

Obstacles and Enablers to the Professional Development of Skilled Birth Attendants: a Case Study of the Shoklo Malaria Research Unit on the Thailand-Myanmar Border

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ABSTRACT

Although Skilled Birth Attendance has been universally acknowledged as essential to progress in the field of maternal health (WHO, 2004), Human Resources for Health (HRH) deficits are currently impeding the sustainability of essential maternal health interventions on a global scale. Over the past 30 years, the Shoklo Malaria Research Unit (SMRU), along with other agencies such as non-governmental organizations and community-based organizations, have developed a self-contained health system, which provides health services, including maternity care, to migrants and refugees at the Thailand-Myanmar Border. The staff necessary to the provision of care in SMRU's clinics are mostly recruited from within the migrant and refugee populations, and trained internally by SMRU.

In the last decade, SMRU has experienced high-turnover rates and shortages of Skilled Birth Attendants (SBA). Consequently, their current maternity workforce is characterized by an acute shortage of SBAs who have attained senior status, and a higher concentration of SBAs at the assistant and junior levels. As a response to these HRH challenges, this case study aimed to conduct a multi-level analysis of obstacles and enablers to professional development amongst Skilled Birth Attendants working for SMRU. This single descriptive case study with embedded units of analysis, which incorporated non-participant observation, a template-based personnel file review, individual interviews, and focus groups at two of SMRU's Birthing Units, represented a unique opportunity to observe and analyze the multiple influences that interact at various levels of a relatively self-contained health system. By highlighting the obstacles and enablers present within the system, this study purposed to identify means by which to empower lower level SBAs, support their professional development, and create a more sustainable maternity workforce.

The study found that SMRU has been successful in providing its SBAs with the appropriate midwifery skills to fulfill a limited scope of practice, and in fostering strong intra-professional relationships that allow the SBAs to motivate and mentor each other. Achieving workforce sustainability with a model of care that implements task-shifting requires a balance of appropriate and constructive consultation structures without enabling the stagnation of SBAs' skills and confidence. This study also reveals the importance of context and culture to a health system's capacity to optimally plan and implement its HRH functions. Finally, in the case of SMRU, persistent recruitment and retention concerns underscore that workforce sustainability cannot be achieved through professional development alone. Therefore, this study reveals a need for further inquiry into the complexities of maternal health workforce planning in contexts of protracted displacement, and the challenges associated with developing appropriate supervisory structures for lower level health professionals.

STATEMENT OF THE PROBLEM

As questions of gender inequity have risen to the forefront of social consciousness, the persistent risks associated with pregnancy and delivery in many areas of the world have become important development priorities. The emergence of maternal and reproductive health as a key area of focus for the international community was manifested in the elaboration of the Millennium Development Goals (MDG) in 2000, and continues to be reflected in the 2030 Agenda for Sustainable Development.

Although Skilled Birth Attendance has been universally acknowledged as essential to progress in the field of maternal health (WHO, 2004), human resources for health (HRH) deficits are currently impeding the sustainability of essential maternal health interventions on a global scale. South-East Asia and Africa face the most significant needs-based shortages of health workers (WHO, 2016). In order to address these deficiencies, many of the studies that have highlighted the importance of HRH for the achievement of global development priorities have not only prescribed an acceleration in workforce growth (Campbell et al, 2013; Koon & Mayhew, 2013; Sousa et al, 2014), but acknowledged that this new wave of health workers must be supported in the acquisition of appropriate skills and the development of high levels of motivation, which are necessary to the effective fulfillment of their professional responsibilities (Hongoro & Normand, 2006; Nandan et al, 2007; Rowe et al, 2005; Tangcharoensathien et al, 2013; Vujcic et al, 2012). Human resources for health are indispensable to the provision of care and represent a fundamental component of all health systems (WHO, 2009). If health systems strengthening efforts aiming to reach the most vulnerable segments of society are to succeed, ensuring that an adequate number of appropriately skilled health workers are equitably distributed, and sufficiently supported will be imperative.

Much of the current literature on health workforce development highlights the value of continuing education, as well as supportive supervision and coaching, as contributors to the ongoing professional development and capacity building of the Skilled Birth Attendant (SBA) workforce (Adegoke & van den Broek, 2009; Byrom & Downe, 2010; Walker et al, 2013; McNamara et al, 2014; Rafferty & Fairbrother, 2015). Existing studies also emphasize the importance of workplace culture and positive interactions (Hongoro & Normand, 2006; Hoopes-Bender et al, 2014; Bedwell et al, 2015) for the development of confidence and motivation amongst SBAs. The existing literature has yet to address how multiple factors at the micro (individual), meso (organizational), and macro (contextual and cultural) levels interact within a complex health system to either enable or impede the professional development of SBAs.

Over the past 30 years, the Shoklo Malaria Research Unit (SMRU), along with other agencies such as non-governmental organizations and community-based organizations, have developed a self-contained health system, which provides health services, including maternity care, to migrants and refugees at the Thailand-Myanmar Border. The staff necessary to the provision of care in SMRU's clinics are mostly recruited from within the migrant and refugee populations, and trained internally by SMRU. In the past decade, SMRU has experienced high-turnover rates and shortages of SBAs. Consequently, their current maternity workforce is characterized by an acute shortage of SBAs who have attained senior status, and a higher concentration of SBAs at the assistant and junior levels. As a response to these HRH challenges, this descriptive case study aimed to conduct a multi-level analysis of obstacles and enablers to professional development amongst SBAs working for SMRU. This case study represented a unique opportunity to observe and analyze the multiple influences that interact at various levels of a relatively self-contained health system. While contextual instability and cultural inhibitions constitute significant barriers

to optimal workforce planning and development at the operational level of SMRU's microsystem, the solidarity and sense of community exhibited by the SBAs represent important enablers to health system resilience that could be leveraged through culturally sensitive professional development practices.

STATE OF KNOWLEDGE

Persistent Challenges for Global Maternal Health

Whereas the global annualized rate of change in maternal mortality ratio was limited to -0.3% for the period between 1990 and 2003, it attained -2.7% between 2003 and 2013, demonstrating the considerable acceleration of progress in the area of maternal health following the establishment of the Millennium Development Goals (Kassebaum et al., 2014). Despite significant progress between 2003 and 2013, the gap between developing and developed countries remains. In 2013, the maternal mortality ratio (MMR) for developed countries was 12.1 per 100 000 live births, whereas the MMR for developing countries lagged far behind at 232.8 per 100 000 live births (Kassebaum et al., 2014). Worldwide, 292 982 women died in 2013 of causes related to pregnancy or childbirth, of which only 1811 were from developed countries (Kassebaum et al., 2014). Thus, as Ronsmans and Graham (2006) accurately characterized, maternal death is a “21st century problem essentially only for the poor, and one virtually eliminated for people with the means and status to access health care” (p.1189).

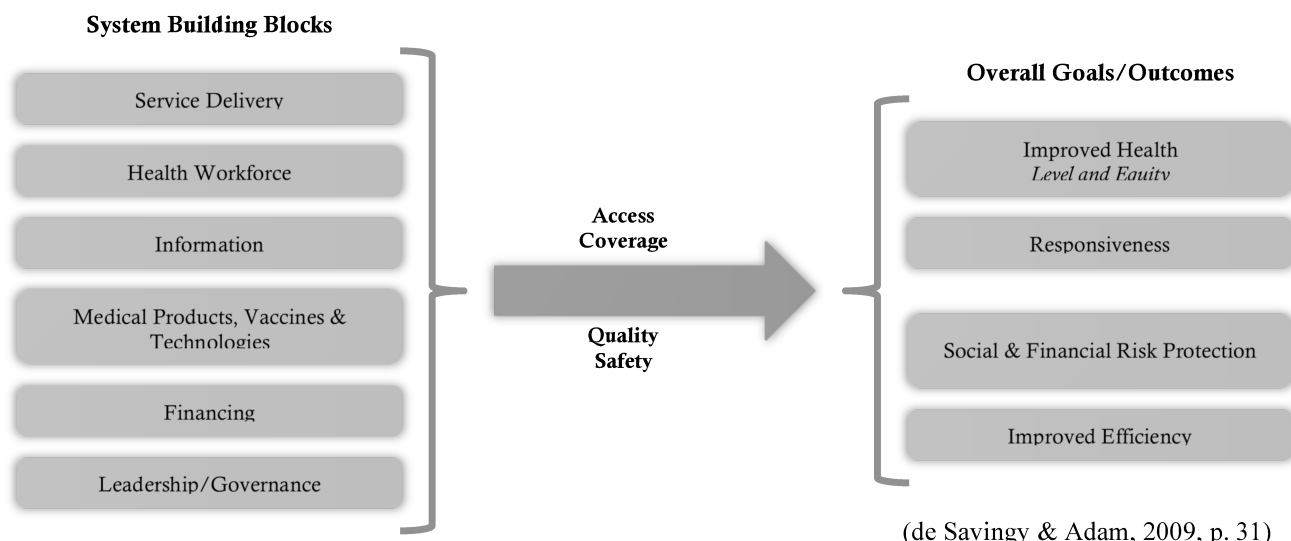
In addition to the disparities in coverage and outcomes between nations, pervasive inequities within populations must be considered in any assessment of progress in the field of maternal health. Wealth is one of the most prominent factors contributing to this inequity, which also include gender, rurality, age, legal status and ethnicity (Harris Requejo et al, 2014; Ronsmans &

Graham, 2006; Ki-Moon, 2013). Therefore, coverage of essential health services remains inadequate and inequitable, particularly amongst the most vulnerable subsets of populations. These gaps in coverage are of considerable concern due to the strong correlation between intervention coverage and maternal survival (Harris Requejo et al., 2014).

Human Resources for Health as an Essential Component of Health Systems

The World Health Organization (WHO) has identified health workforce as one of the six pillars of its Health System Framework, which is represented in the figure below (de Savigny & Adam, 2009). Within the framework, these building blocks interact to regulate the access, coverage, quality and safety of a given health system, which in turn influence the goals and outcomes that the system can achieve.

Figure 1: WHO Health System Framework



The WHO further underscored the importance of human resources within health systems by identifying people as the mediators, beneficiaries, and drivers of health systems. The dynamic relationships between health system building blocks demonstrate the need for systems thinking in any analysis of human resources for health. This perspective allows for a more complete

understanding of the elements within a given system, as well as the contextual factors that are exerting influence on the health workforce sub-system.

“The building blocks alone do not constitute a system, any more than a pile of bricks constitutes a functioning building. It is the multiple relationships and interactions among the blocks – how one affects and influences the others, and is in turn affected by them – that convert these blocks into a system. As such, a health system may be understood through the arrangement and interaction of its parts, and how they enable the system to achieve the purpose for which it was designed” (de Savigny & Adam, 2009, p.31).

Human Resources for Health Considerations

As we prioritize universal health coverage in the pursuit of the sustainable development goals, HRH considerations will be essential to the establishment of equitable and sustainable health systems (Campbell et al, 2013; Koon & Mayhew, 2013; Sousa et al, 2014).

“The health workforce is the backbone of each health system, the lubricant that facilitates the smooth implementation of health action for sustainable socio-economic development” (Anyangwe & Mtonga, 2007, p.93)

In light of the acknowledged importance of HRH to development goals, the current global shortage in health workforce personnel becomes all the more concerning. As of 2013, the global needs-based shortage of health workers was estimated at 17.4 million. Regionally, South East Asia displayed a shortage of 6.9 million health workers, 3.2 million of which were nurses and midwives (WHO, 2016). This crisis in human resources is hindering the sustainability of health systems on a global scale, and preventing the equitable provision of essential services of acceptable quality, particularly for vulnerable populations such as refugees or migrants (Aluttis et al, 2014; Anyangwe & Mtonga, 2007; Bangdiwala et al, 2010; Bossert & Ono, 2010; Chen et al, 2004; Dalton, 2014; Dayrit et al, 2011; Kanchanachitra et al, 2011; Narasimhan, 2004; Rispel & Barron, 2012; Sousa et al, 2014).

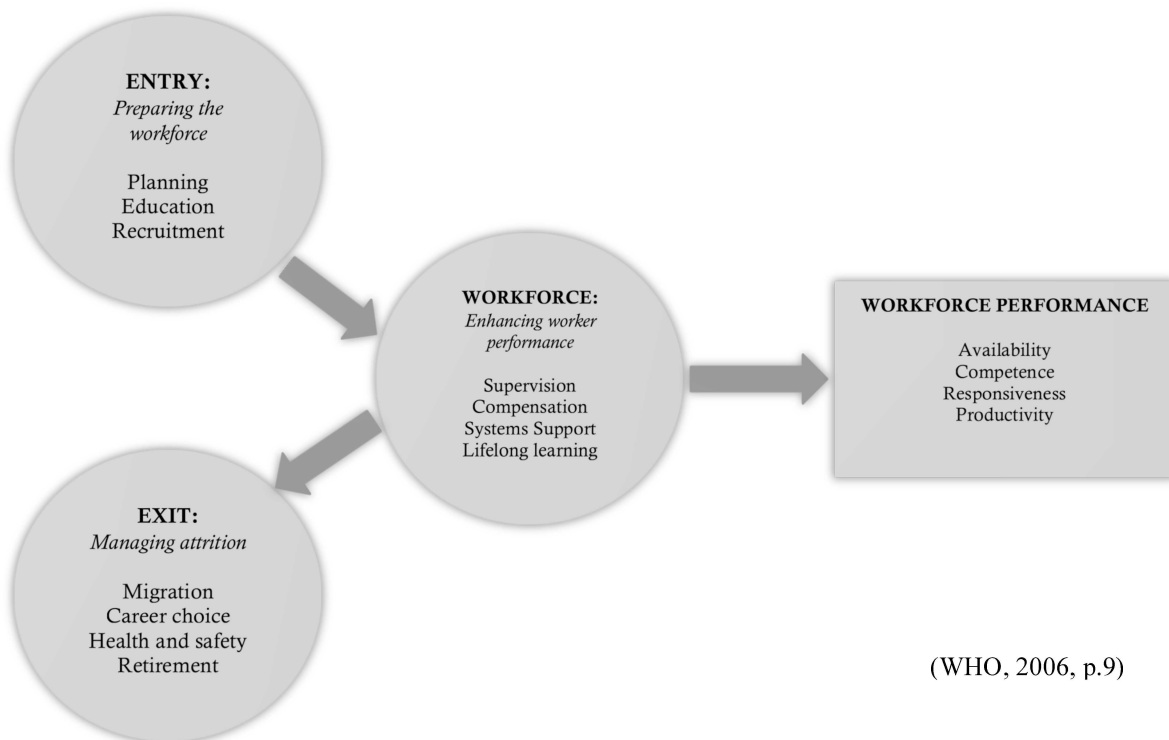
“Policy on human resources for health should support health policy objectives and be a means for achieving policy goals. The implication of such a focus is that health systems development should start by identifying the tasks that must be carried out and the skills needed to perform them. Meeting policy goals depends on being able to recruit, train, and retain staff with the necessary bundles of skills.” (Hongoro & Normand, 2006, p.1309)

In their 2006 World Health Report, which focused on addressing the global crisis of HRH, the WHO stated:

“In tackling these world health problems, the workforce goal is simple – to get the right workers with the right skills in the right place doing the right things! – and in so doing, to retain the agility to respond to crises, to meet current gaps, and to anticipate the future.” (p.xx)

In order to meet these goals, and achieve health system resilience, they propose a Working Lifespan framework of strategies, which is represented in figure 2. By prescribing investments in appropriate recruitment and educational practices, enhancement of human resource management practices, and mitigation of premature attrition, this framework aims to enable workforce performance improvements.

Figure 2: Working lifespan strategies



(WHO, 2006, p.9)

Health workforce shortages have constituted a common obstacle amongst developing nations in the implementation of quality maternal health interventions. Out of necessity, these shortages have led to innovative models of practice, which incorporate task shifting and the increased utilization of lower-level health workers, including midwives, skilled birth attendants, and community health workers (Harris Requejo et al, 2014). In rural communities, innovations also include mechanisms to mobilize local assets in order to mitigate physical, human, and fiscal resource shortages within the health sector (Pennel et al, 2008). A review conducted by Dielman et al. (2007) also underlined the importance of local adaptation and participation to the success of human resource management interventions. Mobilization of local assets is of utmost importance in these rural and remote regions where challenges surrounding recruitment and retention of health professionals are common. These challenges are often exacerbated by health professional emigration (Hongoro & Normand, 2006; Smith & Hyre, 2009).

A systematic review conducted by Colvin et al. (2013) revealed that challenges associated with task shifting to midwives from other health professionals did not usually stem from problems acquiring new knowledge and skills, but rather from deficiencies in the planning, support, training, and integration of the new tasks. The authors cautioned against *ad hoc* forms of task shifting, which jeopardize the midwives' confidence in their new skills, and explained:

“Though task shifting may serve as a powerful means to address the crisis in human resources for maternal and newborn health, it is also a complex intervention that generally requires careful planning, implementation and ongoing supervision and support to ensure optimal and safe impact” (Colvin et al., 2013, p.1211).

Their review also revealed that disparities in social status and power, uncertainties surrounding roles and responsibilities, as well as barriers in communication and collaboration could impede the success of task-shifting initiatives.

Hence, HRH considerations cannot be reduced to sheer numbers: successful health systems must recognize the importance of planning, training, and continuous professional development to the creation of a sustainable, competent, effective and motivated health workforce (Hongoro & Normand, 2006; Nandan et al, 2007; Rowe et al, 2005; Tangcharoensathien et al, 2013; Vujicic et al, 2012). Giri et al. (2012) define continuing professional development as:

“all of the activities that health workers undertake—both formal and informal—to maintain, update, develop, and enhance their professional skills, knowledge, and attitudes. Continuing professional development is a systematic and ongoing process of education, in-service training, learning, and support activities that build on initial education and training to ensure continuing competence, extend knowledge and skills to new responsibilities or changing roles, and increase personal and professional effectiveness.”(p.1)

In their 2004 report entitled *Making pregnancy safer: The critical role of the skilled birth attendant*, the WHO enumerated 5 essential components of an appropriate human resources and management system: adequate volume and appropriate distribution of suitably trained skilled attendants, acceptable compensation, career advancement and continuing education opportunities, supportive supervision mechanisms, and accessible referral systems to higher level care.

In May 2016, the World Health Assembly adopted the *Global strategy on human resources for health: Workforce 2030*, which states that:

“Mere availability of health workers is not sufficient: only when they are equitably distributed and accessible by the population, when they possess the required competency, and are motivated and empowered to deliver quality care that is appropriate and acceptable to the sociocultural expectations of the population, and when they are adequately supported by the health system, can theoretical coverage translate into effective service coverage.”(WHO, 2016, p.6)

This statement reflects the key dimensions of effective coverage, as described by Campbell et al. (2013), that have been adopted by the Global Health Workforce Alliance: availability, accessibility, acceptability, and quality.

Importance of Skilled Birth Attendance

Skilled Birth Attendance is defined by the presence of skilled health personnel providing adequate support during labour, delivery and the early post-partum period in an enabling environment, which includes appropriate supplies, equipment, transportation, and communication systems (Adegoke & van den Broek, 2009). The current international definition of a Skilled Birth Attendant is that of “an accredited health professional — such as a midwife, doctor or nurse — who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns”(WHO, 2004, p.1).

By identifying the rate of skilled birth attendance as a target indicator for MDG 5, the international community emphasized the critical importance of investment in health human resources to progress in the field of maternal health (Krupp & Madhivanan, 2009; Nabudere, 2011; Rasch, 2007; Wyss, 2004). As we move forward with the 2030 Agenda for Sustainable Development, target 3c reinforces the importance of human resources for health as a key driver of health and wellbeing, and aims to “Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States” (UN, 2015, p.19).

Historical analysis reveals that countries that have achieved advancements in their maternal mortality ratios have done so through improved access to skilled health professionals (Adegoke & van den Broek, 2009).

“The single most critical intervention is to ensure that a health worker with midwifery skills is present at every birth, and transportation is available in case

of emergency. A sufficient number of health workers must be trained and provided with essential supplies and equipment, especially in poor and rural communities'' (Starrs & Inter-agency Group for Safe Motherhood, 1997, p.77)

Density of human resources for health has been significantly positively correlated with skilled birth attendance (Gupta et al, 2011; Roskam et al, 2013), and negatively correlated with maternal, infant, and under 5 mortality (Anand & Bärnighausen, 2004).

Midwives that are educated and accredited according to international standards can fulfill a scope of practice which encompasses 87% of the essential needs of women and newborns (UNFPA, 2014). A Cochrane review published in 2016 (Sandall et al.) confirmed that most women who do not exhibit substantial medical or obstetrical complications should be offered midwifery-led continuity of models care due to the significant benefits it presents when compared to other models of care, including obstetrician-provided care, family doctor-provided care, and shared models of care. These benefits included increased rates of satisfaction, reduced likelihood of obstetrical intervention such as episiotomy and instrumental birth, and reduced rates of preterm birth and fetal death prior to 24 weeks gestation. Most importantly, midwifery-led care did not increase the likelihood of adverse maternal or neonatal outcome.

It is important to distinguish between “trained” and “skilled” attendants. Prior to the establishment of the MDGs, the term “skilled” was introduced as an acknowledgement that training does not necessarily imply that the professional has acquired an appropriate level of skills and knowledge to practice safely and effectively (Adegoke & van den Broek, 2009). Skilled Birth Attendance became all the more important when strategies focusing on utilization of Traditional Birth Attendants (TBA) failed to achieve desired results. Although TBAs are easily accessible within the community, programs’ inability to instill adequate levels of skill and

knowledge, combined with a lack of enabling environment, has limited their capacity to improve maternal outcomes within their communities (Adegoke & van den Broek, 2009). It is equally important to distinguish between the international definitions of Skilled Birth Attendants and Midwives. In order to be considered a midwife by international standards, a Skilled Birth Attendant must, by definition, have completed a midwifery program that meets international standards and is recognized by their national government, and must be registered and licensed to practice with this government (Renfrew et al., 2014). Under unstable circumstances, where registration with a government may be impossible, these standards can complicate licensing and registration of otherwise competent health professionals.

Performance and Motivation

In addition to increased coverage of essential interventions, ending preventable maternal and neonatal mortality will require improvements in the quality of care provided in high-burden countries (Campbell et al, 2016). In many cases, health professionals' performance is limiting the contribution of the existing workforce to the productivity of the system as a whole (Rowe et. al., 2005). As such, studies that have highlighted the importance of HRH for the achievement of global development priorities have not only prescribed an acceleration in workforce growth, but acknowledged that this new wave of health professionals must be supported in the acquisition of appropriate skills and the development of high levels of motivation, which are necessary to the effective fulfillment of their professional responsibilities (Jha & Mills, 2002; Kurowski et al, 2003 in Hongoro & Normand, 2006).

In a review conducted by Willis-Shattuck et al. (2008), seven major motivational factors were identified as relevant across studies examining training and motivation of health workers:

financial incentive, career development, continuing education, hospital infrastructure, resource availability, hospital management, and personal recognition. These factors encompass micro, meso, and macro considerations, and highlight the complexity of professional development.

Although financial incentives can be very effective motivators, other incentives, including workplace environment, recognition, opportunities for advancement, and sense of purpose, can play an important role in a professional's decision to become and remain a productive contributor to the system in question (Dieleman, 2009; Hongoro & Normand, 2006; Smith & Hyre, 2009). As such, investment in the service delivery environment is an important input to motivation and quality improvement efforts. The optimal environment must not only include the necessary tools to provide quality care, but foster collaboration between professionals through efficient regulation and educational practices (Hoope-Bender et al, 2014). "The collaboration [...] must be based on mutual respect and recognition of the specific contribution each type of care provider makes to the continuum of care"(WHO, 2004, p.5).

The Midwifery2030 vision that was brought forward in the *State of the World's Midwifery* highlights the importance performance review and development as means to identify opportunities for continuing professional education and quality improvement. Midwifery2030 also considers advancement opportunities as important contributors to job satisfaction amongst health professionals (UNFPA, 2014). Furthermore, Midwifery2030 underlines the importance of clarity in the definition of roles and responsibilities between different cadres within a team in order to facilitate effective collaboration and communication, and ensure that midwives can work to their full scope of practice, while maintaining appropriate access to consultation and referral (UNFPA, 2014). This vision advocates for a more effective use of available human resources for

health through increased inter-professional collaboration, and less hierarchical organizational structure within health care teams (Campbell et al., 2016).

Confidence and Competency

Education of all health professionals, including skilled birth attendants, is considered to be an ongoing and dynamic endeavor, rather than the finite completion of a curriculum. As such, quality education of health professionals includes pre-service and in-service training, as well as supportive supervision (Adegoke & van den Broek, 2009). These learning opportunities, combined with practical experience, allow health care providers to develop competence, which can be defined as the “ability to perform a specific task in a manner that yields desirable outcomes” (Kak et al., 2001, p.3). Confidence however, is a more personal trait that would influence an individual’s disposition to recognize and act on their ability to perform this task. This definition of confidence goes beyond self-efficacy, which can be defined as the “conviction that one can successfully execute the behavior required to produce the outcomes” (Bandura, 1977, p.193), and incorporates self-esteem, which can be defined as “the overall affective evaluation of one’s own worth, value, or importance” (Blascovich & Tomaka, 1991, p.115).

Smith and Hyre (2009) underline the importance of alignment between pre-service training programs and local service guidelines. They also explain that for in-service training, performance assessments of the health workforce should be analyzed in conjunction with the system’s service objectives in order to identify knowledge and skill gaps, and inform the planning of training interventions (Smith & Hyre, 2009). Furthermore, Smith & Hyre (2009) acknowledge that Maternal Child Health presents unique challenges for supportive supervision due to the unpredictable scheduling of care provision.

In a study conducted in Australia (Walker et al, 2013), which included obstetricians and midwives, researchers observed a significant improvement in confidence and perceived knowledge following the completion of Advanced Life Support in Obstetrics (ALSO[®]) training, when compared with pre-course levels. Conversely, they also observed a significant decrease in confidence and perceived knowledge between the assessment conducted immediately post-course and the assessment conducted six weeks later, demonstrating difficulties associated with long-term skill and knowledge retention. The authors involved in this particular study believed that infrequent utilization of complex emergency obstetrical skills could account for this long-term decrease, and echoed the need for continuing education and experience to reinforce the skills and knowledge acquired during discrete educational programs.

Confidence and competency are of particular importance to the practice of midwifery considering the professional's need to provide patients with safe and appropriate care while respecting midwifery's model of care which places great value on accommodating women's preferences and decisions (Bedwell et al, 2015). Confidence is also a key component of workforce sustainability considering that high levels of confidence are associated with the development of leadership skills, professional identity, and coping mechanisms, while low levels of confidence can be associated with higher rates turnover and absenteeism, lack of ownership, decreased job satisfaction, and increased burnout (Bedwell et al, 2015).

In a recent study conducted in the United Kingdom (Bedwell et al, 2015), regarding midwives' confidence in intrapartum care, colleagues constituted important contributors to the development, stagnation, or regression of confidence amongst midwives. Whereas when colleagues demonstrated trust or allowed for the perception of autonomy, midwives' confidence flourished;

conflicts amongst colleagues or questioning of their actions often led to a reduction in midwives' level of confidence. These effects were particularly apparent when the colleague in question was a superior or someone the midwife held in high esteem; thus highlighting the importance of constructive feedback from the leaders and managers who are responsible for the creation of a positive workplace culture (Bedwell et al, 2015).

Effective Leadership

In a study conducted by Byrom & Downe (2010), midwives explained that effective leaders in their field require both “skilled competence” and “emotional intelligence” in order to gain the respect and trust of both patients and staff. These leaders are expected to be confident in their roles as both clinicians and managers, in order to lead their staff by example. Furthermore, the participants enumerated interpersonal skills, such as empathy, communication, supportive guidance, and approachability, as keys to establishing effective leadership and avoiding the perception of authoritative hierarchy. The authors came to the realization that the skills required for effective leadership of staff are extensions of those midwives use to motivate and support women through labor and delivery. Byrom & Downe also discussed a virtuous circle whereby leaders empower staff through effective communication and support, building their confidence and their ability to empower the women they care for, who in turn reinforce midwives' confidence through positive feedback and outcomes. This boost in confidence encourages midwives to become more actively engaged within their professional environment (Byrom & Downe, 2010).

Focus group participants in a study conducted by Casey et al. (2010) supported the notion that clinical leadership is founded on clinical expertise, experience and credibility. These focus

groups also expressed the belief that adopting a clinical leadership role was more challenging for nursing and midwifery managers due to their position within the organizational hierarchy, and their poor role definition stemming from their numerous responsibilities (Casey et al, 2010).

Rafferty & Fairbrother (2015) reiterate the importance of effective communication as a key leadership competency for nurses and midwives:

“The ‘manager as coach’ concept entails applying deep listening and open questioning to empower employees to think for themselves and take responsibility for their actions, and providing corrective and positive feedback in a meaningful way, to reinforce and improve employee performance” (Rafferty & Fairbrother, 2015, p.1250).

Development and implementation of coaching skills represented a significant challenge for many participants in this same study as it constituted a dramatic and fear-inducing shift from a directive managerial style towards a more collaborative coaching style. The authors highlight the benefits of appropriate integration of coaching into managerial practice, including “increased role clarity, job satisfaction and retention; higher levels of confidence and self- esteem; and enhanced individual goal achievement” (Rafferty & Fairbrother, 2015, p.1250).

As described by McNamara et al. (2014), mentoring, coaching and action learning also formed the foundations of an effective and well-received clinical leadership development program that has been implemented in Ireland since 2011. The strategies utilized within this program take into account the personal, ongoing nature of clinical leadership development. Despite the long-term investment and commitment required to implement action-oriented and experiential interventions, they allow individual practitioners to work towards specific professional development goals and acquire clinical leadership competencies pertinent to their role within their current work environment (McNamara et al, 2014).

In summary, Table 1 provides an overview of the existing literature that frames this study, and of corresponding gaps in knowledge that the study aimed to address.

Table 1: Summary of State of Knowledge

| <i>Existing Knowledge</i> | <i>Gaps that will be addressed</i> |
|--|---|
| Skilled birth attendance is essential to progress in the field of maternal health, but HRH considerations, including personnel shortages and capacity deficits, are impeding the sustainability of maternal health interventions | How a context of protracted displacement affects a health care system's ability to achieve workforce sustainably and maintain their provision of skilled birth attendance |
| Professional education and development of SBAs represent ongoing endeavors that require supportive supervision and coaching | How individual, organizational, and contextual factors interact within a system to either enable or impede professional development |
| SBA confidence can be enhanced, stifled, or hindered based on the nature of their interactions with colleagues | How socioeconomic vulnerability may influence team dynamics, self-efficacy, and willingness to engage in professional development |

BACKGROUND TO THE MICRO-SYSTEM CASE STUDY

This case study encompasses two birthing units; one of which is situated within the Maela Refugee Camp, and one of which is situated in Mawker Thai, a rural migrant site along the Thailand-Myanmar Border in Tak Province. Due to political, social, and economic instability in Myanmar, a large contingent of Burmese, particularly of Karen ethnic origin, have sought refuge in Thailand, or at least at the outer eastern border of Myanmar, over the past 30 years. Thailand has not ratified the United Nations Convention and Protocol related to the Status of Refugees, and has gradually limited the role of external actors, such as the UNHCR, in the country. Absence of formal refugee status or asylum procedures under Thai law leaves refugees and migrants from Myanmar vulnerable to arbitrary regulations imposed by Thai authorities (HRW, 2012). In addition to the 105 935 verified refugees from Myanmar living in official camps along the border (UNHCR, 2016), there are an estimated 2.3 million migrants from Myanmar working

or residing in Thailand (IOM & ARCM, 2015), of which approximately 200 000 are situated in and around Mae Sot, Tak province. Currently, approximately half of these migrants are registered through Thailand's National Verification Program (IOM, 2011). Therefore, the majority of migrants remain unregistered due to such barriers as financial ineligibility. Their pre-existing economic vulnerability is often amplified by barriers of access to health and social services caused by their lack of legal status and documentation. Furthermore, security concerns related to risk of arrest and deportation by Thai police for lack of documentation limit migrants' mobility and deter them from accessing services that have been made available by non-governmental organizations.

As the name suggests, the Shoklo Malaria Research Unit (SMRU) was initially established in association with the Mahidol-Oxford Research Unit for the study of malaria within the local population, and continues to be a world leader in malaria research, including on topics related to malaria in pregnancy. SMRU has integrated general health care provision with field-based research since its inception. SMRU has been providing health care services to refugees from Myanmar since 1986, and has had a clinic in Thailand's largest refugee camp, situated in Maela, since 1995, following the amalgamation of multiple small camps into larger camps under the direction of Thai authorities. In 1995, SMRU also established clinics in rural areas to meet the growing needs of migrants from Myanmar living and working in neighbouring villages, of which a large portion are Karen. The initial response from SMRU sought only to meet the demand for access to early diagnosis and treatment of malaria amongst migrant workers (Carrara et al, 2006). In these rural areas migrant workers often move as family units. Inevitably, the problem of malaria in pregnancy and lack of access to maternal and child health services became apparent, and SMRU's service provision in these areas expanded accordingly.

The staff necessary to the provision of care in SMRU's clinics are mostly recruited from within the migrant and refugee populations, and trained internally by SMRU. Overall, SMRU employs over 400 local staff, which include health care workers, laboratory technicians, administrative personnel, and support staff. Of the five clinics operated by SMRU, three include birthing units staffed by skilled birth attendants: Maela refugee camp, Wang Pha, and Mawker Thai. The services provided by these units include antenatal care, care during labour and childbirth, postpartum care, and referral to the adjacent Special Baby Care Units as needed. Combined, SMRU's clinics attend more than 2300 deliveries per year. These SBA-led units also have access to consultation with doctors on the premises during regular office hours, and by telephone during evenings and weekends. These doctors with obstetrical training, the vast majority of which are expatriates, complete work terms of varying lengths with SMRU. Whereas some of SMRU's permanent doctors have over 20 years of experience working in the clinics, others complete temporary assignments ranging between 6 weeks and 3 years.

All but one WHO EmONC signal functions are available in the birthing units, the exception being the availability of caesarean section (Hoogenboom et al. 2015). In the event of serious complications, which require surgical intervention, patients are transported to the nearest Thai hospital at SMRU's expense. These referrals, which are often unavoidable and unpredictable, represent a significant burden on SMRU's already limited budget.

As is the case for many organizations working with migrants and refugees at the border, SMRU is not registered with the Thai Government as an NGO, narrowing their access to funding. Funding at the border is also limited by the fact that most organizations operate within Thailand, which is defined as a middle-income country and ineligible for many maternal and child health

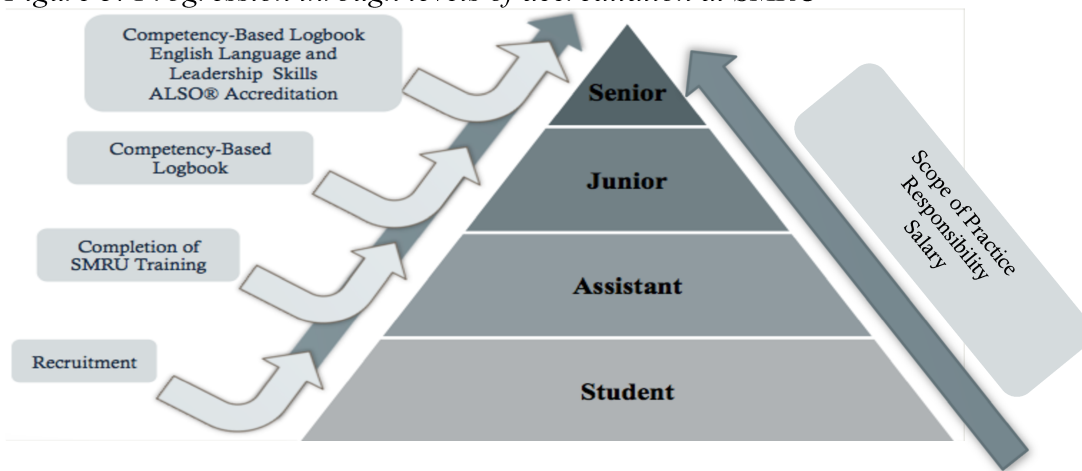
funding campaigns. Accordingly, SMRU funds the vast majority of its operations through research grants and donations. SMRU receives funding from the Wellcome Trust of Great Britain through their affiliation with the Mahidol-Oxford Research Unit, and from a variety of other donors, which include the European Union, DFID, The Global Fund, and the Bill and Melinda Gates Foundation. These grants provide SMRU with baseline research funding, and allow SMRU to cope well with day-to-day clinic operating expenses related to their humanitarian services, which are provided with no fee-for-service for patients. The budget remains operationally tight for resource intensive services such as referral to the Thai Health System as the safest service in the area in the event of complications, in which case SMRU pays for the fees in full.

Within SMRU's model of service provision, the integration of clinical research and care enables the use of the evidence produced internally and by visiting researchers to improve their practice. For instance, a previous study of SMRU's birthing unit in Maela (Hoogenboom et al. 2015), which assessed the quality of intrapartum care using the WHO Safe Motherhood Needs Assessment, found that the SBAs' complied with the protocols set forth by SMRU, could recognize most danger signs and symptoms, received both theoretical and hands on training, and attended deliveries regularly. The study also identified specific areas where quality improvement was necessary, including hand washing, episiotomy rates, and newborn monitoring in the first hour after birth. These results were fed back to the SBAs in question and informed subsequent coaching efforts by doctors who worked with the SBAs for a number of years.

Since 2009, SMRU has delivered a 15-month formal SBA training program to new recruits based on SMRU's locally developed evidence-based Obstetric Guidelines and standardized curriculum. As illustrated in figure 3, SMRU has developed a tiered system of accreditation for their SBAs,

who are identified as Senior, Junior, Assistant, or Student, depending on their level of training and competency. Assistants have successfully completed SMRU’s formal SBA training program, whereas students are in the process of completing the theory and competency component of this curriculum. In order to achieve junior status, SBAs must complete the junior logbook, which involves a series of competency-based assessments supervised by senior SBAs. Finally, progression to the senior level requires basic English language skills, leadership abilities, fulfillment of the senior logbook under the supervision of consulting doctors, and successful completion the Advanced Life Support in Obstetrics® (ALSO®) course (accredited by the American Academy of Family Physicians). English language skills are important to this progression because SMRU’s primary working language is English; all research forms and patient records must be completed in English, and most of the SBAs’ interactions with consulting physicians are conducted in English.

Figure 3: Progression through levels of accreditation at SMRU



Due to the limited connections that SMRU can establish with the Thai government, none of SMRU’s training programs constitute recognized accreditations, limiting the SBAs’ professional mobility. In light of the gradual shifts that are occurring in Myanmar and the impending repatriation process, SMRU is endeavouring to have their training recognized by the Government

of Myanmar. Additionally, Myanmar is currently in need of SBAs for their own workforce in Kayin State. SMRU has expressed willingness to send some of their staff to a standardized countrywide program to accredit midwives that has been proposed by the International Rescue Committee.

In the past decade, SMRU has experienced high-turnover rates and shortages of SBAs. Since the initiation of its formal training program, SMRU has lost 2/3 of the trainees from their first two cohorts. Resettlement and enhanced family responsibilities were important contributors to this attrition. Their current maternity workforce is characterized by an acute shortage of SBAs who have attained senior status, and a high volume of SBAs at the assistant and junior levels. In light of this challenge, the purpose of this study was to identify obstacles and enablers to the development of the competencies required to attain higher levels of accreditation within SMRU's SBA workforce.

Health systems are complex, and as such health workforce analysis is multifaceted and must take into account numerous contributing factors at all levels of the system. This case study was of intrinsic value as it presented an opportunity to observe and analyze a self-contained health system in its entirety. As SMRU is a non-governmental entity, providing care which is parallel to, and independent of, the official health care system, it constitutes a microsystem which plans and implements all of its functions at the local level. Accordingly, this study aimed to contribute a more holistic, dynamic and nuanced representation of the interacting factors affecting the professional development of skilled birth attendants at all levels of a given health system. By highlighting the obstacles and enablers present within the current system, the study aimed to

identify means by which to empower lower level SBAs, support their professional development, and create a more sustainable maternity workforce.

RESEARCH QUESTIONS

- What factors promote the professional development of SBAs providing maternity care at SMRU's clinics? How can these enablers be reinforced?
- What factors impede the professional development of SBAs providing maternity care at SMRU's clinics? How can these obstacles be addressed?

METHODOLOGY

Ethics

This project received ethical approval from the University of Ottawa Health Sciences and Science Research Ethics Board on January 18, 2016 (see Appendix 1 for University of Ottawa Ethics Certificate). Local ethical approval for this project was granted by the Tak Community Advisory Board on December 5, 2015 (see Appendix 2 for Tak Community Advisory Board Ethics Certificate).

Qualitative approach

In order to achieve this study's stated research purpose, the employment of a qualitative research approach was most appropriate. As described by Bourgeault et al. (2010), a qualitative approach can provide a deeper understanding of the "what", "how", and "why" of a phenomenon, which often cannot be appropriately addressed by quantitative measurement.

Correspondingly, the provider experiences that this study aimed to explore, and the factors that shaped them, could not be measured or fully captured using quantitative tools. Furthermore, these authors explain that:

“Qualitative health research helps close the gap between objective and subjective reality by examining: behaviours, attitudes, and perceptions influencing health outcomes; [...]; the experiences of both professional and non-professional health care workers, from initial socialization to the provision of care in organizational environments; the development, execution and evaluation of interventions, programmes, and clinical trials; and the wider understanding of the policy, social, and legal contexts of care” (Bourgeault et al. 2010, p.4)

This statement demonstrates the established utilization of qualitative methodology to effectively address research questions that are congruent with the objectives of the study at hand. Myers (2013) also adds that “One of the key benefits of qualitative research is that it allows a researcher to see and understand the context within which decisions take place” (p.5). The efficacy of a qualitative approach in forming a complex understanding of the participants’ environment facilitated the development of a more holistic and comprehensive interpretation of their perspectives. Finally, Creswell (2013) reiterates the importance of context to qualitative research and adds the notion of empowerment, which is relevant to this study’s purpose and contribution.

“We conduct qualitative research when we want to empower individuals to share their stories, hear their voices, and minimize the power relationships that often exist between a researcher and the participants in a study” (p.48).

Case study design

In accordance with Yin’s (2003) recommendations, this study was an ideal candidate for a case study design in light of the study’s open research questions, and the presumed significance of contextual conditions to the phenomenon at study. This methodological design was also particularly amenable to the complexity associated with health systems research.

“This qualitative case study is an approach to research that facilitates exploration of a phenomenon within its context using a variety of data sources. This ensures that the issue is not explored through one lens, but rather a variety of lenses which allows for multiple facets of the phenomenon to be revealed and understood.” (Baxter & Jack 2008, p.544)

The design chosen for this study corresponded with Yin’s (2003) description of a single descriptive case study with embedded units. As a descriptive case study, this project aimed to

describe the SBAs' professional development process and the factors that contribute to this process within the context of SMRU's clinics. As a single case study with embedded units, which were represented by the individual clinics, this project aimed to provide holistic, disaggregated, and comparative descriptions of this phenomenon. Baxter & Jack (2008) describe the value of this approach:

“The ability to look at sub-units that are situated within a larger case is powerful when you consider that data can be analyzed within the subunits separately (within case analysis), between the different subunits (between case analysis), or across all of the subunits (cross-case analysis).” (p.550)

In order to limit the scope of this study, two of SMRU's three birthing units were included as embedded units of analysis. The exclusion of one site also allowed for more in-depth analysis of the remaining sites. In order to optimize the significance of the study's findings for SMRU's workforce planning and development, it was decided that the study should encompass one refugee site and one migrant site. This led to the automatic inclusion of Maela, as it is SMRU's only refugee site. The decision to prioritize Mawker Thai over Wang Pha as the chosen migrant site was guided by a desire to maximize contrast between the two study sites; whereas Maela had built a full roster of SBAs, Mawker Thai was facing the most acute shortage of SBAs.

Data collection and sampling

The researcher completed a preliminary field visit in July 2015. At this time, the researcher was invited to spend 4 days conducting informal observations at two of SMRU's Birthing Units to identify potential lines of inquiry that could be of value to the organization. A subsequent conversation with SMRU management enabled the development of the specific research questions that are addressed in this study. Data collection and preliminary analysis were conducted during a second field visit from January 25-March 4 2016.

For data collection, Creswell's (2013) defined list of activities was followed. The site of this study was located by binding the case to a defined population of providers: SBAs providing maternity care to migrants and refugees, mostly from Myanmar, at two of SMRU's clinics; Maela Refugee Camp, and Mawker Thai Migrant Site (see figure 4 for a map of SMRU's sites). Access to the sites was acquired through collaboration with SMRU's management team.

Figure 4: Map of SMRU sites



Rapport was established with potential participants through an introductory meeting at each site, which described the purpose of the study and provided potential participants with the opportunity to raise any questions or concerns related to the study. The SBAs' attitude towards this first meeting was significantly different for each site, and constituted an early indicator of future findings. Whereas the entire team at Mawker arrived at the meeting and consented to all data collection activities without raising any questions, a select number of SBAs at Maela attended the meeting, asking a multitude of questions about the purpose, content, and structure of the study, and demonstrating more reluctance towards partaking in all data collection activities. In the end, all 14 SBAs who were working at Mawker Thai consented to all four data collection activities,

although one SBA's personnel file was not available for review because she was on temporary assignment from SMRU's Wang Pha birthing unit. Of the 20 SBAs working at Maela, all consented to partake in the non-participant observation and focus groups, 17 consented to the personnel file review, and eight consented to individual interviews.

Rapport was reinforced through four consecutive days of non-participant observation at each site prior to the initiation of interviews. In order to capitalize on the rapport established during those four days, individual interviews were conducted immediately following the completion of the observation period, allowing the researcher to spend six consecutive days at the same site. Throughout data collection, continuous efforts were made to minimize the distance between the researcher and the participants. First, the researcher attempted to personalize her interactions with the SBAs by asking them to wear nametags that were color coded based on their level of accreditation for their first shift of observation. During this first shift, the researcher learned all of the SBAs' names and levels of accreditation, and subsequently addressed them by name without the need for nametags. Additionally, the researcher attempted to separate herself from the doctors and managers by making sure not to enter or exit the unit with the doctors, by following the SBAs during observations rather than following the doctor, and by limiting social interactions with the managers and doctors on-site. This reinforced the researcher's identity as a third party with whom the participants could be open and honest about the challenges they faced while working for SMRU. Furthermore, the researcher made herself readily available to the SBAs 24/7 by working with all three shifts and sleeping within the units in order to ensure that SBAs would feel comfortable waking her if cases presented themselves overnight.

Multiple sampling methods were implemented in this study to accommodate the various sources of data. All members of the birthing unit teams were included in the sample for non-participant observation, the review of personnel files, and the focus group discussions. An additional focus group discussion was held for consulting physicians and the management team. Stratified purposive sampling, as described by Patton (2002), was employed to select appropriate candidates for individual interviews at Mawker Thai. Three SBAs from each level of accreditation were selected for the individual interviews. Stratified purposive sampling was not possible at Maela since only eight SBAs consented to individual interviews; all of whom were subsequently interviewed. These eight interviews included four senior SBAs, one junior SBA, and three assistant SBAs. Table 2 summarizes the data collection activities that were implemented at each site over six weeks (see Appendix 3 for the data collection schedule).

Table 2: Data Collection Activities

| <i>Data Collection Activities</i> | |
|---|---|
| <i>Mawker Thai Migrant Site</i> | <i>Maela Refugee Camp</i> |
| <ul style="list-style-type: none"> • 4 days of Non-Participant Observation (n=14) • 13 Personnel File Reviews • 9 Individual Interviews • 3 Focus Groups (n=14) | <ul style="list-style-type: none"> • 4 days of Non-Participant Observation (n=20) • 17 Personnel File Reviews • 8 Individual Interviews • 2 Focus Groups (n=17) |
| <i>Obstetrics & Management</i> | |
| <ul style="list-style-type: none"> • Participants in Non-Participant Observation • 1 Focus Group | |

Prior to the initiation of data collection in the field, a template-based personnel file review was completed. The information in this template included the SBAs' level of accreditation, age, marital status, number of children, education (health or otherwise), ALSO[®] certification, midwifery training, and start date. This review of employee profiles enabled the development of an overarching understanding of the current status of maternal HRH at the two sites and informed the purposive sampling process for individual interviews at Mawker Thai.

Non-participant observation constituted the first data collection activity in the field. Four consecutive days of observation were conducted at each site. Two of these observation days were in the presence of a doctor, and two of these observation days were in the absence of a doctor. It should be noted that the doctor was present on-site on a third day of observation at Mawker Thai, but did not partake in any clinical activities. Copious hand-written notes were taken over the course of the observation. These notes were used to inform the development of interview and focus group protocols, and supplement the findings of these discussions. These notes detailed work environment, intra-professional interactions, inter-professional interactions, and provider-patient interactions (see Appendix 4 for the full Observation Guide).

Individual interviews and focus groups were conducted using a combined interviewing strategy described by Patton (2002). Whereas Patton's (2002) guide approach entails a generic list of topics to cover over the course of an interview without specific wording or sequencing, Patton's standardized format prescribes predetermined wording and sequencing for the entire interview, leaving little to no flexibility to the interviewer.

“You can combine a guide approach with a standardized format by specifying certain key questions exactly as they must be asked while leaving other items as topics to be explored at the interviewer's discretion. This combined strategy offers the interviewer flexibility in probing and in determining when it is appropriate to explore certain subjects in greater depth, or even to pose questions about new areas of inquiry that were not originally anticipated in the interview instrument's development” (p.347)

As such, an initial interview protocol was developed containing a series of questions that were informed by the existing literature, the personnel file review, and the non-participant observations that had been conducted to-date (see Appendix 5 for the individual interview protocol). The strategy allowed the interviewer to engage in flexible probing in order to delve deeper into participants' responses, and to adapt the sequence of questions based on topics raised by the

participant. As prescribed by Patton (2002), the final question of each interaction allowed participants “to have the final say” (p.379).

In order to record and store the data collected, all interviews and focus groups were audio recorded with the approval of participants. Due to the language barrier between the researcher and participants, an interpreter, who spoke Burmese, Karen, and English, was present during observations, interviews and focus groups to provide consecutive translation. A second interpreter subsequently produced the verbatim transcripts of the focus group discussions by simultaneously translating and transcribing the recorded materials. The use of two interpreters increased the reliability of the translations in light of the relative concordance between the consecutive translation provided during the encounters, and the translated transcriptions of the participants’ answers.

Quotes extracted from these transcripts that will be presented in the findings section of this report will be identified based on the speaker’s site and position. This label will also state whether the excerpt is a direct English quotation (*Mae Sot, Doctor, direct quotation*), or has been translated from Burmese or Karen (*Maela, Senior SBA, translated quotation*). Mae Sot will be identified as the site for members of the management and obstetric teams, including doctors and HR staff. Certain quotes will contain Karen terms where direct translations would not accurately reflect the speaker’s meaning. First, the word *Tharamu* will appear, which is a Karen term used to address a woman with respect. It is frequently used in conversations with superiors and loosely translates to “teacher”. The term *Kolowah* will also be used, which means “white skinned” and is routinely used to refer to foreigners, particularly those in positions of authority, including the expatriate doctors working for SMRU. Internally, SMRU refers to its SBAs as midwives. Accordingly,

some quotes use the terms midwife or midwifery when referring to SBAs and skilled birth attendance. It should be noted that original transcriptions of the quotes used in the findings section of this report were revised to ensure that the participant's message was not obscured by errors in grammar; though efforts were made to remain as close as possible to the participants' original wording.

Before proceeding to the observation and interview period at the Mawker Thai, descriptive summaries of each interview from the first set of interviews at Maela were produced based on the audio recordings. The interviews conducted at Mawker Thai underwent the same process at a later date. These descriptive summaries provided concise representations of the content of each encounter, and allowed for the identification of emerging themes that could be incorporated into the interview protocol, and later the focus group protocol. These summaries were later incorporated into the coding exercise.

Once the observation and interview period had been completed at each site, the descriptive summaries informed the development of a focus group protocol for the obstetrical and management team (see Appendix 6 for the obstetrics and management focus group protocol). This focus group included permanent SMRU staff involved in the training, supervision and management of the SBAs, as well as visiting medical professionals who had been working with the SBAs. A descriptive summary of this focus group was immediately produced and informed the development of a focus group protocol tailored to the SBAs (see Appendix 7 for the SBA focus group protocol).

Originally, focus groups were planned for each SBA level of accreditation at each site, but this format would have imposed an undue time burden on the participants who already faced a very rigorous schedule. Therefore, it was decided that separate focus groups would be held for each shift (morning, afternoon, night) at each site, with the exception of two shifts that were combined into one focus group at Maela due to a scheduling conflict. This format allowed for the focus groups to be scheduled immediately before or after the corresponding shift and limited the effects of data collection activities on the units' workflow and the participants' schedules. Although this alternative format served practical purposes, it introduced certain limitations to the study considering that the assistant SBAs did not play an active role in the focus group discussions despite extensive probing, and may therefore be underrepresented in the study's findings. Although an interpreter eventually transcribed all focus groups, descriptive summaries were produced for all six focus groups as means to explore preliminary findings in the field and allow for member checking through presentations to participants.

Data analysis

The coding and overall data analysis process that was implemented during this study is inspired by the procedures and considerations described by Charmaz (2006). Immediately following each interview or focus group, a descriptive summary was produced based loosely on the line-by-line coding described by Charmaz (2006). Each idea was summarized and the codes remained as close to the data as possible. Once focus group transcripts were obtained, these encounters underwent a second round of initial coding in order to fully explore the participants' own words. During the initial coding process, analytical memos were noted in a separate column. By creating a separate space for analytical memos, which can serve as reminders of avenues of exploration in coming steps and go beyond description of data, the initial codes remained true to their purpose

in providing a rich description of the data without skipping any steps in the analytical process. Once initial coding was complete, an inductive focused coding process was initiated using *NVivo 11* software. This process incorporated all transcripts of focus groups and descriptive summaries of individual interviews. Due to financial and temporal constraints, it was decided that it would be appropriate to restrict full transcription to the focus groups as they had served as overviews of all themes that had emerged during data collection. Each salient excerpt of data was attributed a focused code, which reflects the theme it describes. As an inductive coding process was implemented, there were no preconceived codes; instead, codes were built to fit the data. However, many of the codes that were developed were informed by themes or vocabulary that were grounded in existing literature. As such, many of the codes are classified as deductive (Hennink et al., 2011). Table 3 provides examples of both deductive and inductive codes used during the focused coding exercise, along with the studies from which the deductive codes were derived. Once a focused code had been developed, congruent excerpts were labeled with this same code. In the event that one excerpt was representative of multiple themes, and by extension codes, the excerpt was coded in all relevant categories. In some cases, the original focused code was subject to revisions as additional excerpts were added and the category became better defined.

Table 3: Examples of Inductive and Deductive Codes used in Coding Exercise

| <i>Deductive Codes</i> | <i>Inductive Codes</i> |
|---|---|
| <ul style="list-style-type: none"> • Confidence (Bedwell et al, 2015) • Morale & Motivation (Hongoro & Normand, 2006) • Performance Management (UNFPA, 2014) • Leadership (Byrom & Downe, 2010) • Supportive Supervision (Adegoke & van den Broek, 2009) • Teamwork & Relationships (Campbell et al., 2016) • Training and Learning (Smith & Hyre, 2009) | <ul style="list-style-type: none"> • Addressing Crises • Feedback from the Community • Cultural Aversion to Feedback • Helping their Community • Eager to Learn • Working Hard • Gradual Restriction of Scope of Practice • Repatriation & Resettlement |

Using *Nvivo 11* software, an in-depth study of the content attributed to each code, and a holistic analysis of possible relationships between codes was initiated. The analytical cycle described by Hennink et al. (2011), which involves describing, comparing, categorizing and conceptualizing the data that has been coded, was highly beneficial to the analytical process and allowed for the development of a nuanced, holistic, and detailed understanding of the various themes at study, and the linkages between them. During this analytical cycle, codes were categorized as macro (contextual and cultural), meso (organizational), or micro (individual) in nature, in order to facilitate mapping of relationships between major themes. At this stage, observational notes were used to supplement and triangulate the findings of the coding process.

Validation

Creswell (2013) prescribes making use of at least two of the strategies for validation he describes in order to promote the validity of a study's findings. First, the results section of this report develops rich and thick descriptions of the data, and provides the reader with the means to assess the validity of the study's interpretations. Second, the study will continue to undergo an extensive peer review process through a defense adjudicated by a panel of experts, and close collaboration with thesis supervisors. Myers (2013), reiterates the importance of peer review as a system of quality assurance, and explains that conducting research according to a scientific model of research increases the reliability of findings and interpretations. Therefore, by providing a thorough description of the methodological strategies implemented, the reliability of the associated findings is increased. This study also incorporates multiple data collection activities, which allowed for triangulation of findings between interviews, focus groups, observations, and the personnel file review. Finally, preliminary findings were presented to participants in order to confirm that the interpretations made were accurate depictions of their points of view. SMRU

management will also be provided with a report summarizing the study’s key findings and recommendations.

FINDINGS

Following the Workforce Profile that is presented in Figures 5-11, findings are organized into three sections, exploring the contextual and cultural, organizational, and individual-level factors that exert influence on the professional development of the SBAs within SMRU’s health system, and SMRU’s capacity to plan and implement its HRH functions.

Workforce Profile based on Personnel File Review

Figure 5: Level of Accreditation of SBAs

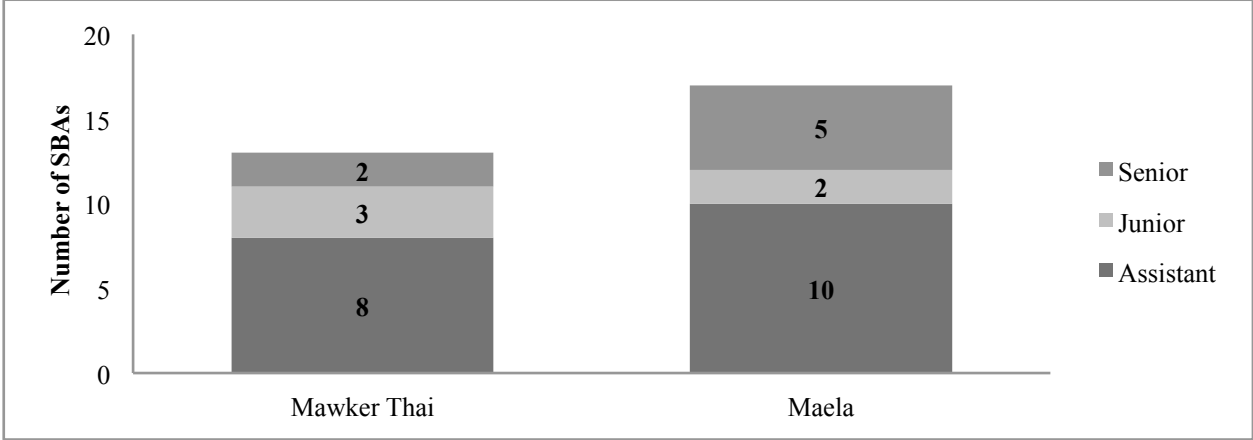


Figure 6: Age of SBAs

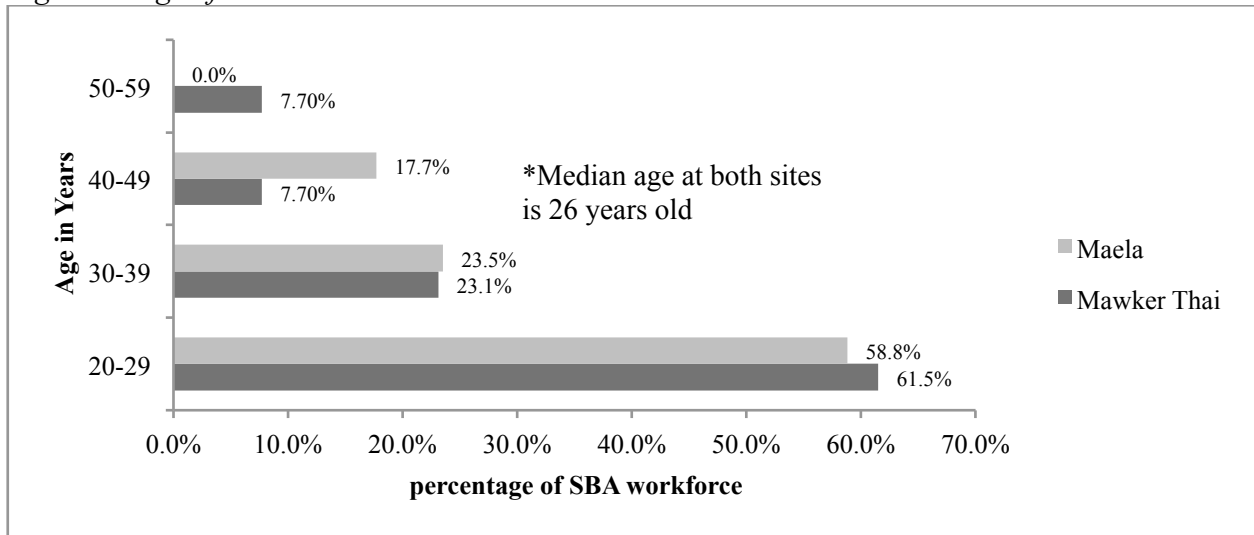


Figure 7: Marital Status of SBAs

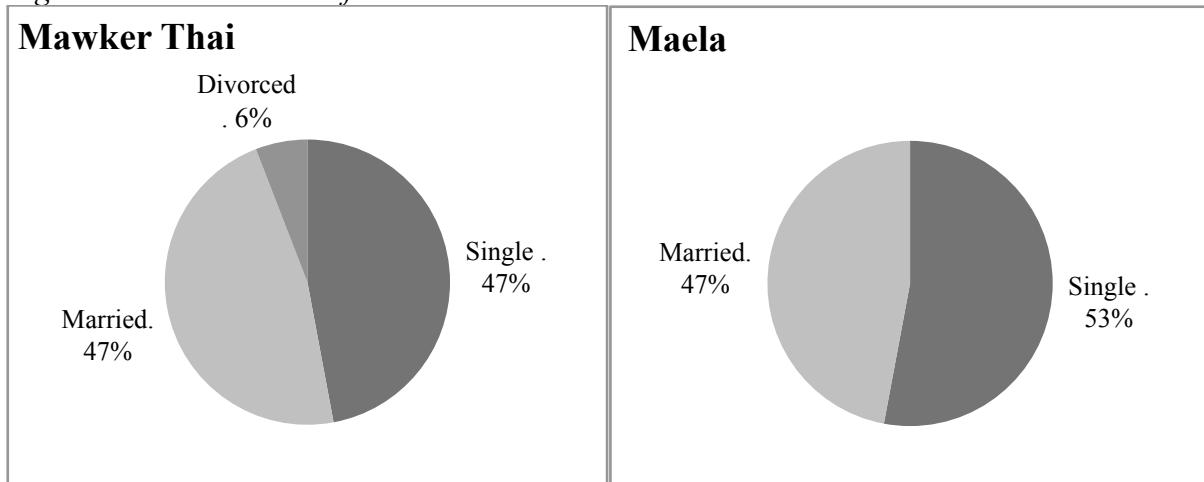


Figure 8: SBAs' Number of Children

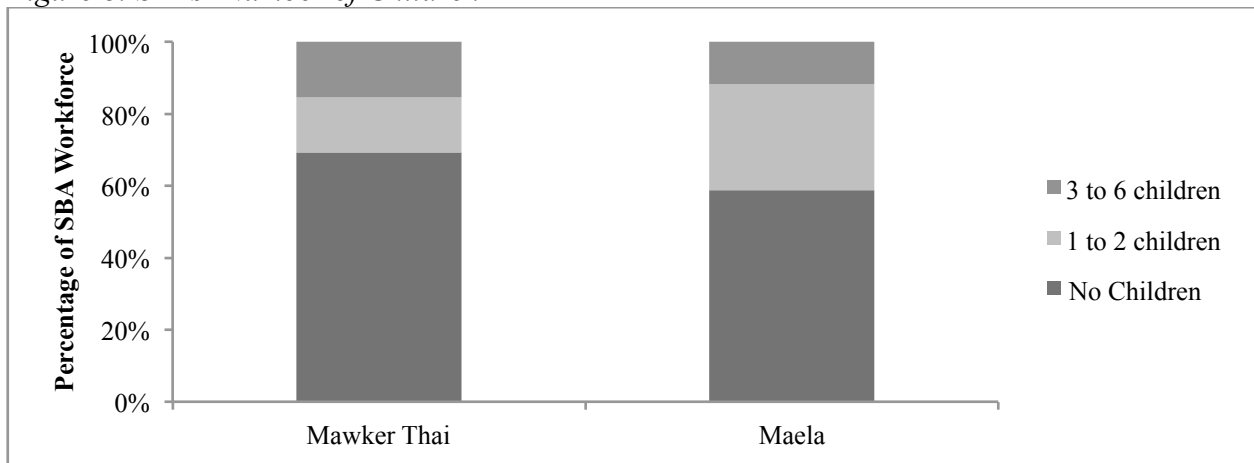


Figure 9: SBAs' Level of Education

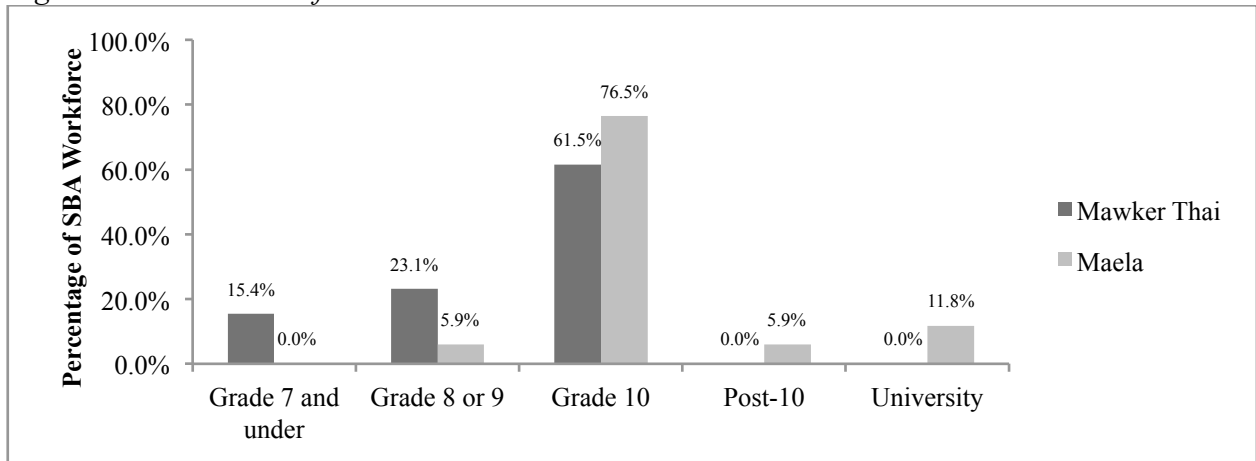


Figure 10: ALSO[®] Completion Rate amongst SBAs

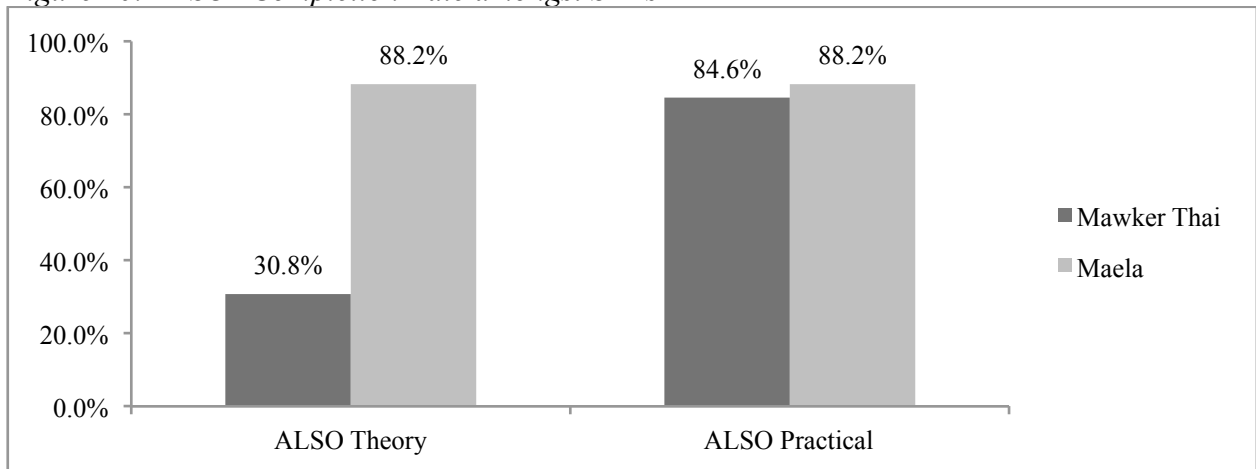
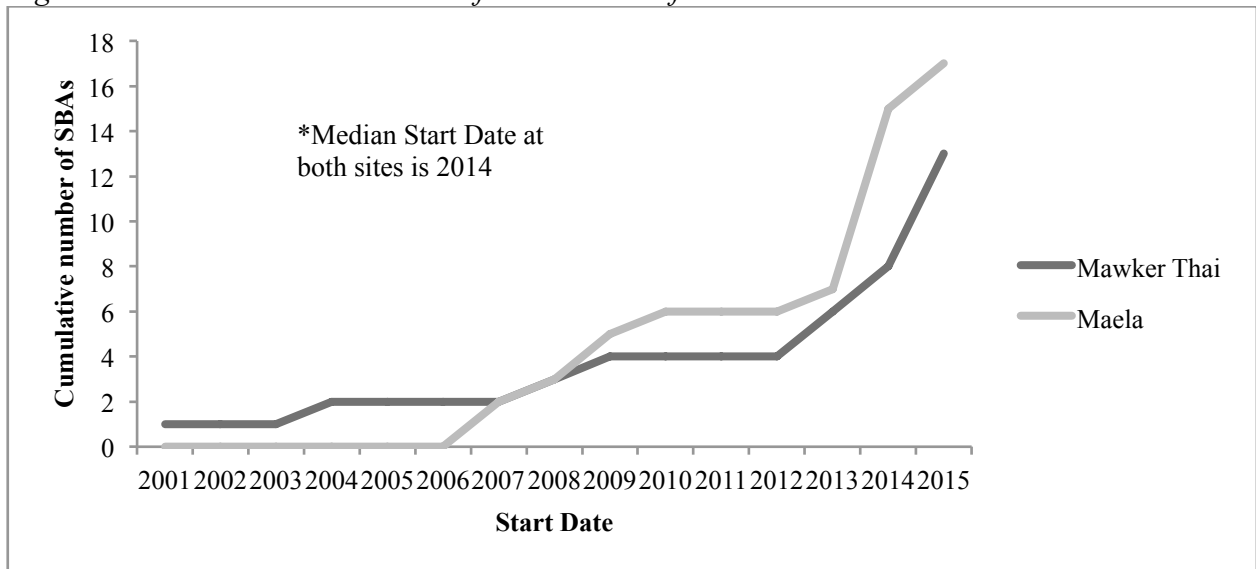


Figure 11: Cumulative Start Dates of Current Workforce



Contextual and Cultural Considerations

Resettlement

Over the years, waves of resettlement have been particularly prominent sources of instability in SMRU's SBA workforce. When SBAs were asked why their peers had left SMRU, resettlement was recognized as a key source of attrition. During the focus group with management, the head of obstetrics explained that the evolution of the SBA's scope of practice had been influenced by sudden and significant losses in staff due to resettlement. Recent efforts to replenish their workforce are illustrated in figure 11, which demonstrates that 50% of the SBA workforce at both sites began working for SMRU in 2014 or 2015. Although the SBAs' original scope of practice included the medical component, the waves of attrition led SMRU management to decide that in order to rebuild their workforce more quickly and ensure the system's survival, they would skill the SBAs for the delivery room, and allow medics to help with the medical components of the work.

“20 years ago the midwives did do everything and did a lot of the medical, and then we ran into a crisis of not having enough delivery room staff because of the relocation, and then to counteract that very sudden and large loss, we said ok, lets skill people for the delivery room because that's what difficult and we let the medics help us for the medical, which probably created some friction...but it was a survival...or collapse”(Mae Sot, Head of Obstetrics, direct quotation)

SMRU's formal SBA training program was also established as a response to this workforce crisis. In the coming years as repatriation becomes imminent, SMRU will likely face new waves of attrition, and need to develop the means to continue providing care to those who remain. SMRU management explained that they would continue providing services until women are able to go to a Burmese Hospital and have a safe delivery free of charge.

Level of Education

The levels of education in the region pose a significant barrier to the recruitment of qualified personnel, which is amplified by the limited salary that SMRU is able to provide its SBAs. For instance, even in Maela, the site that has a more educated workforce, 37% of the camp's population has no formal education, and only 6% the population have completed 10th standard (Hoogenboom et al. 2015). Accordingly, whereas SMRU asks for a 10th standard level education, most people in the region who have completed this level of education seek better paying jobs, namely in Mae Sot or Bangkok. The management team explained that they often have trouble finding 20 suitable candidates for training, and have had to lower their criteria in order to fill the available training positions. As an extension of this recruitment challenge, SMRU also faces challenges with retention associated with SBAs resigning to pursue more lucrative employment, either locally or in urban centers.

While SMRU now requires that their candidates for training have completed 10th Standard, in the past some SBAs with lower levels of education were accepted based on their experience and their certifications from other organizations. For example, SMRU's youngest senior SBA only had a 4th grade education, but had worked her way up and acquired extensive practical experience in a number of health care organizations. As a result, the levels of education amongst staff were more variable amongst long-standing or senior staff, whereas the assistants who were recruited through SMRU's formal training program have more homogenous educational backgrounds. While four of the five juniors and seniors at Mawker Thai had an 8th grade education or less, all but one of the assistants at the same site had a 10th grade education, with the exception having completed the 9th grade. At Maela, the overall level of education amongst SBAs was higher; with the exception of one senior who had completed grade 8, all SBAs had completed 10th grade, and 3 of the

juniors and seniors had completed post-10 or university level education. Whereas staff at Mawker Thai were generally from the border region, where the formal education system has been faltering for some time due to instability, the staff at Maela were either educated in the camp, where basic education is more readily accessible, or from regions further inside Myanmar where relative stability allows for increased access to formal education. The SBAs at Mawker Thai recognized this difference between the two sites and reported that their counterparts at Maela were more educated. The disparities in levels of education between the two sites are also apparent in their rates of completion of ALSO[®] accreditation. While the SBAs at both sites have high completion rates in the practical portion of the ALSO[®] course, Mawker Thai displays significantly lower rates of completion in the theory portion of the course, with only 30.8% of SBAs having passed this component versus 88.2% at Maela. There were also a few cases of SBAs at Mawker Thai who had been stalled at the junior level for extended periods of time. Although there were multiple factors, including health, age, and family responsibilities that seemed to affect this stagnation, a notable barrier to progression for the individuals in question was their inability to pass the theory portion of the ALSO[®] certification or communicate effectively in English.

For their last cycle of formal training, SMRU added a pre-test to the selection process, which evaluates the candidate's basic understanding of midwifery, their educational background, as well as their Burmese and English language skills. This pre-test, which is conducted by the trainer, is combined with the Human Resource team's assessment which focuses on the candidate's attitude and behaviour, in order to make the final selection. The selected candidates are then asked to observe the SBA's work in the birthing unit for between 1 and 3 weeks in order to decide whether or not they are interested in pursuing this career, and proceeding with the training program.

For many of the doctors who worked with the SBAs, it was clear that although SBAs were regarded as having an excellent knowledge of their drills and protocols, doctors thought that only exceptional SBAs understood the “why”, or the medical reasoning, behind their actions. Still, the doctors acknowledged that the SBAs displayed an interest in acquiring the knowledge that would fill this gap. The management team explained that despite the SBAs’ enthusiasm for learning the “why”, it was very challenging to incorporate these more complex notions into their training because of the language barrier as well as the SBAs’ minimal scientific background. Due to the deficiencies of the local educational system, the scientific background is difficult to establish even amongst those who have completed their 10th standard.

“they want to know but you can’t explain it because there’s not enough language, yes, but also not enough science background for me to, “why do we give dexamethasone?”, cannot, cannot, cannot explain it. They want to know, yes, and I think that’s a big problem is, and a little bit why the structure is like it is, when the science is missing, the big background of science is missing, which is what midwifery training spends years putting in place in school and then the midwifery training, we can’t, we let back, so it’s a bit of a block point.”(Mae Sot, Doctor, direct quotation)

Nevertheless, the management team seemed to think that the SMRU’s formal training program has allowed them to build a basic level of knowledge amongst their SBAs who are now ready and able to receive wider training to address the “why”.

Inherited hierarchy

Both management and the SBAs provided insights into organizational structures and dynamics that may have been inherited from the Burmese system. For example, although SMRU’s formal SBA training is longer than their medic training, the SBAs fall below the medics within SMRU’s organizational hierarchy (discussed in further detail in the section on gradual restriction of scope of practice). This reporting structure mirrors that of the rural health teams inside Myanmar. In addition, SBAs reported that when they treat patients who are affiliated with the Karen National

Union, they sense that the patients are of a higher level than them and do not respect them, which leads the SBAs to step back. This power dynamic reflects the context within which SMRU operates and the system within which their staff were socialized:

“So when you talk about hierarchy, its also the environment that we’re in, this has been for many decades a military dictatorship and a little bit we’ve inherited some of that and I don’t know if the population also like it, not like it like that, but don’t know another way”. (Mae Sot, Doctor, direct quotation)

There was also evidence that SMRU was making efforts to try to move away from this inherited hierarchy and develop a more horizontal form of leadership and management. One of the SBAs noted that in Myanmar, the midwives would not dare communicate with the doctors, but at SMRU she appreciated the fact that she had the opportunity, and felt comfortable, talking to the doctors. Another SBA explained that the leadership training significantly changed the way she worked because she was accustomed to the hierarchical form of leadership that is maintained in Myanmar. Following the training, she understood that the seniors should try to stay at the same level as their coworkers.

Choosing Skilled Birth Attendance

Following the management focus group, a question related to the reasons that the SBAs had chosen this profession was integrated into the Focus Group Protocol. The management team wondered if the SBAs at SMRU would convey the passion that is associated with midwifery in western settings, or if they had chosen midwifery for more pragmatic purposes like the status and salary that the profession provides.

Although many displayed an interest in the profession from the onset, others developed an interest for the profession over time as they completed training and accumulated more experience. One such SBA explained that in the beginning, she would even pray that no patients

come in during her shift, and was angry if they did come. On a few occasions, the lower level SBAs explained that when they were recruited they did not fully understand what they were signing up for, or what role SBAs occupied.

“When people came and I filled the form, I didn't know it was to attend midwifery training. My friends told me that it was for midwifery. I knew nothing. After I filled the form and started working here, I knew about midwifery. After knowing about midwifery, I have interest.”(Maela, Assistant SBA, translated quotation)

Some of the SBAs explained that the fact that Skilled Birth Attendance is considered to be a good profession influenced their decision to become an SBA. In a particularly interesting case, an SBA explained that she had delivered her child at the clinic and became interested in the SBAs work, so she asked one of her friends to inform her if ever a position opened.

Many SBAs explained that they had chosen the profession because it was their “hobby” or their field of interest. Although this was a common answer, it should be noted that over the course of the interviews and focus groups it became clear that this was a default answer for those who did not feel confident or comfortable enough to share. It was also mentioned that you could not do the work of an SBA without having a will and an interest to do so.

Throughout all interactions, the SBAs displayed a strong desire to help their community through their knowledge and skills. The management team also recognized that many of the local staff that work for SMRU are driven by a desire to help their community and appreciate the fact that they are working together with people of their own background towards this common goal. A phrase that management has heard over the years from their staff, particularly at Mawker Thai, was “for my people, for my people”. In their longstanding resistance towards a military dictatorship, the Karen people have built a strong sense of community and solidarity.

Many of the SBAs working for SMRU had family members who were traditional birth attendants, midwives, or health workers, which exposed them from a young age to the profession and to the consequences that arise when appropriate health care services are not available or accessible. Similarly, multiple SBAs chose to seek training with SMRU because they had witnessed maternal deaths or complications in their communities that could have been prevented if the attendant had been properly trained. Numerous SBAs also explained that there were no health facilities in their own communities, and that they chose to become a SBA in order to be able to help those in their community who do not have access to safe health services.

“When I was a child, my uncle and aunt were health workers. When I was a child, I could do nothing. In the village, the transportation was bad. If someone who we knew had labor pain, we tried to give her the delivery in the village. I found out that it was very far to hospitalize at the general hospital and thought to myself that if I become a midwife, I can help my village.” (Maela, Assistant SBA, translated quotation)

The SBAs seemed to be keenly aware of the importance of maternal and child health, and the risks and responsibilities surrounding delivery. Multiple SBAs explained that they had chosen to become SBAs because they understood that around the world there were women who did not have access to safe delivery services and they were aware that rates of morbidity and mortality amongst women and children were high.

The SBAs’ limited geographic and professional mobility also seemed to favour recruitment and retention. When asked why they chose to work for SMRU, the most common response at Mawker Thai was that the clinic was close to their home village. At Maela, the SBAs explained that SMRU was the only organization that hired and trained SBAs in Maela. Many SBAs at Maela explained that they could not leave the camp to work, for either family-related or legal reasons, which meant that SMRU was their only employment option if they wanted to continue

working as an SBA. Due to their attachment to either the refugee camp or the villages surrounding the migrant site, transferring to such organizations as Mae Tao Clinic that provide similar delivery services in Mae Sot did not seem to be an option that the SBAs considered.

Cultural Inhibition and Aversion to Feedback

Throughout all data collection activities, it became clear that any form of feedback that was perceived to be negative by the SBA had a significant impact on their morale. In many cases the effects of this feedback went so far as to threaten the retention of those SBAs who were distressed by these remarks. During both the SBA and management focus groups, participants explained that Karen people are not typically confident in themselves.

“As for Karen, we are always behind others. We feel shy and not brave enough to talk.”(Mawker Thai, Senior SBA, translated quotation)

The SBAs also indicated that the Karen people were not prone to open communication, meaning that the staff had a tendency to keep their grievances to themselves until they could no longer cope with them and left. For example, the SBAs at Mawker Thai explained that when HR comes to host meetings to discuss problems within the clinic, the SBAs chose to “bare” what they perceived to be negative feedback, and did not respond. One SBA explained that she would like for HR to come and observe the situation in order to better understand the challenges the SBAs face. She emphasized that these interactions would be of particular importance because of the Karen tendency to keep their feelings inside rather than communicate them openly, which could lead an SBA to resign if these unaddressed challenges became overwhelming. A member of the management team, who is of the same ethnic background as most of the SBAs, provided insight into the challenges of performance management with this particular group:

“for me I think culturally we underestimate our ability, and also another problem is [...], we don't know the purpose of appraisal, we think that appraisal is just someone trying to find our faults, so you don't know really what you have to put in there, and if anything is too negative then

you don't know, you are afraid that the criticism is whether you can take it or not" (Mae Sot, Administrator, direct quotation)

The head of obstetrics pointed out that not only do the SBAs seem uncomfortable receiving feedback, but they also are resistant to providing feedback, as illustrated during the feedback sessions of their ALSO[®] training. According to the management team, this lack of confidence limits the SBAs' willingness to take on responsibility and leadership roles.

Feedback from the community

The management team explained that most women appreciate the service they receive and that complaints from patients are quite rare. According to the SBAs, the doctors do not witness all of the negative remarks they receive from patients due to the limited time they spend in the clinic. It should also be noted that due to the language barrier, the expatriate doctors have no way of knowing exactly what is exchanged between the patient and the SBA. The interpreter, who explained that the SBAs were not always relaying all of what the patients said back to the doctors, confirmed this issue.

Despite their hard work, many SBAs felt that the feedback from patients was largely negative.

"Though we try our best but they don't feel good in their mind. They gossip outside about how the midwives are. That makes us unhappy. We make our best but they don't feel that we take care of them well. This goodwill becomes no benefit to them."(Maela, Junior SBA, translated quotation)

Most of the negative feedback from the community that was reported related to the amount of care that the SBAs provided, and their communication with patients. Other incidents that were reported involved reportedly unsuitable physical contact between an SBA and a patient (unclear if this involved hitting or grabbing).

The SBAs felt that some of the pressure they received from patients was caused by the community's lack of understanding of the correct protocols that the SBAs must observe before referring a patient. Although most SBAs thought that their patients generally respected and trusted them, some SBAs reported that their work became challenging if their patients or their patients' families did not seem to trust them. For example, in Maela, the SBAs had heard gossip about a patient whose family did not think that she was referred soon enough. They also explained that some patients did not understand why they were unwilling to refer even though it was at the SMRU's cost, not the SBA's.

The SBAs also reported that there is a significant difference in the patient populations for the two sites. Whereas most of the patients who access the services at Maela live within the camp and therefore have had access to some level of education, the patients that access the services at Mawker Thai generally have lower levels of education, which complicates the counselling process. During the management focus group, all of the local participants agreed that the SBAs at Mawker Thai must cope with more pressure and aggression from their patient population, many of whom are Burmese and Karen migrant workers. They explained that whereas the refugees in Maela have camp committees to protect and advocate for them, the migrant workers feel that they must fight for what they need which can lead them to be more combative towards the staff. According to local staff, the migrants believe that they can say and do anything to the staff and staff are still obliged to treat them. This fundamental difference in their working environment means that the staff at Mawker Thai receive criticism directly from their patients, rather than through official channels that SMRU can manage. One of the most disconcerting examples of the pressure that the SBAs in Mawker Thai faced from the community was when patients' families would threaten to broadcast negative comments and pictures of them on social media.

“ We always face complaints from patients. How should we improve? Sometimes, they find our weak points and post them on Facebook. So we feel shy and want to quit our job.” (Mawker Thai, Senior SBA, translated quotation)

It was also mentioned that the patients at Mawker Thai come from further away to access services; limiting their ability to return home if they are undergoing more extensive treatment. Conversely, the patients at Maela usually live within a reasonable distance of the clinic meaning that they can come and go as needed, and maintain a certain level of independence. When the head of obstetrics heard the other administrators’ accounts of the pressure the SBAs at Mawker Thai experienced, she was caught off guard and noted that they had not provided any training to the SBAs on this issue.

One Senior SBA from Mawker Thai explained that sometimes the negative comments they receive from patients affect the way the SBAs think of themselves and their confidence in providing care to these patients. The SBAs indicated that much of their stress with regards to complaints from patients or the community stems from the fact that they do not feel that HR consults them sufficiently to ascertain the veracity of the claim and understand the SBAs’ point of view. The SBAs indicated that the dip in motivation that stems from negative feedback from the community could be mitigated if the management team displayed greater understanding and acknowledgement of their hard work.

Organizational Considerations

Compensation

SBA compensation at SMRU is set at a standardized rate for each level of accreditation at each site. The compensation at Maela is slightly lower than at the other sites in order to account for the food rations that the staff at Maela receive through their UNHCR refugee status. Because the

salary is a set amount based on level of accreditation, the SBAs who remain with SMRU state that if they are not satisfied with the salary they receive they have no other recourse than resignation. Both the management team and the SBAs reported there have been cases in the past where SBAs have chosen to leave SMRU because they were not satisfied with their salary. Interestingly salary was not a theme that was raised by any of the SBAs during the initial individual interviews, it was only after a specific question related to compensation was integrated into the focus group protocol, at management's request, that the SBAs discussed this issue. It should be noted that when the topic of salaries was raised during the focus groups, most SBAs were not averse to discussing their compensation but rather displayed a willingness to engage in the discussion. Although the SBAs reported that some of their past colleagues had left SMRU because they were unsatisfied with the salary, the current staff seemed to think that if they left their position, it would not be because of the salary. In many focus groups, the SBAs pointed out that salary was not their main concern, but rather their happiness and peace of mind in their job.

“because we love our job Tharamu, even with a low salary we cannot leave our job” (Maela, Senior SBA, direct quotation)

It should be noted that at Maela, where the salaries are set at a lower rate, the SBAs communicated stronger dissatisfaction with their salary than at Mawker Thai. Some SBAs acknowledged that they themselves have considered resigning because of the salary. One SBA commented that the salary she received was not commensurate with her workload and her level of fatigue. Another SBA explained that if she thinks about her salary, she is not motivated, but she loves her job, so she tries not to think about her salary and continues to work.

It is important to take into consideration the local employment market when assessing the appropriateness of compensation. One of the SBAs mentioned that she was particularly satisfied

with her salary with SMRU when she compared it to the meagre income that she used to receive as a migrant worker. Another SBA explained that she was satisfied with the work-life balance that she maintained with SMRU because the salary she received was much more motivating than what she received when she worked at Mae Tao Clinic. This may indicate that the salary SMRU provides is, at the very least, competitive with other health care organizations in the border region.

A recurring comment from the SBAs at both sites was that their salary was adequate to provide for their own needs when they are single, but was insufficient to support their family members, such as spouses, children, and parents. Those who did have a family to support often said that they needed to use their money sparingly in order to accommodate all of their expenses.

Training

Formal training and accreditation

SMRU plans its cycles of formal SBA training based on need. The SBAs explained that the training they received granted them knowledge and skills that were reinforced through practical experience. During the last cycle of midwifery training, all of the in-service SBAs attended the midwifery lectures as refreshers. Management felt that border organizations had continued to invest the education of their employees despite the risk of resettlement or repatriation. They also stated that in light of the current changes in Myanmar, acquiring recognized accreditation for their staff has become a significant priority.

As was mentioned in the background section of this report, SMRU's training is not recognized as an official accreditation by the governments of Thailand or Myanmar. Although this may be favourable to retention, the lack of recognized accreditation limits the SBAs' job mobility

considering that their certification has no value outside the border area. Management explained that the ideal of providing their SBAs with recognized accreditation is contingent on the situation in Myanmar, which remains unstable. Recently the government of Myanmar has however shown increased openness to recognizing training and accreditation in light of their own HRH shortages. Management also acknowledged that career paths are difficult to predict or discuss in unstable situation such as their own, and this difficulty is exacerbated by their inability to provide their staff with recognized accreditation.

At first, when the question was asked, the participants seemed to accept their lack of recognized accreditation, and focused on the fact that their certificate was valued by border organizations and that they had gained knowledge and skills that they could continue using to help their community.

“It is not recognized but we have experience and we are able and know. We will help our friends or relatives if they need help for delivery. It is not recognized but we will help other people and our Karen people.”(Maela, Junior SBA, translated quotation)

Nonetheless, when asked directly if they would like for their accreditation to be recognized, the answer was a resounding “yes”. A senior SBA who had previously worked in Myanmar explained that she believed that the SBAs at SMRU deserve recognition from Myanmar because she believed that their clinical skills were superior to those of the midwives working in Myanmar.

In-service training

The management team explained that the in-service training is “a bit haphazard” because it depends on the availability of trainers who are balancing multiple responsibilities including clinical care and research. Although the SBAs appreciated the training that they received from the

various doctors they worked with, they acknowledged that the high rate of turnover amongst the doctors confuses their learning process.

“One comes and teaches us one way. Another one comes and teaches us another way. We are not able to follow them. When we know the doctor's ways of working, they change. The new one arrives.”(Mawker Thai, Junior SBA, translated quotation)

The SBAs explained that it can be challenging to adjust to each new doctor's preferred way of working. This can be particularly confusing for lower level SBAs who are still learning SMRU's protocols. For example, on her first day at Mawker Thai, an expatriate midwife was observed asking the SBAs multiple questions related to their newborn checks, and correcting them on elements of this task that she would do in her own practice but were not part of the SMRU protocol. Nevertheless, the SBAs remarked that some doctors were very good at referring to SMRU protocols to inform their decisions. One of the senior SBAs at Maela explained that if a doctor proposes a plan of care that is not in line with the SMRU protocol, she shows the doctor the obstetrical guideline and how the protocol recommends they address this particular issue.

Through the regular provision of ALSO[®] training, the SBAs have gained confidence in their ability to address obstetrical complications such as postpartum haemorrhage. Both visiting and permanent staff recognized incredible achievement that the SBAs' completion of ALSO[®] accreditation represented. The SBAs seemed to respond well to the clear structure that accompanied the ALSO[®] drills, which was similar to the step-by-step format of their SMRU protocols. The SBAs also demonstrated a proclivity for structure in their performance of patient checks, which were almost always performed at the exact time that was prescribed in the protocols.

Hierarchical Organizational Structure

Gradual Restriction of Scope of Practice

The independent scope of practice for the SBAs at SMRU has been confined to attending normal vaginal deliveries. Any medical complications or additional interventions require consultation with a doctor or a medic. In the event of obstetrical emergencies or complications, the protocols dictate that the SBAs must consult with the doctors, whether the consultation occur face-to-face or over the phone. Based on the SBAs report of the case, the doctor determines their course of treatment, or if necessary, approves the patients' referral to a local Thai hospital. It should be noted that in consultation with the doctor, the SBAs could perform a number of interventions, including vacuum deliveries. Medics, who were men and women recruited locally and trained internally by SMRU, also reported to consulting doctors in their provision of primary medical care to patients in SMRU's in-patient departments, out-patient departments, and special care baby units. The medics provided SBAs with complementary consultation. If the doctor was not on site, the SBAs referred to medics for non-urgent medical matters, and could turn to them for their hands-on medical skills in the event of emergencies or complications. The medics also performed intermediary assessments of patients' medical status, to determine whether a call to the doctor was warranted. Furthermore, the medics performed daily rounds on the neonates in post-natal care.

The management team explained that in addition to accommodating waves of resettlement (discussed in the section on contextual and cultural considerations), the scope of practice of SBAs has seen gradual restriction stemming from isolated incidents of obstetrical complication. As an example, SBAs were allowed to rupture membranes without consulting with the doctor until there was a case of ruptured membranes where there was a complication, which led to an

amendment to the protocol stating that the SBAs must consult with the doctor prior to rupturing the patients' membranes. The SBAs were aware that their level of independence in administering interventions fluctuated, but these fluctuations did not necessarily correspond with their level of confidence with the interventions. Senior SBAs from different sites explained that although they had to consult the doctors for these interventions within the clinic, they would be confident performing these interventions independently if they worked elsewhere. Some of the senior SBAs expressed stress associated with the need to report on activities that used to be within their independent scope of practice.

“Now we have the right to do the parts we can do but we have to discuss the symptoms [...] We have to tell even if we break the amniotic sac [...] We feel stress about this [...] We can do this kind of work and we normally do it, but we have to inform them.”(Mawker Thai, Senior SBA, translated quotation)

Top-down decision-making

During the management focus group the head of obstetrics identified the top down organizational structure that has been established as a factor that may contribute to the lack of self-confidence that the SBAs display. Despite the expatriate medical professionals' best efforts, from the moment that a doctor or visitor walked into the clinic, there was a strong power dynamic that was established between the SBAs and their “superior”. The SBAs displayed a great deal of respect for the doctors, and subordinated themselves to the doctors' authority. While the doctors' status as obstetrical specialists and foreigners seemed to contribute to this power dynamic, the overarching deference displayed by the SBAs towards all doctors did not appear to vary based on the doctors' gender. When SBAs were asked about the decision-making process, the hierarchy of SMRU's system became very clear; when an issue arose the lower level SBAs would inform senior SBAs who would consult with the doctor.

Within the birthing units the responsibilities attributed to each level of accreditation were also clearly defined. Whereas the assistants and the juniors are responsible for completing tasks that are delegated to them, it was the senior who was truly responsible for overseeing all cases. Accordingly, the SBAs' experience with regards to decision-making depended largely on their level of accreditation. While the senior SBAs had some decision-making responsibilities, and had experience contributing to the medics' and doctors' decisions, the lower level staff, and particularly the assistants, made it very clear that making decisions was not within their realm of responsibilities, which were more focused on executing the decisions made by others. The assistants often represent this distribution of authority by stating that the senior SBAs make decisions and the lower staff follow. Within the current system, the assistant and junior SBAs' responsibilities are defined by set of tasks in the execution of protocols. For example, during delivery one SBA is in responsible for monitoring vital signs and caring for the baby post-delivery, one SBA is responsible for delivering the baby and the placenta, and one SBA is responsible for documenting, prepping, and supervising.

Certain SBAs demonstrated an interest in adopting a more active role in treatment planning for patients, but acknowledged that they did not yet have sufficient medical knowledge or confidence to make these decisions. The SBAs indicated that their lack of confidence in making decisions stemmed from the fact that they were never required to make decisions. Conversely, the SBAs expressed a higher level of confidence in their practical skills based on the fact that they were able to apply them frequently. When asked why they felt that they had more confidence in their practical skills than in their decision-making abilities, one of the SBAs responded that:

“Practical is the work that we are ordered to do. Decision-making is to make the decision by ourselves. It is important not to make mistakes.”(Mawker Thai, Assistant SBA, translated quotation)

This comment illustrates that the SBAs do display some level of risk aversion towards their professional responsibilities. Others mirrored this sentiment in saying that they were confident in completing a task if the doctor has made the decision to proceed with that particular course of action.

In addition to their dependence on doctors and medics for consultations, the SBAs also relied on the members of their team for joint decision-making processes. The SBAs, and particularly the seniors, explained that they often discussed any issues that their patients were facing amongst themselves before consulting with the doctor or medic. One senior SBA illustrated the team focus at all levels by explaining that she would find it difficult to take on the responsibilities of her position alone, but the seniors share the responsibility amongst each other. This strong focus on teamwork limits the SBAs' individual ownership of cases.

One of the key phrases that the SBAs would say to the researcher directly rather than through the interpreter was “step-by-step”. At times it referred to the protocols and drills that they completed in an orderly fashion, and at times it referred to the levels in their organizational structure. Whether it was for lines of communication or decision-making procedures, all of the SBAs accepted that there was an established structure that needed to be followed “step-by-step” until it reached the appropriate level with the authority to make a decision, or take action. For those at the bottom of this chain, the constant need to consult seemed to serve as a regular reminder of their “lower” status within the organizational hierarchy.

“because there is the superior above us. We can't do as we wish. We can make decisions ourselves outside, but making decisions here, there are some superiors above us.”(Mawker Thai, Junior SBA, translated quotation)

Numerous SBAs expressed that they had “no right” to make certain decisions themselves, so they needed to call the doctor or the medic. Some added that this need to consult weakened their self-confidence because they could not depend on themselves, but rather depended on others for treatment and decisions.

Interactions with physicians

Supportive Supervision

Overall, the SBAs felt that their superiors, whether they were seniors or doctors, valued their opinion and were confident in their abilities. The SBAs seemed to gauge their supervisors’ confidence in their abilities based on the procedures that they would allow them to perform. Congruently, throughout the management focus group, it was very clear that the doctors and senior management were very confident in the SBAs’ clinical abilities. The doctors that worked with the SBAs recognized their skills and noted that in many ways they can be considered “experts” because they perform tasks that midwives would not typically perform in western settings, such as vacuum deliveries. Their knowledge of drills and protocols was particularly lauded.

Based on the SBAs’ accounts, the style of supervision provided by consulting doctors seemed somewhat variable, which introduced potential for disruption within the units. Whereas the SBAs responded well to doctors who demonstrated appreciation, understanding and positivity towards them, their morale seemed to falter if the consulting doctor was negative or critical. The SBAs felt that some doctors they worked with understood them, and some simply wanted to find their mistakes. In the latter case, which appeared to be rare, the SBAs explained that the scrutiny would make them depressed. Overall, the feedback that they receive on a day-to-day basis from the seniors and the doctors seemed to be appreciated by the SBAs who felt that it was given in a

positive manner. The SBAs emphasized the importance of their superiors' support to their learning and progress:

“In order to have interest, the teacher supports us. It is the same for promotions; you will be happy if there is someone who supports you. If you have to learn, you will be happy to learn and won't get tired. When the teacher comes together with the students, the learners are interested to work. Due to this support, the learners are motivated and want to try harder. This is my opinion.”
(Mawker Thai, Senior SBA, translated quotation)

During the management focus group, the doctors explained that the SBAs were very hesitant to provide their own answers to questions that arose during cases, particularly when the doctors were in the clinic. Subsequently, they discussed the ways in which they try to empower the SBAs to think critically about a case and make decisions. They explained that they would often abstain from providing an opinion, or intervening in a clinical situation in order to encourage the SBAs to formulate a decision and take action independently. They also described instances during which they had asked the SBAs to act as if they were not available, or guided the SBAs through a decision “tree” that would identify the pros and cons of each possible course of action and allow them to make an informed decision. During observations, one common practice was observed in all doctors that interacted with the SBAs: quizzing. This practice was particularly present during rounds, when the doctor would ask the SBAs questions related to the case, such as the normal range for a particular test, or the most effective way to treat a particular symptom, and their answers would become part of the diagnosis and treatment plan. The doctors were often seen reinforcing correct answers with verbal approvals, or high-fives. In the event of an incorrect answer, or if the SBAs did not know the answer to the question, the doctors seized the teaching opportunity. This constant quizzing reinforced the teacher-student dynamic between the SBAs and the doctors, but also represented an effective way of integrating the SBAs into the decision-making and care-planning process.

Language Barriers between SBAs and Expatriate Doctors

Both management and SBAs recognized that English language skills could be a barrier to progressing to the senior level since the Senior SBAs are the units' primary liaison with the expatriate doctors, and SMRU's working language is English. One of the current senior SBAs explained that some of her staff had the clinical skills to be seniors, but their lack of communication skills limited the doctor's confidence in their abilities.

“sometimes when we train the senior midwife, tharamu we have problems. Some of have clinical skills, we feel the clinical side of their work is ok already, but their communication is not ok tharamu. If communication is not ok, for the doctor it is not ok, because we need to discuss with doctor. If the doctor does not trust this midwife maybe they cannot become senior midwife. We train long time tharamu, some midwives feel “oh this midwife works ok already” but communication, I mean especially English language, if it is not ok, maybe they do not become senior midwife yet because if they become senior the midwife needs to take responsibility for the case. It is difficult when many doctors change” (Maela, Senior SBA, direct quotation)

There was also a noticeable difference in the level of English exhibited at each site. In line with their lower levels of education, the SBAs at Mawker exhibited lower proficiency and confidence in English compared to the SBAs at Maela. One clear example of the lack of confidence in English observed at Mawker Thai was when a senior SBA left the group of SBAs who were socializing to take a phone call. When she returned she explained that she had left because it was the doctor calling and she didn't want anyone to hear her speaking in English. These displays of insecurity often led visiting professionals to note that Maela seemed to have a more confident team of senior SBAs than Mawker Thai.

The SBAs at both sites, as well as the doctors, also agreed that distance amplified the language barrier between the SBAs and the expatriate doctors. As such, understanding between the two parties was more difficult to establish during emergency phone consultations than during face-to-

face encounters. During face-to-face encounters, SBAs could rely on gestures or written materials to get their point across, but over the phone, they could only rely on their verbal skills to communicate their message effectively. The SBAs at both sites communicated significant concern that the doctors would not understand, or would misunderstand, the information that they transmitted. The SBAs tried to alleviate these communication issues with the doctors by being “short to the point”. During data collection, a visiting midwife from Australia focused her attention on teaching the SBAs the internationally recognized ISBAR method for clinical handover (Identify, Situation, Background, Assessment, Recommendation) (Marshall et al., 2009), in order to provide structure to their phone calls and facilitate communication. On their end, the doctors were often observed taking notes for all patients in the unit before they left for the day in order to facilitate their understanding of the cases if ever there were emergency calls overnight or over the weekend.

The SBAs demonstrated considerable perseverance in their interactions with the doctors; trying time and time again until both parties completely understood each other. The SBAs also made use of their teamwork to alleviate the language barriers they experienced. If one of the SBAs was having difficulty communicating with the doctor, she would often ask another one of her colleagues who was more comfortable speaking English to translate for her. Some SBAs noted that a better knowledge of the medical components of their work would facilitate their communication with the doctors about these topics. Although language barrier certainly limits SBAs’ ability to openly communicate their opinions to the doctors, most SBAs indicated that they were confident and comfortable sharing their opinions within their teams.

Physician Turnover

As was indicated in the background section of this report, SMRU's restricted budget complicates their ability to recruit physicians for long tenures. Although SMRU does have some permanent expatriate staff who are incredibly experienced in this region, they do not have enough permanent or long-term staff to cover all three birthing units at all times, forcing them to fill staffing gaps with doctors who come on short-term contracts that are often voluntary or funded by grants. SMRU encourages incoming physicians to stay for a minimum of six months to a year, but sometimes operational need pushes them to accept shorter work terms. As a means to avoid further disruptions within the units, SMRU limits rotation of physicians between the various clinics, and encourages them to dedicate their efforts to a single clinic during their work term.

The SBAs explained that one of the challenges associated with the high turnover of physicians was that each new doctor has their own accent and style in English, which temporarily limited their understanding. Accordingly, the visiting doctors explained that the most significant challenge they faced in integrating themselves into the birthing unit team was the language barrier between themselves and the SBAs. In some cases, English was a second language for the doctor as well, which made establishing understanding between the two parties all the more challenging. It was also mentioned that phone conversations were rendered more difficult if they were with a new doctor. One SBA provided a poignant example of how physician turnover, language barriers, and limited medical knowledge can come together to complicate emergency cases:

“One of the doctor listened to the foetal heartbeat on phone. She listened to the variability. At that time, we were not studied. When there was deceleration, she told me to listen but I didn't know. At that time, I had just become a senior. I didn't have enough experience. The doctor was African American [...] they spoke very fast. I didn't understand what she

said. The medicine the doctor wanted to give was one kind but the medicine that I gave was another kind. Both medicines are the same antibiotic. The doctor wanted to give an injection but we gave oral. Sometimes, we miss the information. If we have only permanent doctors for a long time, it will be consistent. If we are familiar with only one doctor, it is easy to understand. If not, it is difficult.” (Maela, Senior SBA, translated quotation)

In addition to their need to adjust to the doctors’ style of communication and work, some SBAs felt that it took time to build trust with incoming doctors who gradually gain a better understanding of the SBAs’ knowledge and skills. The SBAs explained that the level of consultation required varies between doctors; some want to know about everything, and others would prefer to not be called very often. Since the physicians are required to observe the SBAs work and sign off on their logbooks, many of the SBAs see the high rate of physician turnover, and the trust-building period that accompanies each change, as impediments to their promotional process, particularly during the transition from Junior to Senior. One of the senior SBAs suggested that outgoing and incoming doctors should engage in some form of handover in order to inform the incoming doctor of the current status of the team and of the skills that each SBA possesses.

Many SBAs noted that often, just as they had finally established a strong working relationship with the short-term doctor, they were set to leave and the period of adjustment was reinitiated. Both the management team and the SBAs indicated that the challenges raised with regards to the collaboration between new doctors and the SBAs subsided when doctors spent longer periods of time in the clinics (longer than six months). It should be noted that following data collection, each site was set to have a stable doctor on staff for six months.

“One opinion is that language seems to be the obstacle, I agree, but whether it is the foreign doctor or the Burmese doctor, when they stay longer, I mean more than 2 years, or 3 years [...]the midwives work with

integrity and can synchronize, and what the foreign doctors want to say, they already understand. At this stage they have mutual understanding and mutual trust, so language at first is a problem, but later, when they stretch their stay longer, they know each other and they can work, synchronizing, and building the trust [...] and then their skill is also boosted. At the time Dr Jack stayed we had a lot of senior midwives, we can have and Dr Jill, because they worked more than 2 year. Even though they are kolowah, they are foreign doctors, we can work with synchronicity and integrity” (Mae Sot, Head Trainer, direct quotation)

Performance Management

Addressing Complaints

It was interesting to note how prominently negative feedback from management and the community featured in the participants’ description of the challenges they face. The meetings with management were relatively rare occurrences and the SBAs themselves acknowledged that cases where their patients’ families harassed them happened relatively infrequently. In the days leading up to the first data collection activities in Maela, a meeting was held to discuss a complaint that had been raised at the camp management meeting regarding the SBAs use of phones and the quality of care they were providing to labouring patients. This feedback had shaken the staff, who had learned to “be kind” to their patients, and felt that they had been providing a good standard of care. It should also be noted that due to the timing of this meeting, and the staff’s attitude towards feedback, the challenges associated with negative feedback from the community were most likely overrepresented in interactions with both the SBAs and management.

When discussing negative feedback that was received from the community, many SBAs mentioned that they wanted the management team to come on site and see their work for themselves rather than taking for granted that what was reported is true. These comments were particularly geared towards the HR team because the SBAs felt that the doctors knew them well

enough based on the work they conducted together on a regular basis. For example, many participants at Mawker Thai referenced the same incident where a patient's family had accused the SBAs of hitting a patient. The SBAs explained that no one on the management team, who had heard about the incident from a community leader, had asked them whether the allegations were true before hosting a meeting. Conversely, one of the HR officers explained that when they receive a complaint, the administrative team discusses the issue, reformulates the message to make sure that it was not too harsh or negative for the SBAs and then try to determine what really happened. Once they have collected some information, they consult with the site manager who discusses the issue with the senior SBAs and then holds a meeting to discuss the issue with the entire staff, including medics, in order to avoid singling out the SBAs. Following this meeting, they try to schedule related training sessions for the staff.

SBAs explained that the previous HR team would come on-site more often to understand their work, but that the new HR team only came on-site for meetings and did not show as much interest in their work. However, the staff expressed general satisfaction with the management practices at SMRU and appreciated the support they received. Select SBAs seemed to have had very positive interactions with the new HR team, who had sought to learn about their problems and motivate them by proposing solutions. When asked how they would like the management team to communicate concerns with them, multiple SBAs from both sites explained that they would like for the HR team to take the time to come and observe their work, even overnight, and speak with them face to face.

“If HR wants to know about us and what we do here, they can come overnight and observe. If they are not listening to the news from above and seeing the situation for themselves, I think that they will give more understanding to us.”(Maela, Senior SBA, translated quotation)

The SBAs indicated that if they want to contact HR, they must pass through a number of intermediaries who chose whether or not to escalate the issue to the next level. At Mawker Thai, the SBAs indicated that rather than informing the management team of the issues they were facing with patients, they dealt with the issue on-site.

Annual Appraisal

The management team acknowledged that their current performance management system was in need of strengthening. The annual appraisal that was conducted at the end of 2015 included 10-point scales for a variety of categories covering communication, leadership, and technical skills. One of the HR officers noted that within their current appraisal structure there is no way to achieve consistency in grading standards between different supervisors. She also noted that the issue of language played into consistency in grading because the appraisal template had been translated into Thai, Burmese and Karen, and the descriptions of the categories were not consistent between the three versions. Finally, she explained that HR was exploring options to make sure that members of staff are not penalized if they did not have a good relationship with the supervisor who has the final say over their appraisal.

Many of the SBAs stated that, overall, they thought that the points that they received on the appraisal were fair. From the SBAs' point of view, there was one predominant issue with the current format of the annual appraisal: that they must give themselves scores out of ten, which are subsequently approved or revised by a supervisor. One SBA explained that even if she deserved a high or full score on a particular item, she would not give it to herself because she did not think that her supervisors would trust her assessment. In order to avoid the disappointment of a supervisor lowering a self-determined score, they would give themselves lower marks that the

supervisors would either maintain or increase. Another SBA explained that even though she thought that based on how hard she had worked she deserved full marks on certain sections of her appraisal, she knew that she would not receive 10/10 because HR had indicated that a 10/10 would indicate the person worked 24 hours a day. A few of the SBAs also noted that those who will be reviewing and confirming their marks should make sure that they have spent a sufficient amount of time observing their work.

Many SBAs explained that they were disappointed with the appraisal process because of the weak points that were identified despite their best efforts. A senior SBA explained that her staff was often demoralized by “negative” feedback because they felt that they were trying their best and were not appreciated for their strengths. In their discussions of the negative feedback they receive from either the management team or the community, the SBAs communicated time and time again that they did not feel that their hard work and goodwill were recognized.

“It is not like we don't work, we work but if they lessen our points under five, we aren't satisfied and can't bare it. We work so much but they give us these points. We work here, we eat here and we sleep here but we never get full points.”(Mawker Thai, Junior SBA, translated quotation)

One SBA revealed that in the past, the annual appraisals incorporated hour-long one-on-one interviews with each SBA. She appreciated this format because it provided her with a private setting that allowed her to talk openly about the challenges she was facing and learn about her weak points in order to improve. She noted that she would not feel comfortable talking about these same challenges in a public setting.

Promotional Process

Practical experience

While the case volume at Mawker Thai has been steadily increasing, historically, Maela and Wang Pha have had a higher case volume than Mawker Thai. One of the SBAs at Mawker Thai who had visited Maela pointed out that because of their increased case volume, the other sites did not have as much “study time” during their day. Conversely, the SBAs at Mawker Thai recognized that they had less practical experience than the other sites because of their lower case volume. Accordingly, the SBAs at Maela acknowledge that they have more practical experience than the other sites as a result of their heavier caseload.

A common practice at SMRU is to temporarily transfer SBAs between sites. Due to limited case volume at Mawker Thai, many SBAs who are in the process of completing logbooks are temporarily sent to Maela to expedite the promotion process through increased exposure to cases. A reported issue during these transfers is that Maela also have staff completing logbooks, and visiting staff may lose out on cases in favour of permanent staff that are also in need of experience. Despite variability in caseloads between sites, all of the SBAs declared that they had ample opportunities to practice their skills.

In addition to the respect that SBAs’ received from their colleagues as a result of their level of experience, multiple SBAs expressed that they derived a sense of confidence and pride from the experiences that they had accumulated. One of the SBAs explained that she is proud of the experiences that she has gained because she knows that one day she will be able to use these experiences to help people inside Myanmar, or in other developing contexts, where the maternal child health situation is worse than in the camp. The SBAs shared that they built up their

confidence as they gained more and more experience with a particular task or procedure. This was particularly true for the more complex procedures that the seniors must undertake. One senior SBA explained that her confidence had been enhanced by her need to be “brave” when the doctors were not in the clinic. In light of this, the logbooks become all the more relevant as a process that safely and gradually exposes the SBAs to their forthcoming responsibilities under the supervision of mentors. The logbook component of the promotional process ensures that the SBAs have developed the requisite skills and accumulated sufficient exposure to the tasks that they will be asked to complete at their next level of accreditation. Consequently, the SBAs explained that they were confident in performing the tasks that corresponded with the scope of practice attributed to their level of accreditation. The head of obstetrics also explained that the junior and senior logbook process require the SBAs to take on more responsibility as they progress through the levels of accreditation.

The SBAs indicated that in order to progress, they needed to work on their skills and their confidence in order to complete their logbooks and gain the doctors’ trust. A challenge that was foreseen by some SBAs in progressing to higher levels of accreditation was the need to take on more responsibilities and decisions. The doctor that is in charge of training the SBAs explained that although they have the requisite skills, the SBAs’ lack of self-efficacy, which is likely linked to the cultural tendencies described in the section of this report on Cultural Inhibition and Aversion to Feedback, renders them hesitant to accept additional responsibility:

“sometimes our midwives don’t know when they are competent users or not competent users, they don’t know that they are great. It means that, they are less self-confident, so actually sometimes they have enough knowledge and they can do it, but they are reluctant to act and feel shy, so to take responsibility and accountability, being accountable, sometimes they are not, [...] we need to promote their self-efficacy skills”
(Mae Sot, Head Trainer, direct quotation)

When discussing the challenges associated with completing their senior logbooks, the SBAs noted that doctors cannot sign their logbook if they are not on site to observe them performing a delivery or a procedure that is part of the logbook requirements, which extends the promotional process considering the limited case volume for more advanced procedures such as vacuum, breech, and twin deliveries. Both the SBAs and the management team explained that on multiple occasions, SBAs have left their positions during the transition between Junior and Senior because they felt that the training and the fulfilment of the logbook was taking too long. The SBAs in question explained that they themselves had considered leaving for the same reasons, but had no choice but to stay because they had built their family around the clinic.

Fast-tracking promotions

The management team explained that in the event of acute shortages of SBAs at a particular level, they have “fast-tracked” promotions in order to remedy their staffing gaps. When SMRU is facing an acute shortage, the doctors that are working at the site in question will often take a more active role in prioritizing the completion of the staff’s logbooks that would allow for their promotion to the next level of accreditation. Most recently, prior to the maternity leave of a long-standing doctor at Mawker Thai, there had been a concerted effort to push as many SBAs through the logbook process as possible in order to remedy their current shortage of senior SBAs. The completion of one of the junior SBA’s senior logbook was a particularly high priority. This junior SBA was on call 24/7 in order to gain as much experience and accumulate as many cases as possible for her logbook in order to expedite her promotion. The same SBA was allowed to complete “trial” shifts as a senior, without any other seniors on duty. In their descriptions of their progression through the levels of accreditation, multiple senior SBAs provided examples of how shortages can expedite the promotional process by explaining that when they were juniors, there

were little to no seniors on site, which pushed them to take on more of the responsibilities of a senior, and to be promoted relatively quickly in order to fill the gaps in the sites' organizational structure and allow the unit to continue functioning.

The management team recognised that some of the SBAs that were promoted during these periods of need did not originally want to adopt a supervisory role.

“willing to take responsibility is difficult because in general they don't want to [...] seniorX for example was very reluctant and probably still reluctant, but she's a very very good midwife, but has no confidence in herself, and brilliant on ALSO[®] and she's a very good senior midwife”
(Mae Sot, Head of Obstetrics, direct quotation)

The head of obstetrics noted that those senior SBAs who were not originally keen on adopting supervisory roles had since grown into their roles and developed a certain level of confidence in their own abilities.

SBAs at Maela contended that progressing from one level to another took longer at Maela than at Mawker Thai. This observation reflects the effects of staffing shortages, where “fast-tracking” is necessary, compared to a promotional process within a unit that is fully staffed. Based on feedback from management, this might also be a reflection of budgetary constraints; since higher levels of accreditation receive higher levels of remuneration, the organization can only afford to employ a certain number of SBAs at each level. These financial considerations can limit management's ability to hire and promote otherwise qualified candidates.

Teamwork

Strength of relationships

The SBAs at both sites characterized their relationships with coworkers by words such as “love”, “friendship”, “siblings”, and “family”, which reflect the strength of the bonds they had

established. The SBAs explained that the unity and understanding within their team made the team stronger and more motivated to work.

“When we cooperate together, we must give understanding to each other. When I look at all the midwives, they have understanding.” (Mawker Thai, Senior SBA, translated quotation)

The SBAs also explained that in emergency situations, if they are not united, negative outcomes can ensue, which upsets them, so they try to stay united as much possible. The SBAs reported that by working together on a daily basis, they had established a good workflow where all members of the team understood what needed to be done next, so they could help each other complete the processes step-by-step. The doctors, whether long-standing or visiting, and management staff also recognized the strength of the SBAs’ teamwork.

Despite the overwhelmingly positive depictions of interactions amongst the SBAs, some SBAs shared that there was occasional gossip or misunderstandings within the team, which incite dips in morale and motivation. Because of the strong bonds that exist between the SBAs, they explained that even if they are facing problems, they could discuss and solve them together.

Coping with shortages

Throughout the data collection process the SBAs at Mawker Thai demonstrated their ability to cope with workforce shortages by tapping into their commendable teamwork. As many of the SBAs live in the adjacent staff quarters, the group that was on duty could call in additional team members, who would respond at any time of day, if they needed back up. There were other instances when SBAs would work double shifts, multiple days in a row, in order to allow their colleagues to take their vacation days. Interestingly, the shortage of SBAs at Mawker Thai, and the rigorous schedule it generated, did not encourage others to leave, but fostered a sense of

solidarity between the SBAs that encouraged the retention of those who remained. The positive relationships within the team at Mawker Thai also seemed to encourage retention because the staff enjoyed working with their friends. Furthermore, multiple SBAs explained that their motivation to continue working was, at least in part, informed by their commitment to their colleagues and the understanding that if they resigned their team would be one member down.

“If I am not here, it is Ok but my superiors need me. They show me. So, I continue to work. If I am not here, my team will be less one. It has no effect on other teams. It affects my own team members. So, I look at the face of my superiors and I work with goodwill for the patients.”(Mawker Thai, Senior SBA, translated quotation)

On a number of occasions, the SBAs at Maela praised the teamwork and unity that the SBAs at Mawker Thai had established. Although Maela had experienced shortages in the past, SMRU’s SBA training had allowed them to build a full roster. Nonetheless, the SBAs in Maela explained that when other sites were facing acute shortages and they were required to send their own SBAs to temporarily fill the gaps, the remaining staff had to work more in order to compensate for the loss, which was often open-ended. For instance, during the data collection period a senior SBA from SMRU’s third birthing unit at Wang Pha was working at Mawker Thai. She had originally been posted to Mawker Thai for five months, and when data collection was completed, she had already been working at Mawker Thai for over eight months.

The SBAs also added that these losses are difficult to accept due to the disparity in case volume between the two sites. Most SBAs from Maela explained that when seniors were temporarily transferred to Mawker Thai, their workload was less intensive, but they knew that they had left their team members behind with an even heavier workload in their absence. In contrast, one of the SBAs described her experience at Mawker Thai when it was very busy and she could tell that there were not enough SBAs to cope with all of the work. The discrepancies between the

accounts of visiting SBAs reflects the variability in workload that can be observed at Mawker Thai, and the importance of the SBAs “call for help” mechanism. At times during observation at Mawker Thai, six-hour stretches would pass by with little to no work for the SBAs to perform, but there were other times when three women were in the delivery room at once.

Mentorship

In all interactions with the SBAs it was very obvious that a strong mentorship had been established between the senior and the lower level SBAs. The assistants and the juniors demonstrated a great deal of respect for the seniors based on their level of experience and skill, and the seniors, in turn, made conscious efforts to guide, support, and empower the lower level SBAs. One of the assistants explained that as new staff members, the quality of their work was enhanced by the guidance and encouragement they received from the senior SBAs.

“When we were new staff, we couldn't work very well but the seniors, they took care of us, encouraged and guided us on how to do things and then we became skilful”(Maela, Assistant SBA, translated quotation)

Another assistant SBA explained that in emergency situations, the seniors guide them through the protocols so they can all work together. The lower level SBAs also looked to their seniors as a source of strength and guidance if their motivation is failing. If the staff ever had questions, they would go directly to the seniors. In these cases, the senior were good at recognizing teaching opportunities and providing the SBAs with tips and tricks as they performed their daily tasks. This mentorship role persisted between older and younger senior SBAs, who valued the knowledge and wisdom that the more experienced seniors had accumulated over their years of service. One of the senior SBAs at Mawker Thai explained that it would be good to have a senior SBA with more experience on site to learn from when they are facing particularly challenging situations.

On their end, the seniors adopted a managerial role, organizing and supervising their team's activities. Since the SBAs begin their work in the clinic while they are still in training, the senior SBAs' additional role as a teacher is particularly prominent within the birthing unit's workflow. The seniors seemed to take their role as teachers very seriously and granted their staff every opportunity to practice skills under their supervision. For those SBAs who were in the process of learning new skills, the higher-level SBAs would first demonstrate and explain the protocol, then allow them to practice the skill under their supervision, and provide them with feedback as necessary. The seniors and the juniors conveyed a relative confidence in the assistants' abilities, which was periodically fettered if the assistant neglected to complete a task that they were assigned. The seniors had a genuine interest in sharing their knowledge and helping their staff progress. Many of the senior SBAs noted that the leadership training that they had received recently had helped them understand what it meant to be a good leader, how to encourage and motivate their staff. For example, one of the seniors explained that under her supervision, she granted full authority to her juniors and tried to show confidence in their abilities in order to maintain their morale. Multiple seniors would also delegate the responsibility for handover, which would typically fall under the purview of a senior, to a lower level SBA to boost their motivation and encourage them to adopt a more active role within the unit.

Collaboration with medics

SBAs did not report any difficulties with accessing the doctor on-call over the phone, but there were reports of instances where the medics were either late in arriving, or completely unavailable for consultation. The SBAs explained that in emergency situations everyone has a role to play, including the medic, but issues arise when the medic is not available or does not arrive on time.

Although the relationships within the SBA teams were strong, the relationships that the SBAs maintained with the medics seemed to be strained. The SBAs indicated that at times, they felt that the medics' lack of availability was an indication that they did not enjoy working with them.

“If I couldn't call this medic, we think that they are not happy to cooperate with us?”(Mawker Thai, Senior SBA, translated quotation)

One SBA at Mawker Thai reported that when she had worked at Wang Pha and faced similar difficulties, the doctor had arranged a meeting between the SBAs, medics and doctors, in order to facilitate communication and cooperation. The SBA in question requested a similar meeting for Mawker Thai in order to alleviate the issues they were facing.

Individual Considerations

Family Responsibilities

Overall, the SBAs reported that they were able to maintain a satisfactory work-life balance. Most of the Assistant SBAs were single, which limited the incidence of personal responsibilities affecting their work. Nonetheless, the most common sources of loss within SMRU's workforce are family responsibilities that render their staff incapable of maintaining the required work schedule, or force them to relocate. Many SBAs reported that past colleagues have been forced to quit in order to take care of their ailing parents who often do not live in the vicinity. Others have noted that if a SBA's husband works and lives far away, this can lead the SBA to resign in order to join him. The importance of proximity to family members was reinforced by other SBAs who explained that part of their motivation to keep working for SMRU was that it allowed them to stay close to their family. For instance, one of the SBAs that had been recruited from Mae Tao Clinic chose to transfer to SMRU because it would allow her to be closer to her family. Family responsibilities also favoured retention in cases where the SBA must continue to work in order to support themselves and members of their family who depend on their income.

“I have a mother and son. I have to support them. If I was alone, I would have left a long time ago. That's why I keep working here.” (Maela, Senior SBA, translated quotation)

During data collection, one of the senior SBAs at Mawker Thai had decided to resign because she had recently had a baby and was having difficulty balancing the baby's care and her professional responsibilities while being away from her extended family that resided in Maela. Her husband would come to work with her to take care of the baby and pass her off when she needed to be fed. During both our individual interview and our focus group, the baby became upset outside the room and was brought in so she could feed her. This was not an uncommon scenario; the SBAs often brought their children with them to work, particularly when they were working the night shift, and their child was unwell or they could not arrange for childcare. A few of the SBAs provided examples of circumstances where they were working hard to fulfill their responsibilities at home and at work, but had received feedback stating that they were not working hard enough, which affected their morale. A rare example of gossip amongst the SBAs came from an assistant who was struggling to cope her responsibilities at home, which involved taking care of her infant as well as her husband who was an amputee, and led her to be late for work at times. The SBA explained that although the seniors did not make any comments to her directly, her morale was affected by the comments that were being made behind her back.

Eagerness to learn and progress

Across both sites, the SBAs displayed an eagerness to learn, and a desire to improve their work. When explicitly asked if they had ever received unnecessary training, every SBA who was interviewed responded that they appreciated any and all training they received, whether it served as a refresher or conveyed new material. The SBAs seemed to be in-tune with their own weaknesses and openly expressed a desire to receive additional training in order to acquire the

knowledge and skills necessary to alleviate these deficits. Language, medical, and counselling skills were the three areas of interest most commonly highlighted by the SBAs. The management team recognized the SBAs' enthusiasm for training, pointing out that even if they were recovering from a night shift, they would return to work in the afternoon to attend the trainings that the doctors provided.

“Because we work, we have skills. Before, we were not able to do something a lot but when we come and work here, the trainer comes and trains us. We study and we work at the same time as well and then we are able to do something.”(Mawker Thai, Junior SBA, translated quotation)

The vast majority of the SBAs also displayed a keen interest in progressing to higher levels of accreditation. The lower level SBAs' motivation to progress to higher levels of accreditation was often fed by a desire to be able to perform a wider range of more complex procedures. It is notable that there is limited upward mobility within SMRU's organizational structure for SBAs. The SBAs can move through the three levels of accreditation, but once they have achieved senior status, there are very few opportunities for advancement. One senior SBA explained that she was “bored” with her work as an SBA and that acquiring more knowledge and skills on the medical side would renew her interest in her position. The SBAs reported that some of their past colleagues had left the unit to pursue medical training. For instance, a SBA at Maela had left SMRU a few years earlier to gain more medical knowledge as a medic at AMI, and had recently come back to the unit. Conversely, an assistant SBA who had been a laboratory technician prior to completing SMRU's SBA training explained that part of her motivation in this position stemmed from the opportunities to progress and to help her community, while as a laboratory technician you always perform the same tasks and stay at the same level.

Desire to gain medical knowledge and skills

In their interviews, the SBA displayed awareness towards their dependence upon the doctors and medics, and some conveyed a desire to acquire more medical knowledge in order to gain more independence. The SBAs believed that an increased understanding of the medical components of their work would allow them to make decisions and limit their need for consultation with the medics and doctors. They also believed that increased medical knowledge would allow them to provide more comprehensive care to their patients who have medical issues. Additionally, the SBAs deemed that increased medical knowledge would improve their performance in their current positions by limiting the number of mistakes they make in treating the medical ailments of their patients.

“We give the delivery. There are other cases linked with the medical. If we have some knowledge, it is better for us. And then if we give treatment, we make less mistakes. Sometimes, we are ordered to do something but we do another thing.” (Mawker Thai, Assistant SBA, translated quotation)

Some of the SBAs pointed out that their lack of medical knowledge can delay necessary interventions if the medic is unavailable due to separate emergency cases in the in-patient department. As an alternative to gaining more medical knowledge themselves, some SBAs suggested that the birthing unit should have a permanent medic on staff to treat the patients' medical issues.

Their restricted scope of practice also impeded their fundamental desire to help their community. They explained that delivery skills would not suffice if they returned to their communities. Some SBAs feared that the people in their village would look down on them if they were unable to answer medical questions. This fuelled their desire to gain more medical training in order to be able to help their communities with both deliveries and medical issues.

“because we are able only to attend deliveries. If we are only able to attend deliveries and go back to our village, it is not fine. So, we should have medical knowledge. That's why they want to attend the medical training.” (Mawker Thai, Senior SBA, translated quotation)

On a more personal level, a number of SBAs were distressed by the fact that they were health workers who did not have the medical knowledge to help and treat their own families' ailments if they were not directly related to delivery. The SBAs also perceived their limited scope of practice as a factor that restricted their ability to work elsewhere since their knowledge is limited to delivery, and they could not help patients with any medical concerns. In some cases the SBAs' desire to expand their scope of practice was offset by their understanding that new medical responsibilities would increase an already heavy workload.

Sense of responsibility

The SBAs also described changes in their morale based on the maternal and neonatal outcomes they achieved. The SBAs, and particularly juniors and seniors, gain significant confidence and satisfaction when they achieved a positive outcome. Conversely, the SBAs explained that their original confidence in performing a particular task could be marred if it results in a negative outcome or referral.

Generally the SBAs recognized that their communication with patients was one of their weaknesses. Some SBAs explained that at times they resort to stronger language with the patients when they are frustrated that the patient is not understanding or listening to them, particularly if they are concerned that the mother and/or baby are high risk. A junior SBA explained that she felt less confident in emergency situations because there is more risk for the mother and child involved. Another SBA explained that this sense responsibility sometimes led her to scold

patients if they were not following their instructions and their behaviour was putting the baby at risk.

“If you consider the work of a midwife, we don't work with one life, we work with two lives. Sometimes, the child is about to be delivered and we acknowledge the patient in many ways (Sometime soft, sometime hard). Sometimes, they don't do the right thing, for example, get into the position on the bed when they are about to deliver. If they are not in right position, it can break the child's neck. Sometimes, we have to scold them and they respond to us. The people from outside hear us and think that we are bossy. Actually, we scold them because we are worried for them. The people from outside, they don't see the real situation and just see our scolding”(Mawker Thai, Senior SBA, translated quotation)

Although not consistent in all observed deliveries, the SBAs were often observed making efforts to provide support to labouring mothers through comfort measures such as massage, counter pressure, and swaying. If one SBA was strongly focused on the clinical care, another SBA would compensate by focusing on the support and coaching. When participants were asked what characterizes a good SBA, some of the main qualities identified were being kind and encouraging towards patients. However, during observations of deliveries that presented higher risk of complication, some SBAs could not keep calm and became more forceful with the patient.

Counselling and communication

Counselling and communication were widely recognized as significant challenges for the SBAs. For instance, the SBAs had a good understanding of the available family planning options, but found that they did not have the communication skills to effectively transmit this knowledge to their patients. The SBAs consistently reported such emotions as disappointment, frustration, and sadness when patients were either uninterested, did not trust, or did not understand the counselling they were striving to provide. Conversely, the SBAs gained a sense of motivation and pride when they succeeded in counselling clients, and in providing them with quality care. The SBAs were motivated to augment their family planning counselling skills because they

recognized the necessity of family planning amongst their patients who are very young or at high risk of obstetrical complication.

In part, the SBAs attribute the misunderstandings between themselves and their patients to their patients' lack of health knowledge and education. The SBAs felt that family planning counselling was particularly difficult because of their patient population's apprehension towards many forms of contraception. These issues are exacerbated by the low levels of knowledge and the prevalence of misconceptions with regards to family planning that persist within their patient population.

“Our ethnic group, they fall in love with each other and get married. If I know it, I use it but if they don't know and you explain, they don't accept it. They don't have foreknowing. Even their parents didn't use family planning and delivered. Their grandparents also didn't use it. They don't have foreknowing.”(Maela, Senior SBA, translated quotation)

During observations, SBAs would often pull out an illustrated family planning booklet as a visual support for their counselling. The lack of health literacy amongst their patients forced them to use the diagrams to first explain how conception occurred before they could move on to explaining how the family planning methods prevented conception.

In addition to the sense that family planning counselling is one of their weaknesses, some of the SBAs reported that they do not have enough time to provide adequate family planning counselling because they are always busy with delivery and postpartum care. The SBAs at Mawker Thai recognized that the number of available SBAs was not sufficient considering the volume of work they were charged with, particularly when there were influxes of patients. One of the SBAs at Mawker Thai noted that despite their best efforts they do not always have the volume of staff necessary to provide the “detailed” level of care that the patients demand.

It should also be noted that the language barriers within this health system are not limited to those between the SBAs and the expatriate doctors; the staff have varying levels of comfort in Burmese and Karen (including Sgaw and Poe dialects), the hospitals they refer to use Thai as their working language, and their patient populations represents a wide variety of ethnic groups that each have their own dialects. In a particularly interesting patient encounter, one of the physicians was speaking in English to a senior medic who was translating the physicians' questions into Burmese for the patient's son, who was then translating the question into Mon for the patient, whose answer then went through the reverse order of translations to get back to the physician. Although arrangements can be made to alleviate these language barriers, they present an ongoing challenge for the SBAs' provision of quality care.

DISCUSSION

Table 4 provides an overview of the obstacles and enablers to professional development present within the system at study. It also highlights the difficult context and cultural environment within which SMRU operates. These macro level obstacles hamper both their capacity to plan and implement optimal HRH strategies. Nevertheless, SMRU and its employees have risen to task and integrated a number of enablers into their system. The following section will highlight the most prominent obstacles and enablers to professional development that feature within SMRU's system, and situate them within existing literature.

Table 4: Obstacles and Enablers to Professional Development Summary Matrix

| | <i>Obstacles</i> | <i>Enablers</i> |
|---|---|---|
| <i>Contextual & Cultural</i> | -Limited Resource Availability -Levels of Education -Resettlement and Return -Cultural inhibition -Embedded Hierarchy -Community Pressures | -Desire to help their community |
| <i>Organizational</i> | -Hierarchical Organizational Structure -Restrictions on Scope of Practice -Physician Turnover -Performance Management Mechanisms | -Formal Training Program -Logbook Process -Teamwork & Mentorship -Supportive Supervision -Integration of research and service provision |
| <i>Individual</i> | -Communication & Counselling Skills -Language Skills -Confidence & Responsibility | -Passion for Skilled Birth Attendance and improving maternal health -Eagerness to learn and progress |

Recruitment and Retention

The study underlined the complexities of maternal health workforce planning in contexts of perpetual instability. Considering more than 50% of SMRU’s SBA workforce at these sites have been hired in either 2014 or 2015, persistent recruitment and retention concerns reveal that workforce sustainability within SMRU can not be achieved through professional development alone. This conclusion is in line with the working lifespan framework of strategies (WHO, 2006) that recognizes the need to prepare health professionals for their entry into the workforce, enhance their performance during their active engagement in the workforce, and manage their exit and reduce unnecessary attrition in order to remedy the crisis in human resources and promote more productive and resilient health systems.

The recruitment and retention issues within SMRU’s system were linked to the context they are working in, which faces waves of resettlement and repatriation as well as educational deficits, the feminization of their workforce, which amplifies the challenges associated with balancing

personal and professional responsibilities, and their lack of governmental recognition, which limits the compensation and recognized accreditation that can be provided to their employees. Whereas non-NGO status limits humanitarian funding, lack of designation as educational institutions limits recognition of training provided by organizations working at the border, including SMRU.

The sources of attrition within SMRU's system, including migration and family responsibilities are also well documented within existing literature. Health professional migration represents a significant obstacle to health workforce sustainability, particularly in rural and remote contexts where recruitment of qualified personnel presents an additional obstacle (Hongoro & Normand, 2006; Smith & Hyre, 2009). As for gender, family responsibilities have been identified as obstacles to professional advancement amongst health care workers across both developed and developing contexts (Standing, 2000), while the study of the unique practice patterns of female health professionals has primarily focused on developed contexts. Given that the SBAs constitute an entirely female workforce, SMRU experiences amplified effects of workforce feminization. The fixed schedule at SMRU does not allow for flexibility in the SBAs' schedule to accommodate for increased personal responsibilities, which means that those who cannot meet the demands of a full time schedule exit the workforce entirely. Nonetheless, at SMRU, family responsibilities can push the SBAs in one of two directions. In some cases, the SBAs must continue to work to support their families financially, and in other cases they are forced to leave the workforce because their families require more domestic support. Proximity to their family was an important enabler for retention, as it enabled them to balance their personal and professional responsibilities, while distance from their family often forced them to choose between these two fields of responsibility.

Motivation

Of the seven motivational factors identified by Willis-Shattuck et al. (2008), four factors seemed to be of particular importance to the SBAs at SMRU: career development, continuing education, hospital management, and personal recognition. As described by others (Dieleman, 2009; Hongoro & Normand, 2006; Smith & Hyre, 2009), non-financial incentives seemed to play a much stronger role in the SBAs' motivation to maintain and enhance their productivity. Hospital management and personal recognition often represented sources of distress to SBAs who did not feel that the administrative management understood the challenges they faced, or recognized their efforts. Conversely, career development and continuing education played into their eager desire to learn and progress in order to increase their contributions to their community. The contrast between the assistants' and the seniors' points of view regarding the availability of opportunities for advancement may indicate that the opportunities for advancement are a sufficient source of motivation for the lower levels of accreditation, but that SMRU could explore potential avenues for professional development amongst their higher levels of accreditation. Although the SBAs displayed variability in their reasons for choosing this profession, there was consistency in their strong desire to help their community through their work. The SBAs also shared a passion for the profession, and ultimately even those who did not have initial interest developed it over time. Both their passion for their work, and their desire to help their community serve as important motivational factors that promote retention and inform the SBAs desire to expand their knowledge and skills, improve their performance, and progress to higher levels of accreditation within SMRU's system. As such, they constitute important micro level enablers to both individual professional development, and SMRU's overall workforce sustainability.

Training Program and Promotional Process

The study revealed that at the organizational level, SMRU has established an effective training program that imparts both theoretical knowledge and practical skill that the SBAs require to fulfill their scope of practice. Namely, SMRU has been successful in aligning their pre-service training with clinical practice, the importance of which is highlighted by Smith & Hyre (2009). The SBAs demonstrated strong practical midwifery skills that had been reinforced through a competency-based promotional system and the completion of ALSO[®] accreditation. The logbook process, and the progressive integration of an increased scope of practice and responsibility as SBAs ascended through the levels of accreditation, employed ongoing action-oriented clinical leadership development as described by McNamara et al. (2014). The study established that the logbook system that SMRU has developed is an excellent professional development tool because it capitalizes on the confidence and skills that SBA's acquire through practical experience and provides them with the appropriate supervision and instruction to hone their skills before gaining more independence. This means that once the SBAs have completed the logbook they have both the skills and the confidence necessary to be effective in their new position, which is particularly important in a cultural context that is not prone to confidence. The logistical limitations that extend the promotional process at SMRU are largely inevitable. The challenges associated with supervision given the unpredictable scheduling of maternity care has been documented (Smyth & Hyre, 2009), but in the case of SMRU the distance between the central office and clinics, and recourse to remote consultations over the phone, between professionals with varying levels of proficiency in English, add complexity to this barrier. Through their formal training program, and their logbook system, SMRU does a good job of planning for their immediate needs. However, they do not have the financial resources to accommodate the additional staff that would be needed to account for the sudden substantial losses that are to be expected in an unstable

context, limiting the resilience of the system as a whole. This reality exemplifies the relationships between the sub-systems identified in the WHO's Health System Framework (de Savigny & Adam, 2009), by highlighting the interdependence of SMRU's health workforce strategies, and their financing.

In line with global trends (Rowe et al., 2005), certain gaps of the SBAs' skillset are limiting the confidence and motivation they exhibit, and these performance indicators may be mediating the efficiency and sustainability of the SMRU's system as a whole. The SBAs communicated interest in gaining complementary medical, counselling, and language skills to better meet the needs of their patient population. Furthermore, in line with their limited ability to recognize individual strengths, the SBAs displayed a heightened awareness towards weaknesses in their skillset, including counselling and communication skills. These deficiencies seem to have broken down the virtuous circle of empowerment described by Byrom and Downe (2010). While supportive supervision had been established within the system, the SBAs' weaknesses surrounding counselling and communicating with patients, particularly in situations that presented higher risk, occasionally generated negative feedback from patients and the community, which, when combined with their cultural inhibition and aversion to feedback, further restricted their confidence and sense of recognition.

While the Midwifery2030 vision (UNFPA, 2014) presents performance review as an important gateway for quality improvement and professional development through the identification of strategic training priorities, the dichotomy between the SBAs' aversion and desire for feedback renders performance management a delicate process. Due to the timing of meetings related to complaints from the community, which were held immediately prior to data collection,

participants' testimonials may have been disproportionately influenced by recent negative feedback. Overall, the SBAs had very strong aversive reactions to negative feedback, whether it came from management or the community. However, many SBAs stated that they appreciated feedback related to their weaknesses because it allowed them to improve, and requested more feedback from management. Participants' attitudes varied based on the source of the feedback. While feedback from HR and the community was perceived as negative and demoralizing, the SBAs generally perceived the feedback from doctors to be positive and desirable. This seeming contradiction highlights the importance of the delivery with this particular population. The SBAs seem to require feedback formulation in which their hard work and successes are acknowledged, and the challenges they face are understood. If these parameters are met, the effects of "negative comments" on their confidence and motivation could be abated and they could react constructively to performance evaluations. Such an approach could increase the effectiveness of SMRU's performance appraisal system by accounting for ratee reactions and developing a more positive feedback environment; two important contributors highlighted by Levy & Williams (2004).

These findings may indicate a need for more open and direct communication between the management team that works in Mae Sot, and the staff who remain on-site. The distance between Mae Sot and the clinics presents an obstacle to these interactions. The SBAs only represent a fraction of the over 400 staff that are dispersed between multiple sites in the region and managed by a centrally located HR team. Site visits are full day endeavours, which the HR team can only occasionally integrate into their schedule due to the sheer volume of work that is involved in the administration of SMRU's workforce. More frequent site visits and more in depth interactions with the various teams working in the clinics would require additional HR staff, the cost of which cannot be accommodated within SMRU's current operational budget.

Hierarchical Organizational Structure

The study highlighted the delicate task of developing an appropriate and constructive obstetric consultation system for SBA-led models of care. Enabling environments, which are essential to the provision of safe maternity care, foster respectful and effective collaboration between all stakeholders involved in the provision of care (Hoope-Bender et al., 2014). Clear definitions of the roles and responsibilities within these collaborative teams promote midwives' ability to work to their full scope of practice, while maintaining access to consultation and referral (UNFPA, 2014). Although most SBAs found comfort in the hierarchical decision-making structure that SMRU has established, this structure may perpetuate the SBAs' stated lack of decision-making confidence, rather than encourage them to develop the ownership, leadership, and analytical skills that are required in order to achieve higher levels of accreditation, gain autonomy, and potentially broaden their scope of practice. This dichotomy reiterates the importance of supportive supervision, which has been described in existing literature (Adegoke & van den Broek, 2009). These relationships would seek to foster learning opportunities without undermining the SBA-led model of care or creating a power dynamic that is detrimental to the confidence and motivation of SBAs.

Over the years, SMRU has allocated responsibilities and established a workflow to accommodate a workforce that is not predisposed to critical thinking or soft skills. Based on the clear role definition that was established for each level in the organizational hierarchy, decision-making and ownership were largely absent in the work of the lower level SBAs, who perform the tasks they are asked to by superiors who have the authority and responsibility to make those decisions. Conversely, SBAs who had attained junior and senior status displayed a progressive, albeit variable, willingness to accept responsibility. Ownership of practical tasks was more acceptable

than responsibility for decision-making at all levels of accreditation. While it is appropriate that higher levels of accreditation adopt supervisory roles that encompass a higher level of responsibility, such a steeply hierarchical system may not enable the lower levels to develop softer skills like ownership and leadership because their responsibilities are so narrowly defined. Additionally, developing leadership and ownership skills may not be intuitive when all of the SBAs' daily interactions are with health professionals that have more authority and skill. The number of levels within the organizational structure also enables them to pass ownership on to someone else, a tendency that is amplified their cultural proclivity for hierarchy and inhibition. Casey et al. (2010) generated congruent findings in their study of nursing and midwifery managers who expressed that their position within organizational hierarchies presented a challenge in their adoption of clinical leadership roles.

Still, the nature of the leadership training that SMRU provided to their senior SBAs is a positive example of the organization acknowledging the hierarchy within their system and the inefficiencies it can produce, including lack of collaboration and opportunities to acquire the soft skills that are required to ascend. The vision that this training put forward was one of increased collaboration and horizontal structures that limit the power distance between levels and allow for a more productive distribution of ownership and responsibility.

Scope of Practice

The instability that accompanies contexts of conflict and displacement creates recurring crises that must be addressed. Limited resources restrict SMRU's capacity to plan for such events, and the resilience of the system as a whole. *Ad hoc* decisions based on crises and complications are understandable in such a resource-limited and unstable setting; however, these decisions to

ensure short-term survival and viability can impede the long-term sustainability of a system that must meet the needs of a population that is facing a situation of protracted displacement. Although local adaptation was highlighted by Dieleman et al. (2007) as important to the success of human resource management interventions, the complex political, socioeconomic, and cultural context within which this health system operates seemed to exert a much more significant and direct influence on its day-to-day operations than was reflected in existing literature. For instance, in the case of SMRU, restricting the SBAs' scope of practice served to mediate acute shortages and enable faster replenishment of their workforce. This allowed SMRU to continue their provision of services, but undermined the ownership and confidence of their SBAs, who were henceforth dependent on other "more skilled" "higher-level" health workers in order to meet the needs of their patients. In losing their independence, the SBAs also lost a portion of their motivation and pride that comes from helping their community. This can contribute to a feeling of helplessness because they no longer have the knowledge and skill that would be necessary to function as a health worker providing broader care in other settings. Out of need, SMRU has built a fit-for-purpose workforce that is tooled to provide care within their particular organizational structure.

Interactions with Physicians

The SBAs' cultural barriers to confidence and communication, combined with the language barrier that separates the expatriate doctors and the SBAs, pose a considerable challenge to their confidence in consultations. The system of consultation observed at SMRU also reinforces Colvin et al.'s (2013) characterization of disparities in social status and authority, as well as barriers in communication between collaborating partners, as potential obstacles in models of care that employ task shifting. Despite certain SBAs' hesitance to convey their opinion to the

doctor, the study found that the doctors made conscious efforts to incorporate SBAs into the process. Throughout their interactions with SBAs, doctors often employed coaching techniques similar to those described by Rafferty & Fairbrother (2015); though again, within this context, the language barrier between the doctors and SBAs, as well as the cultural inhibition that the SBAs displayed, limited the depth of these interactions. The fact that the SBAs recognized that their supervisors are confident in their abilities was a positive indicator of supportive supervision. The SBAs also felt that the feedback they received on a day-to-day basis was generally delivered in a positive way, indicating that their relationships with the physicians in question were supportive.

In line with the recognized influence of inter-professional interactions on the confidence of midwives (Bedwell et al., 2015), this study also highlighted that turnover amongst health professionals in supervisory roles can introduce increased variability in style of supervision and risk of disruptive practices into the unit. Financial considerations have led to high turnover rates amongst consulting doctors, creating recurrent disruptions in workflow and training within the birthing units. With the arrival of a new foreign doctor, the SBAs experience a transitional period where they must adjust to the doctor's dialect, build trust and rapport with the doctor, adapt their existing protocols to the doctor's preferences, and transfer their progress logbooks to the new supervisor. The need to adjust their practices may be alleviated if all senior SBAs are encouraged to become more assertive with their consulting physician, as was displayed by select SBAs during observation. High physician turnover also allows for the introduction of select physicians into the unit who are perceived as negative or critical, setting back the efforts made by others to establish a supportive and collaborative environment. Overall, the doctors observed made concerted efforts to be supportive of SBAs but power dynamics remained and deviations from protocol occurred.

Teamwork

The case of SMRU is consistent with existing literature, which acknowledges the importance of intra and inter-professional interactions to the development, stagnation, or regression of confidence amongst midwives (Bedwell et al., 2015). This study also provides a strong example of how positive intra-professional interactions can contribute to the confidence, motivation, and retention of an SBA workforce. The teamwork that the SBAs displayed was exemplary and served as one of the principal motivating factors within both teams. Recognition and reinforcement of this strength could be of added value to SMRU. The overall sustainability of SMRU's workforce is improved by the SBAs' solidarity, which pushes them to accommodate crises and work together to ensure that all of the units' functions are fulfilled.

The SBAs' exceptional teamwork and respect for hierarchy come together to form an invaluable form of supportive supervision: SBAs mentoring SBAs. The senior SBAs provide the lower levels with examples of good practice, encourage them to exercise and hone their skills, and allow them to communicate comfortably with someone who is part of their ethnic community and can share a wealth of knowledge and experience. Some senior SBAs were more engaged in adopting this role than others, but overall, the lower level SBAs had access to excellent role models who mentored them, and invested in their success.

RECOMMENDATIONS

In light of the discussion presented above, the following section will develop upon the four key recommendations listed below that aim to relieve obstacles, and reinforce enablers within SMRU's current system, as means to encourage professional development and improve the resilience of SMRU's health system towards macro-level instability.

- 1. Provide the SBAs with targeted opportunities to expand their knowledge and skills*
- 2. Moderate rates of promotion in order to make optimal use of an effective competency-based system of accreditation*
- 3. Formalize personal recognition and increase the cultural sensitivity of performance management mechanisms*
- 4. Integrate all stakeholders into the positive team dynamics that have been established between the SBAs*

Provide the SBAs with targeted opportunities to expand their knowledge and skills

SMRU could capitalize on the SBAs' expressed eagerness to learn by providing them with the opportunity to expand their knowledge and skills. These training opportunities could allow the SBAs to increase the quality of the services they provide within SMRU's system, and to remain motivated in their positions. In light of the SBAs' avid interest in in-service training, and the benefits that the SBAs glean from structured training programs like ALSO[®], it could be advantageous to conduct training needs assessments for each birthing unit. This assessment would enable the formal identification of current gaps in knowledge and skill amongst the SBAs, and inform the development of a more structured in-service training schedule. This could ensure that the SBAs are receiving the training they need when they need it, and limit the recourse to training as a response to incidents (ie. a complaint from the community).

Instead of allowing rotating doctors to make training decisions based on their initial observations of the SBAs, doctors could be given a particular topic to focus on during their tenure, that fits in with the training needs assessment and the timeline that was established to address gaps. If it is not possible to provide the doctors with training modules that are standardized and conform to SMRU protocols, then the doctors could be provided with a clear outline of the material to be

covered and the sources to be used. These measures would ensure that the training provided fits with the SBAs' pre-existing knowledge, and is an accurate reflection of practice in the clinic.

Finally, communication and counselling training could be of significant benefit for these SBAs; this training could boost their confidence, and improve the quality of care they are providing. These skills are particularly important when the patient population's level of education is a barrier to knowledge transfer. The SBAs at Mawker Thai in particular could also be provided with training and support to cope with the pressures they face from patients.

Moderate rates of promotion in order to make optimal use of an effective competency-based system of accreditation

Continuous promotional efforts could be made as a means to build resilience in the event of attrition, and avoid the need for *ad hoc* responses to acute crises such as fast-tracking promotions and restricting scopes of practice. Moderating the rate of promotions could provide some SBAs with more time to develop the necessary confidence, leadership and ownership that they will need to fulfill their responsibilities at the next level of accreditation, and alleviate the sense that promotions take too long amongst others. Nevertheless, this ideal is likely unrealistic in the short term given the budgetary restrictions that SMRU must accommodate.

Formalize personal recognition and increase the cultural sensitivity of performance management mechanisms

Efforts could be made to open the lines of communication between HR and the SBAs, ensuring that the SBAs feel comfortable contacting HR and that their problems are not suppressed by intermediaries before they reach the proper authorities. This could be of particular importance considering the Karen tendency to internalize problems rather than speak out about them. Better

communication between HR and staff would provide HR with the information they need to plan quality improvement interventions and provide appropriate support.

Given the pressure associated with these positions, increased attention to the SBAs' morale and motivation could be of significant interest. In their efforts to develop a more positive performance management strategy, HR could hold staff meetings both to address challenges and to recognize achievements. For example, during data collection, a visiting midwife presented the improved maternal outcome statistics that Wang Pha had achieved since their completion of ALSO[®] training, which the SBAs at the third site thoroughly enjoyed. This is an example of how simple interactions can provide SBAs with the recognition they are seeking, the motivation to continue their efforts, and a concrete representation of how their training and hard work is helping their community. While accounting for resource constraints, the HR team could spend some informal time in the units getting to know the SBAs, and developing an understanding of their work. By approaching the SBAs and discussing their concerns, HR could make them feel like their voices are heard and considered, rather than feeling like they have a bad reputation with management. These interactions could improve rapport between the management team and the SBAs, and could serve a strategic entry point to initiate a more productive and culturally sensitive performance management program.

SMRU's performance management system could be reformulated to take into account the SBAs' cultural aversion towards feedback, and capitalize on their eagerness to learn, improve, and progress. By removing the scaled grading system from the annual appraisal, issues with consistency and impartiality could be resolved, and the distress associated with self-assessments could be avoided. A more effective way of framing the annual appraisal could be the

establishment of a professional development plan for each SBA that would be reviewed on a yearly basis. This professional development plan could identify the successes that the SBA has achieved over the past year, the goals that she would like to accomplish in the year to come, and the steps that she would need to take in order to realize these objectives. These next steps could include strengths that she should sustain, weaknesses that she should improve, and training that she should complete to reinforce her skill set. By recognizing their strengths, and framing areas for improvement as a means to achieve individualized goals, the professional development plans could allow SMRU to manage the performance of their employees in a culturally sensitive and empowering way. All of these elements could be developed jointly between the SBA and a supervisor during an in-person discussion. By re-instating the hour-long in-person discussion, management could reinforce their relationship with the SBAs, provide them with a private opportunity to discuss any challenges they may be facing, and create a more effective performance management system which empowers SBAs to engage in their professional development.

Integrate all stakeholders into the positive team dynamics that have been established between the SBAs

Inter-professional communication and collaboration could be reinforced so that all professionals who work in the birthing units are incorporated into the positive team dynamic that has been established amongst SBAs. The SBAs displayed a desire to develop strong bonds of friendship with the doctors over time, which may indicate a desire to integrate the physician into this positive and productive team dynamic. Establishing similar collaborative bonds between the SBAs, doctors, and medics, could constitute an important contribution to the units' efficacy, and to the morale and motivation of all involved.

As was reflected in their positive perceptions of the head of obstetrics, the SBAs interactions with long-term physicians are productive. If SMRU could find the funding necessary to recruit expatriates for a longer period of time, a multitude of barriers could be alleviated. Another option that could be ideal is the recruitment of Burmese doctors to work in the units. Although SMRU does have a select pool of doctors from Myanmar on staff, this does not appear to be a viable solution for all three clinics in the foreseeable future considering that the recruitment of these professionals is hampered by the compulsory service programmes that are imposed within Myanmar's health system.

In light of this population's sensitivity towards feedback and lack of confidence, preparing incoming doctors for the context they are entering could facilitate the transitional period. In order to establish consistency in the unit's workflow, incoming doctors could be informed of the status of the workforce, including their skills, knowledge, and the current status of logbooks, could be asked to refer and conform to the SMRU protocols for all decisions, and could be made aware of the unique cultural context as well as the supervisory techniques that SMRU expects them to adopt. This consistency could be particularly desirable in a setting of continuous professional development and learning, where deviations from the protocols that the SBAs thrive on could be a serious impediment to their learning process and create confusion as to the appropriate practices to adopt.

Language is an inevitable challenge when making use of expatriate doctors, which is exacerbated when turnover is factored in. First, the SBAs could be provided with additional English language training in order to enhance their confidence and skill in this domain, and by extension facilitate their interactions with the consulting doctors. The language barrier can have considerable effects

on the doctors' perception of the SBAs' confidence. Although communication with doctors is essential to the senior SBAs' role, ideally, they could be assessed based on the level of confidence they display in their interactions with their peers and their patients, rather than those with the doctors.

In order to provide the SBAs' with the knowledge they would need to make more substantive contributions to their consultations with medics and doctors, SMRU could explore the possibility of enhancing the SBAs' understanding of the medical reasoning behind their actions, or the "why". It should be noted that developing stronger critical thinking skills may present a challenge due to the SBAs' proclivity for strict adherence to structured protocols. SMRU could also encourage the SBAs to engage in questioning and turn the quizzing mechanisms that the doctors utilize into a 2-way dialogue. SBAs could be encouraged to ask the doctor why they chose a particular course of action over another and use every consultation as an opportunity to learn rather than simply "following" what their superiors have prescribed. This highlights the need for action on both sides of this supervisory relationship. Not only would the doctors provide supportive supervision, but the SBAs would act upon their eagerness to learn and become assertive agents in their own learning process and professional development.

LIMITATIONS

The limitations of this study fall into four main categories: the language barrier between the researcher and participants, the potential under-representation of assistant SBAs' points of view, the time frame within which data was collected, and the transferability of the findings.

The challenges associated with multilingual research are well documented and to be expected. Within this particular context, where the same organization operates in four different languages and their patient population introduces even more, the employment of an appropriately skilled interpreter was key. Due to logistical limitations, the researcher was not involved in the selection of the interpreter, which was completed by SMRU management. The chosen interpreter was Karen, had worked as an SBA for SMRU in their early years of operation, and had subsequently worked for multiple health care organizations in the border region. Her knowledge of the region, SMRU as an organization, and skilled birth attendance as a profession, made her an excellent source of complementary information throughout data collection. Her existing personal and cultural connections with the staff at SMRU, as well as her outgoing personality, enabled her to quickly establish rapport with participants. She also had a working knowledge of English, Karen, Burmese, and Thai, meaning that she could communicate with all SMRU staff in their language of choice.

While this interpreter offered multiple assets to the project, some challenges associated with depending on an interpreter presented themselves during data collection. First, when relying on consecutive interpretation, which summarizes the participants' responses during interviews, it can be difficult to gauge how much information is being gathered and where it would be necessary to probe for more details. Due to this limitation, it was important for the interpreter to understand the intent of each question, and be able to reformulate and probe semi-independently to gather the desired information. Whereas the structure of interviews and focus groups clearly defines the role of an interpreter, longer and more passive exercises such as non-participant observation can lead the interpreter to lose focus on the task at hand. It was often necessary to ask the interpreter "what did she say" or "what are they discussing", or to seek her out when seemingly important

interactions were occurring. These lapses may have affected the breadth of the data that was garnered from observations. During non-participant observation it was also a challenge to mediate the Hawthorne effect (Mays & Pope, 1995) exerted by the interpreter who was excellent at establishing rapport, but whose persistent social interactions with the SBAs most likely influenced their workflow during observations. In *Observational Methods in Health Care Settings*, Mays & Pope (1995) explain that “having a researcher observing actions may stimulate modifications in behaviour” (p.182). Throughout data collection, these issues were addressed with the interpreter, who made efforts to remedy these issues. Finally, plans for transcription were modified once it became clear that it would not be feasible for the first interpreter to complete the transcriptions that were part of her original contract. A second interpreter, with transcription experience, was hired to perform the translation and transcription of the focus groups. Although this adjustment came at a substantial financial cost, it increased the reliability of the translations, and produced detailed transcripts that were vital to data analysis. While full transcription of the focus groups was sufficient to reach saturation, full transcription of individual interviews could have increased the availability of supporting quotations, particularly stemming from assistant and junior SBAs.

As noted in the methodology section of this report, the focus groups adopted a sub-optimal structure due to logistical constraints. Originally, separate focus groups were scheduled for each level of accreditation at each site. This structure was envisioned as a means to provide each level of accreditation with the opportunity to discuss the obstacles and enablers that they experience, without needing to account for the presence of either their staff or their superiors in their answers. However, SMRU management immediately informed me that this structure would not be feasible given the SBAs’ schedule, and proposed that separate focus groups be conducted for each shift at

each site. This structure fostered discussions that were reflections of the team dynamics that could be observed in the daily workings of the unit: the seniors and the juniors led the conversation, standout assistants who had outgoing personalities voiced their agreement with what was being raised by the juniors and seniors, and the assistants who had more shy dispositions were largely unheard despite extensive probing. Although this lack of participation may reflect the assistants' limited experience within the system, it certainly limits the representation of the assistants' views in the dataset. Assistant and Junior SBAs were provided with the opportunity to share their experiences through participation in individual interviews.

Data collection was completed over the course of 6 weeks. As such, this dataset is a snapshot of SMRU at a particular moment in time, and the findings of this study may have been inordinately affected by finite events that occurred before or during data collection (ie. complaints from the community). However, the findings related to organizational practices are not necessarily finite, and represent structures that either enable or impede the SBAs' ability to cope with acute events. Furthermore, the findings related to the cultural and contextual factors that affect the planning and implementation of these organizational practices constitute relatively constant sources of influence within SMRU's system. The temporal limitations of this study have been partially mitigated through the continued involvement of SMRU management in the review and refinement of its findings.

Finally, the distinctive configuration of SMRU's system, and the unique contextual and cultural factors that influence the recruitment, training, retention, and development of their workforce, limit the transferability of the study's findings. These findings could be of significant interest to

other health care organizations operating in situations of protracted displacement, but their application to other contexts should be carefully assessed.

CONCLUSION

The systems perspective adopted in this study increased the value of its findings for the organization by facilitating the development of a comprehensive and nuanced representation of the obstacles and enablers to professional development and workforce sustainability present within its system. This multi-level analysis also strengthened the study's contribution to existing literature by allowing for a more thorough exploration of how context and culture can have a profound influence on health workforce policies, planning, and management. Furthermore, much of the intrinsic value of the study stems from its examination of skilled birth attendance and HRH considerations in a context of protracted displacement; a setting which has yet to be adequately studied in HRH or health systems literatures.

This case study finds that SMRU has been successful in providing its SBAs with the appropriate midwifery skills to fulfill a limited scope of practice, and in fostering strong intra-professional relationships that allow the SBAs to motivate and mentor each other. The competency-based promotional system that SMRU has established provided an excellent framework for professional development, which allowed SBAs to safely gain knowledge, skills, experience and confidence over time under the supervision of trusted colleagues. SMRU's micro-system highlights the significance of context and culture to a health system's capacity to plan and implement its HRH functions. In order to establish an optimal environment for professional development of SBAs, SMRU could focus their efforts on establishing culturally sensitive performance management and consultation mechanisms that would incite SBAs to embrace increased ownership of their work

as well as their professional development. Finally, in the case of SMRU, persistent recruitment and retention concerns reveal that workforce sustainability cannot be achieved through professional development alone. By addressing sources of attrition within their system, SMRU could allow professional development efforts to make more effective contributions to the sustainability of their workforce. Whether a SBA does not stay with the organization long enough to attain higher levels of accreditation, or is lost after significant investments have been made into her professional development, the levels of attrition faced by SMRU are a source instability within the system, bringing about impromptu decisions to address short-term problems, and limiting their capacity to instil long-term solutions. Therefore, this study reveals a need for further inquiry into the complexities of maternal health workforce sustainability in contexts of protracted displacement, and the challenges associated with developing appropriate long-term supervisory structures for lower level health professionals working in such contexts. These lines of inquiry present a paradox; at its core, humanitarian relief aims to render itself unnecessary, but when crises become chronic, humanitarian organizations often accommodate their models of care to maintain service provision over the long term. In the case of Myanmar, the situation of conflict and instability has lasted over three decades; nonetheless, efforts to achieve health system sustainability remain counterintuitive and bittersweet when the need to extend service provision is fed by a population facing seemingly unending displacement and vulnerability.

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APPENDIX 1- UNIVERSITY OF OTTAWA ETHICS CERTIFICATE

File Number: H10-15-12

Date (mm/dd/yyyy): 01/18/2016



Université d'Ottawa **University of Ottawa**
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Ethics Approval Notice Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

| <u>First Name</u> | <u>Last Name</u> | <u>Affiliation</u> | <u>Role</u> |
|-------------------|------------------|----------------------------------|--------------------|
| Ivy | Bourgeault | School of Management / School of | Supervisor |
| Caroline | Chamberland | School of Management / School of | Student Researcher |

File Number: H10-15-12

Type of Project: Master's Thesis

Title: Obstacles and enablers to the professional development of skilled birth attendants: a case study of the Shoklo Malaria Research Unit on the Thailand-Myanmar Border

| Approval Date (mm/dd/yyyy) | Expiry Date (mm/dd/yyyy) | Approval Type |
|-----------------------------------|---------------------------------|----------------------|
| 01/18/2016 | 01/17/2017 | Ia |

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:
N/A



Université d'Ottawa **University of Ottawa**
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement (2010) and other applicable laws and regulations in Ontario, has examined and approved the ethics application for the above named research project. Ethics approval is valid for the period indicated above and subject to the conditions listed in the section entitled "Special Conditions / Comments".

During the course of the project, the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the project (e.g., change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, including consent and recruitment documentation, should be submitted to the Ethics Office for approval using the "Modification to research project" form available at: <http://research.uottawa.ca/ethics/submissions-and-reviews>.

Please submit an annual report to the Ethics Office four weeks before the above-referenced expiry date to request a renewal of this ethics approval. To close the file, a final report must be submitted. These documents can be found at: <http://research.uottawa.ca/ethics/submissions-and-reviews>.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Signature:



Riana Marcotte
Protocol Officer for Ethics in Research
For Daniel Lagarec, Chair of the Health Sciences and Sciences REB

APPENDIX 2- TAK COMMUNITY ADVISORY BOARD ETHICS CERTIFICATE

Tak Province Community Ethics Advisory Board (T-CAB)
Mae Sot, Tak Province
Thailand



5th Dec 2015

Dr Rose McGready
Shoklo Malaria Research Unit
68/30 Bann Tung Road
Maesot, Tak Province
Thailand

Dear Dr McGready

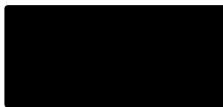
Full Title of Study: "Obstacles and Enablers to the Professional Development of Skilled Birth Attendants: a Case Study of the SMRU"

T-CAB reference: TCAB-01/03/2015

The T-CAB reviewed the above study at the meeting held on 5th Dec 2015.

The committee confirms its favorable opinion of the study.

Yours sincerely



Mahn San Htwe
Meeting Chair

APPENDIX 3-DATA COLLECTION SCHEDULE

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|--|---|---|---|-------------------------------------|---------------------------------|---------------------------------|
| January 25 | 26 | 27 | 28 | 29 | 30 | 31 |
| Arrival | Introduction & Scheduling (Mae Sot) | Introductory Meeting (Mawker Thai) | Introductory Meeting (Maela) | Consent | | |
| February 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Consent | Personnel file review (Mawker Thai) | Personnel file review (Maela) | | Observation day 1 (Maela) | Observation day 2 (Maela) | Observation day 3 (Maela) |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| Observation day 4 (Maela) | Interviews (Maela) | Interviews (Maela) | Descriptive Summaries | Observation day 1 (Mawker Thai) | Observation day 2 (Mawker Thai) | Observation day 3 (Mawker Thai) |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| Observation day 4 (Mawker Thai) | Interviews (Mawker Thai) | Interviews (Mawker Thai) | Descriptive Summaries | Preliminary Analysis | Preliminary Analysis | Developing Focus Group Protocol |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| Obstetric & Management Focus group (Mae Sot) | SBA Focus group discussions (Mawker Thai) | SBA Focus group discussions (Mawker Thai) | SBA Focus group discussions (Maela) | SBA Focus group discussions (Maela) | Finalize Descriptive Summaries | Preliminary Analysis |
| 29 | March 1 | 2 | 3 | 4 | 5 | 6 |
| Preliminary Analysis | Preparation of Presentation | Presentation of preliminary results (Mawker Thai) | Presentation of preliminary results (Maela) | Departure from Mae Sot | Departure from Thailand | |

APPENDIX 4-OBSERVATIONAL GUIDE

| <i>Activities to Observe</i> | <i>Elements to Document</i> |
|--|---|
| <i>SBA staff meetings</i> | <ul style="list-style-type: none"> • Organization and content of meetings • SBAs responsible for meetings • SBAs who participate in meetings • Level of engagement and participation during meetings • Interactions between senior and lower-level SBAs |
| <i>Morning rounds with obstetrician</i> | <ul style="list-style-type: none"> • Frequency, timing, organization and content of rounds • Interactions between SBAs and patients • Interactions between obstetricians and patients • Delegation of responsibility for presenting cases amongst SBAs • SBA ability/confidence/will to develop and communicate a potential care plan • Work dynamics between obstetrician, seniors, and lower-level SBAs |
| <i>Morning rounds with neonatal medic</i> | <ul style="list-style-type: none"> • Frequency, timing, organization and content of rounds • Interactions between SBAs and patients • Interactions between medic and patients • Delegation of responsibility for presenting cases amongst SBAs • SBA ability/confidence/will to develop and communicate a potential care plan • Work dynamics between medic, seniors, and lower-level SBAs |
| <i>Management of labour & delivery</i> | <ul style="list-style-type: none"> • Interactions between SBAs and patients • Organization and delegation of tasks amongst SBAs • Work dynamics between senior and lower-level SBAs • SBA ability/confidence/will to develop and implement care plans • SBA ability/confidence/will to cope with emergency situations and implement appropriate protocols • Environment in labour room and delivery room |
| <i>Continuing care following delivery</i> | <ul style="list-style-type: none"> • Interactions between SBAs and patients • Organization and delegation of tasks amongst SBAs • Work dynamics between senior and lower-level SBAs • SBA ability/confidence/will to develop and implement care plans • Environment in postnatal room |

| | |
|---|---|
| <i>Handover between shifts</i> | <ul style="list-style-type: none"> • Organization of handover • SBAs responsible for handover • SBAs who participate in handover |
| <i>SBA training sessions</i> | <ul style="list-style-type: none"> • Frequency and topics covered by training sessions • Individuals responsible for conducting training session • Attendance at training sessions • Approaches used to convey training material • Level of engagement and participation during training sessions • Level of existing knowledge of the training material • Interactions amongst participants, and between participants and trainers • Environment in training rooms |
| <i>Transfers to Thai hospitals and/or Special Care Baby Units</i> | <ul style="list-style-type: none"> • Decision process for transfers • Individuals responsible for management of transfers • Interactions between individual providers in the implementation of transfer protocols • SBA confidence in implementing transfer protocols |
| <i>Consultation with obstetricians</i> | <ul style="list-style-type: none"> • Frequency, timing, and nature of consultations • Threshold at which SBAs deem fit to consult with the obstetrician • SBA ability/confidence/will to develop and communicate a potential care plan • Obstetrician’s attitude and approach towards consultation |

APPENDIX 5-INDIVIDUAL INTERVIEW PROTOCOL

Interview Guide

******add personalized questions based on personnel file review******

Background Info

- Do you have any children?
 - How Many?
 - Do they live with you?
 - How old are they?
- Where do you live? How far away is your home from the clinic?
- How long have you lived in Thailand?

Education

- Could you describe your educational trajectory prior to your enrolment in SMRU's SBA training programme?
 - Have you worked for, or been trained by, any other health care organizations?
- What kind of training have you received in the past year?
 - How has this training affected the way you work?
 - Can you describe whether or not you feel that you are receiving training that is in line with your needs?
 - Do you have any examples of situations where you received redundant training?
 - Can you identify any additional training that you think would be beneficial to your professional development?

Team

- How would you describe your current role within the team?
 - What role would you like to play within the team?
 - What, if any, changes would need to be made in order for you to adopt your desired role within the team?
- How are decisions usually made within the unit?
 - Do you feel comfortable asserting your opinion during this decision making process? Why?/Why not?
 - Do you feel that your superiors value your opinions? Why?/Why not?
- How would you describe your relationships with the other members of your team?
 - How do these relationships affect the role you adopt within the team?
 - When you have questions or concerns about your work, who do you talk to?
 - Is there anyone within the birthing unit that you particularly admire? What characteristics do you respect in her?

Communication

- Do you feel that you have enough English language skills to accurately convey your point of view to the doctors?
 - Can you provide any examples of situations where you wanted to answer a question, or explain something to a doctor but could not get your point across?
 - Can you provide any examples of situations where you made a mistake or could not complete a task because you did not understand what the doctor was asking of you?

Confidence

- How would you rate your confidence in your ability to make clinical decisions?
- How would you rate your confidence in your ability to perform procedures?
- Do you feel that you get a chance to practice and implement all of your skills on a regular basis?
- Do you feel like you are provided with opportunities to take ownership and responsibility for cases on a regular basis?
- Do you feel that your superiors have confidence in your abilities? Why?/Why not?
- Can you describe any situations or events that have boosted your confidence?
- Can you describe any situations or events that have hindered your confidence?
- Do you feel like you have the respect and trust of patients, or do you feel that you require the doctor's support to gain their respect and trust?

Motivation

- Do you enjoy your work?
 - What are your favorite parts of your job?
 - What are the most challenging parts of your job?
- Do you feel motivated to continue working hard within the unit?
 - Can you describe any situations or events that have boosted your motivation?
 - Can you describe any situations or events that have hindered your motivation?
- Are you able to establish a good work-life balance?
 - Are there any more personal factors that affect your ability to adopt the role you would like to within the team?

Enabling Environment

- Do you feel that you have been provided with the skills, support, and tools to fulfill your duties and continue to grow? How so?
- Do you feel that you receive adequate and constructive feedback from management regarding your strengths and weaknesses? How so?

For juniors and seniors

- Can you describe the process you went through to become a junior/senior midwife?
- What do you believe were the most important factors that enabled you to progress to higher levels of accreditation?
- What were the biggest challenges you faced in trying to progress to higher levels of accreditation?

For assistants

- What do you believe will be the most important factors that will enable you to progress to higher levels of accreditation?
- What do you believe will be the biggest challenges you will face in trying to progress to higher levels of accreditation?

Conclusion

- Is there anything else that you would like me to know that we have not yet discussed?

APPENDIX 6-OBSTETRICS AND MANAGEMENT FOCUS GROUP PROTOCOL

| <i>Focus Group Protocol - Management</i> | | | |
|---|---|---|--|
| <i>General</i> | <i>Recruitment and Retention</i> | <i>Promotion System</i> | <i>Hierarchy and Scope</i> |
| <p>-Based on your experiences, what are some of the biggest challenges SMRU faces in managing the birthing units and the midwives?</p> <p>-What are some of the biggest successes that SMRU has achieved in managing the birthing units and the midwives?</p> <p>-What strengths do the midwives exhibit?</p> <p>-What weaknesses do the midwives exhibit?</p> <p>-What are the main difference that you have noticed between the teams at Mawker Thai and Maela?</p> | <p>-What do you think are the main causes of the recurrent shortage of midwives SMRU faces?</p> <p>-Have you faced any challenges related to recruitment?</p> <p>-What do you perceive as the main causes of employee turnover/loss?</p> <p>-What do you perceive as SMRU's biggest assets in fostering employee retention?</p> <p>-What measures have been taken in order to mediate or resolve the workforce shortages?</p> <p>-How do you think that the current work schedule imposed onto the midwives affects motivation and retention?</p> <p>-How does the lack of official recognition of their training play into these workforce issues?</p> | <p>-What do you see as the benefits of the current promotion system?</p> <p>-What do you see as the weaknesses of the current promotion system?</p> <p>-What are the qualities you look for in midwives that you would like to promote?</p> <p>-How do shortages affect the promotional process?</p> <p>-Can you describe the current system that is in place to provide feedback?</p> <p>-How does funding affect your management of the birthing units?</p> <p>-How does the risk of resettlement or repatriation fit into your workforce planning?</p> <p>-Does the high rates of turnover affect your willingness to invest in the professional development of employees?</p> | <p>-How was the tiered system of accreditation developed for the midwives?</p> <p>-How was the scope of practice of the midwives defined?</p> <p>-How do you think that their dependence on higher-level health workers like medics and obstetricians affects their professional development?</p> <p>-Moving forward, do you think that widening their scope of practice would be feasible? How would this affect the birth units' workflow?</p> <p>-Can you think of any discrepancies between the training that the midwives have received and the work that they are expected to perform?</p> |
| <i>Language</i> | <i>Soft Skills</i> | <i>Physician Turnover</i> | <i>Community Attitudes</i> |
| <p>-How does the issue of language affect the way you work with the midwives?</p> <p>-Would anyone like to share examples of situations where the language barrier became a significant challenge?</p> <p>-Would anyone like to share examples of situations where the midwives exhibited resourcefulness in order to overcome the language barrier?</p> <p>-Moving forward, can you think of any ways to mediate or resolve this barrier?</p> | <p>-What elements of the current system enable the development of soft skills like leadership, confidence, and ownership amongst the midwives?</p> <p>-What elements of the current system impede the development of soft skills like leadership, confidence, and ownership amongst the midwives?</p> | <p>-How have physician supply issues affected the workflow of the birthing units?</p> <p>-Based on your experience, how does the arrival of a new doctor affect the birthing units?</p> <p>-How are physicians prepared to begin work at the sites?</p> <p>-As physicians who have recently arrived to SMRU, what challenges did you face in adjusting to this new work environment?</p> <p>-Can you identify any factors that facilitated this transition and your integration into the birthing unit?</p> | <p>-Can you describe the attitudes of patients and the community towards the services provided by the birthing units?</p> <p>-How do you respond to these attitudes?</p> <p>-How do you think that those attitudes affect the midwives and their work?</p> |

APPENDIX 7-SBA FOCUS GROUP PROTOCOL

| <i>Focus Group Protocol- SBAs</i> | | | |
|--|---|---|---|
| <i>General</i> | <i>Recruitment and Retention</i> | <i>Promotion System</i> | <i>Hierarchy and Scope</i> |
| <p>-Based on your experiences, what are some of the biggest challenges that you face working at SMRU?</p> <p>-What are some of the biggest successes that you have achieved working with SMRU?</p> <p>-What are the strong points of your team?</p> <p>-What are the weak points of your team?</p> <p>- Why do you think that there are such strong relationships within the team?</p> <p>-Based on your experience, have you noticed any differences between Mawker Thai and the other sites?</p> | <p>-Why did you choose to become a midwife?</p> <p>-What attracted you to apply to work at SMRU?</p> <p>-How does the fact that the SMRU training is not recognized affect you?</p> <p>-What are the main reasons why midwives have chosen to leave SMRU in the past?</p> <p>-What, if any, factors would make you consider leaving your job with SMRU?</p> <p>-How has the shortage of midwives affected your work?</p> <p>-How do you feel about your work schedule?</p> <p>-How do you feel about the salaries that SMRU provides?</p> <p>-What motivates you to choose to keep working with SMRU?</p> | <p>-What are some of the main challenges that members of your team have faced when trying to move up to the next level?</p> <p>-Can you think of any factors that helped members of your team move up to the next level?</p> <p>-Can you describe any difficulties you have had in trying to complete your logbook?</p> | <p>-How do you feel about having to consult with the medics or the doctors every time a patient has a medical complication?</p> <p>-Does the need to consult others to make decisions ever affect your confidence?</p> <p>-Would you prefer to be able to make more decisions independently? Why(not)?</p> <p>-Why do you think so many of you have more confidence in your practical skills than in your ability to make decisions?</p> <p>- When I speak with the doctors, they are so impressed with your work, so why do you think it is difficult for you to be self-confident and take on responsibility?</p> |
| <i>Skill Development</i> | <i>Relationship with Management</i> | <i>Physician Turnover</i> | <i>Community Attitudes</i> |
| <p>-How does the language barrier affect the way you work with the doctors?</p> <p>- What strategies do you use to try to cope with the language barrier with the doctors?</p> <p>-Why do you think it is difficult for you to take on training roles?</p> <p>-Why do you think that so many of you are interested in learning more medical knowledge?</p> <p>-Why do you think that so many of you are interested in learning more about family planning counselling?</p> | <p>-What did you think about the annual appraisal at the end of last year?</p> <p>-If the administrative team has to deliver feedback to you, what would be the best way for them to communicate this feedback to you?</p> <p>-If you have questions or concerns how would you describe your access to communication with upper management?</p> | <p>-How does the arrival of a new doctor affect your work?</p> <p>- Can you explain to me some of the challenges you face when a new doctor starts working at the clinic?</p> <p>-Can you think of any benefits that come from having working with many different doctors?</p> | <p>-Can you describe the attitudes of patients and the community towards the services that you provide?</p> <p>- The management team explained to me that most of the feedback that they get from patients and the community is positive so why do you think that the occasional negative comments affect you so much?</p> |