at least every five years</td>
</tr>
<tr>
<td>2.3. Teachers have acquired and maintain their clinical competency</td>
<td>6.3. A mechanism for assessing the competency of graduates prior to deployment with the health system (licensing exam) is in place</td>
</tr>
<tr>
<td>2.4. Teachers have the resources that they need to be effective</td>
<td>6.4. A committed budget for sustaining midwifery education to meet current and anticipated workforce needs</td>
</tr>
<tr>
<td>2.5. Equity in teacher salary</td>
<td>6.5. Teachers have an active role in updating and revising the curriculum</td>
</tr>
<tr>
<td>2.6. Clinical preceptor/teachers prepared for the role</td>
<td>6.6. A midwifery education accreditation system reviews and documents educational quality at least every five years</td>
</tr>
<tr>
<td>2.7. Clinical preceptor/teacher supported in the clinical setting</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Students</th>
<th><strong>Outcome</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Sufficient qualified applicants</td>
<td>5.1. Curriculum is aligned with national health priorities, and has been endorsed by relevant regulatory and professional bodies</td>
</tr>
<tr>
<td>3.2. School is located in communities accessible to targeted students</td>
<td>5.2. Curriculum is competency-based</td>
</tr>
<tr>
<td>3.3. Students are enthusiastic about entering the midwifery profession</td>
<td>5.3. Current and evidence-based curriculum content</td>
</tr>
<tr>
<td>3.4. Student selection criteria account for anticipated deployment and retention</td>
<td>5.4. Curriculum reviewed and updated within the past five years</td>
</tr>
<tr>
<td><strong>Pre-service education</strong></td>
<td>5.5. Teachers have an active role in updating and revising the curriculum</td>
</tr>
<tr>
<td><strong>Influencing factors</strong></td>
<td><strong>Outcome</strong></td>
</tr>
<tr>
<td>6.1. Quality standards for midwifery education, congruent with ICM educational standards are in place</td>
<td>5.1. Curriculum is aligned with national health priorities, and has been endorsed by relevant regulatory and professional bodies</td>
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<td>6.2. A midwifery education accreditation system reviews and documents educational quality at least every five years</td>
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**Fig. 1.** A conceptual model of pre-service education.
program did or did not comply with the reference criteria of ‘good practice.’ The score obtained within any single domain would serve as a marker of the need for attention to be paid to that element of the conceptual model of pre-service education.

**Confirmation of psychometric properties**

The tool therefore emerged as a clinimetric tool, i.e., a type of measurement tool that encompasses assessment instruments such as indexes and rating scales (Fava et al., 2012). The clinimetric approach is appropriate in the attempt to measure multiple constructs with a single index (e.g., the Appgar score, or the Glasgow Coma Scale)(Feinstein 1999). Indices of this sort include items that point to an issue (indicator variables) and may also include items that may have a direct influence on the issue being studied (causal variables). The psychometric approach, on the other hand, is appropriate in the attempt to measure a single construct using multiple items (e.g., depression or anxiety). Psychometric scales typically include only indicator variables (de Vet et al., 2003).

Clinimetric tools, nevertheless, demonstrate certain essential psychometric properties, notably evidence of validity and reliability (de Vet et al., 2011). These particular properties were affirmed for the Midwifery Rapid Assessment Tool via the instrument development methods previously described; and via the field test that is discussed as follows.

**Development of a user’s guide and handbook**

An instructional guide was developed, to assist end-users during conduct of the assessment. The guide provides step-by-step suggestions for how to proceed with collection of information required to make each individual assessment. It identifies the specific individuals from whom the information should be collected, and specifies the academic or clinical setting that should be observed.

The handbook was developed to serve a concurrent purpose as a data-entry tool, and a summative score sheet. The score sheet is useful for purposes of feedback to both those participating in the assessment and stakeholders. Gaps in compliance with ‘good practices’ in education programming are easily identified. The summary sheet therefore serves as a template for planning necessary interventions. Users of the tool are reminded that all criteria are examples of ‘good practice,’ and that they all carry equal weight in the assessment. A higher summative score simply indicates that a programme has already achieved compliance with more of the criteria, and can be advised to focus development efforts (human and budgetary resources) on those elements where a ‘no’ score was documented. The handbook can also be retrieved from the organisation’s website (Jhpiego, 2015).

**Field testing**

The tool and the handbook were both tested for their sufficiency, usability and effectiveness in a field test conducted in 11 of the total 22 midwifery schools in Myanmar. Historically, midwives have been essential providers of care to women and families in rural communities but have lacked the preparation and authorisation needed to provide the full range of globally recommended services expected of skilled birth attendants. Myanmar is presently placing focus on improvement of midwifery education as part of overall efforts to align the midwifery workforce with global and regional standards. The tool was instrumental in identifying both good educational practices in Myanmar midwifery schools as well as several key policy, systems and educational practice issues that must be addressed.

The field testing was conducted by four members of Jhpiego's country-based health professional staff, who also had experience in teaching and programme development. The field test team had the full support of administrators and faculty in each of the schools visited during the assessment. School-based personnel understood that this field-test was being conducted for the purpose of evaluating the usability of the tool, to determine the feasibility that it could be used by individuals (schools; other stakeholders) in the future.

The assessors were oriented to the tool, handbook and scoring guide by a senior staff member from Jhpiego's Office of Global Learning, who was also available for consultation and feedback throughout the process. The three physicians and one nurse-midwife conducting the assessment worked in two–three person teams, accompanied by a member of Jhpiego's technical staff. Six schools were visited in a first assessment period. Team members communicated among themselves during the assessment process, discussing findings or questions of interpretation, in order to promote a high level of inter-rater reliability between team members. This level of agreement was not documented statistically, but rather was aided and affirmed by mutual decision-making around the process of data collection (for example, agreement concerning which courses would be reviewed as part of determining faculty-student ratio) and by final consensus agreement on findings and score assignments. An additional five schools were then reviewed in a second assessment period, using the same strategic approach to data collection and consensus scoring.

The data collection process was anticipated to require up to four days; depending on the time required to access the academic and clinical sites, and to retrieve required information from relevant government or education programme representatives. The actual time required by each team during field testing was up to two to three days per school included in the assessment.

**Findings from the field test**

The results of analysis of findings from the first eleven schools provided the consistency and clarity needed to confidently proceed to interventions aimed at educational improvement. The tool and its user-guide and handbook as tested in this country setting demonstrated the adaptability and usability needed, at least within countries, such as Myanmar, where a clear health workforce plan has been developed, and both government and donor organisation efforts are intentionally targeted to support and promote high quality midwifery education.

Positive findings from the rapid assessment included a robust qualified applicant pool, which, across all geographic locations of the schools in the country, exceeded the number of slots available for admission. This reflects a strong interest in the midwifery profession and opportunity for expansion of the profession given appropriate investments. The findings also revealed a national curriculum that is consistent with the ICM Essential Competencies for Basic Midwifery Practice.

Several notable challenges were revealed as a result of the analysis. Examples of these include inconsistent access to Internet based information, requirements to share resources with other cadres and general challenges to clinical education including insufficient opportunities for hands-on clinical practice, particularly in tertiary hospitals where there is competition with medical students. Midwifery tutors, often lacked authorisation needed to directly coach students in the clinical setting. Administrative and resource related challenges were notably greater in schools preparing both midwifery and nursing students under one administrative and physical umbrella.
Discussion

Interest in development of high quality midwifery education programs and systems is high following publication of the State of the World’s Midwifery report (UNFPA, 2014) and the series of articles about midwifery recently published in the journal Lancet (Renfrew et al., 2014). Jhpiego’s Rapid Assessment Tool emerged as a document useful to countries who wish to take a fresh look at the status of their midwifery education programs, in comparison to global standards and criteria of education quality. The completed tool provides a snapshot of the present-day situation, at the level of the individual school, and/or for comparison between or among schools, including those publicly, privately or donor funded, at the regional or national level.

Jhpiego often finds itself sharing a common public space with partners from a variety of similar global consultant organisations (Bailey and Tulenko, 2015; WHO, 2014), government ministries, and professional councils or associations, all striving for a similar public health impact within the same regions. Some of these stakeholders have developed educational assessment approaches that serve a similar purpose, but are unique in any number of important ways, including their intentional purpose (Australian Nursing & Midwifery Accreditation Council, 2012; International Federation of Social Workers, 2012; Accreditation Council for Pharmacy Education; 2015; Clinical Officers Council, 2015). Lasser and Brand (2014) urge ‘a code of conduct for NGOs’ that promotes harmonisation of their efforts in order to avoid fragmentation of efforts. Accordingly, Jhpiego’s Rapid Assessment Tool is complementary to and not intended to replace macro-level documents that focus on health workforce planning and profiling, and tools that focus on quality of on-going programming.

The challenge was to develop a generalisable tool that would, nevertheless, reflect social, historical, cultural, ethnic and geographical diversity, in ways that could influence the global debate (Ruano et al., 2014) about common ground – the right of all people to expect the same competence-based quality from midwives using that definition (ICM, 2011b). Countries that are focused on expanding the supply, participation and availability of health workers need to make informed decisions about the selection of students, the location, content and mode of training, and the development of appropriate skills. This Rapid Assessment Tool represents a criterion-referenced quality assessment strategy that can both underpin and support that degree and scope of decision-making, and point the way to the most efficient use of global resources that may be offered and/or available to countries.

An additional challenge was to prepare a rapid assessment tool that would augment, but not replace, assessment tools already available for broader purposes, such as programme accreditation. The Rapid Assessment Tool provides a summative account of ‘yes’ (meets criteria) or ‘no’ (needs priority attention) talking and/or action points that can be used to direct timely action aimed at identifying potential ‘quick fixes’ or challenges (bottlenecks that may require long term and sustained interventions). The tool can be used in an overall assessment, or by individual standard, depending on the need and interest of the end-user. Scores can be used to support advocacy and development of proposals to donors and other potential funders. They can also be used to guide planning decisions needed to prioritise actions, develop budgets, allocate resources, and logically sequence steps aimed at improvement. The tool has an additional utility in the monitoring and assessment of progress over time, as the clinimetric tool will provide a rapid assessment of change in scoring status when repeated in a second, or higher-order use.

The tool can enable school-to-school comparisons, (such as between or among government-sponsored schools, or between private and public institutions) if the intention is to prioritise individual institutions for financial or technical assistance or identify schools as model good practice sites in one or more areas assessed. The limitations and inherent constraints of the tool are depicted in Table 2.

The Rapid Assessment Tool will be continually assessed, and revised if necessary, following its application in countries that represent different experiences and patterns of health system design and midwifery education programming. The tool has already been found to be a useful tool for rapid assessment in Afghanistan, Ghana, Lesotho, Liberia and Pakistan, and additional countries plan to use it in the near future. Jhpiego is also building on lessons learned, and modifying this midwifery-focused assessment model to reflect good practices in educational programming across a diversity of health professional cadres (WFME, 2012).

Table 2

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<thead>
<tr>
<th>Limitations and constraints of the Rapid Assessment Tool.</th>
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<tr>
<td>• The Rapid Assessment Tool does not provide a psychometrically accurate measure of quality. In other words, a school that has twice the score of another should not be considered twice as good as the other. It therefore must not be used to provide any sort of total or summative score that has any definitive meaning, with respect to high or low quality.</td>
</tr>
<tr>
<td>• The tool does not replace other macro-level tools that serve a different purpose in health workforce planning or quality assessment. Instead, it should be used in concert with these tools where they are being employed.</td>
</tr>
<tr>
<td>• The tool is not intended to replace existing quality improvement tools aimed at building towards or maintaining educational standards. These processes, which are important to maintaining optimal educational processes, can be used in conjunction with findings collected using the Rapid Assessment Tool.</td>
</tr>
<tr>
<td>• The tool is not intended to serve as an accreditation instrument.</td>
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Conclusion

Global efforts to improve maternal and newborn health depend on a robust midwifery workforce. This requires a quality midwifery education system that can produce sufficient numbers of competent midwives ready to provide the full package of services to communities needed to transform health systems. Universal health coverage goals desired by 2030 are dependent on well designed and carefully monitored efforts towards this end. Positive change depends on the ability to rapidly identify curricular, faculty, infrastructure, management, clinical and student related factors that impact on the quality of the system.

The Rapid Assessment Tool described in this paper, which has been linked to global standards and widely vetted among midwifery and public health experts, is available to guide educators, health professional regulators, policy makers, NGOs and other public health stakeholders toward highly targeted evidence-based interventions. Evidence of the usability of this tool has already emerged from its application in countries in which there is wide diversity in the alignment of the role of midwives within health workforce strategies and alternative pathways to midwifery education.

Conflict of interest

All authors are employees of or consultants for Jhpiego. They have no additional conflicts of interest.

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