Developing collaborative healthcare education programmes for staff in low and middle-income countries: reaching consensus on the most effective approach

Progress update for BICC April 2020

It has been necessary to add another member to the review team in order to complete the reviews of articles and data extraction. Unfortunately, other team members were not available to take on the work due to other commitments:

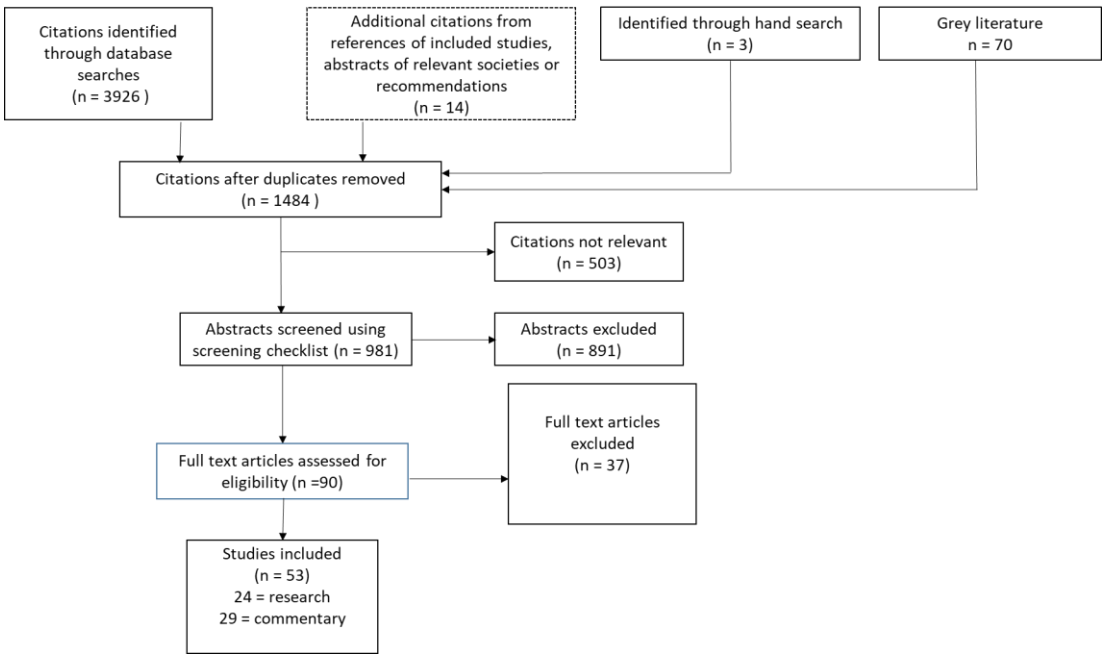
Dawne Gurbutt Professor of Collaborative Education, Head of Centre for Collaborative Learning

dgurbutt@uclan.ac.uk. Harris 112, University of Central Lancashire, 01772 893639

DG has a background in Public Health and community work in socioeconomically deprived areas and service user engagement in Healthcare education delivery. She has undertaken extensive collaborative work in clinical practice and in the education setting for Health and Social Care. She is also experienced in creativity in curriculum design and development around integrated and collaborative education and change management in implementation of educational innovation.

Included studies

In total, 53 studies have been included in the review from an original 1484 citations (after removal of duplicates) and 90 items which underwent full-text screening. Due to the wide range of studies accepted for the review – which includes conference abstracts and posters – they have been placed into two groups – research studies and commentaries. This was necessary as a large number of the studies either focussed on programme design or contained only minimal information, but they were nonetheless highly relevant. However, these studies could not be subjected to the same type of analysis as the research studies. We therefore modified the data extraction table and tool slightly to account for this. Whilst the data extracted from the two types of studies has mostly been analysed together, there are some aspects e.g. Kirkpatrick levels which are only applicable to research designs, and this will be made clear when discussing the findings. Both qualitative and quantitative studies were included in the review. The final PRISMA is provided below:



Key findings

Professions involved: the majority of the studies involved doctors, nurses, midwives or physiotherapists as either educators or learners. Other professions were included but often only for single studies. These other professions did include 'local' ones e.g. trained birth attendants as participants. 31 of the studies included multi-professional learners and/or educators. Two studies went beyond the inclusion of healthcare professionals to accommodate administrative staff, as these were viewed as key to the effective functioning of the healthcare delivery team.

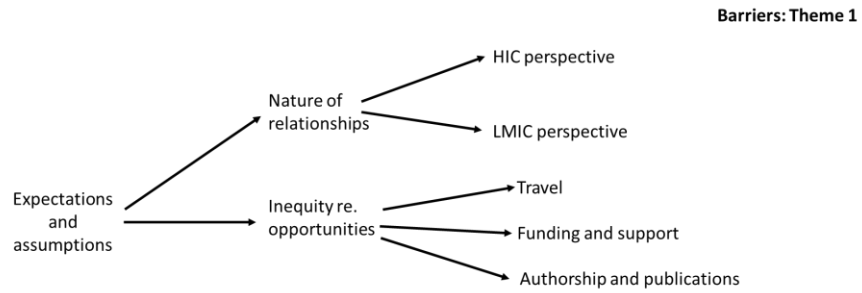
Participant numbers: these ranged from 1-4600, depending on the type of programme, the professionals involved and the methods of delivery. The median number of participants was 22.

Pedogogy and delivery approaches: despite the distances involved, in-person delivery (to either groups or individuals) was the most common approach. Various forms of distance learning, or a mixture of in-person delivery followed by distance support, were also used. Distance support could be either through the provision of materials or teaching delivery to a group, or through individual learner support. A wide variety of paedogogical approaches were used, with experiential learning, didactic delivery and collaborative learning being the three most popular. Paedogogy and delivery approaches were also influenced by the locations of programmes, their duration and patterns of delivery. Some programmes were taught entirely within educational settings, some were delivered entirely in clinical placements and others used a mixture of the two.

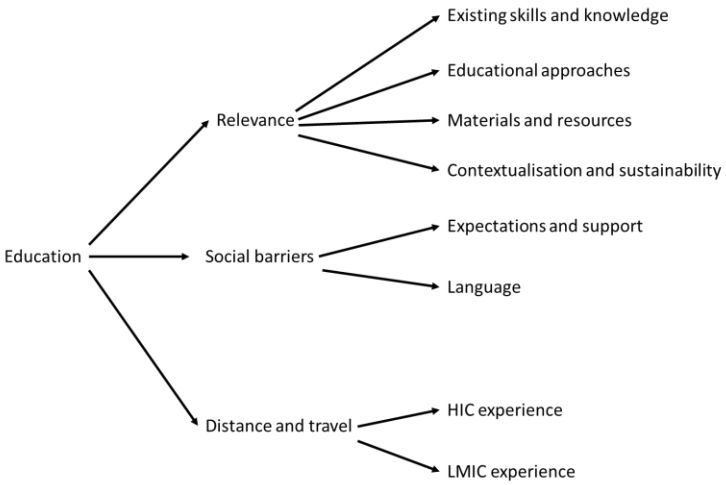
Study designs and levels of achievement (research studies): the most popular approaches were surveys (both qualitative and quantitative), pre-/post- and interviews. Research papers scored at all levels of Kirkpatrick's hierarchy with the majority being rated at either level 1 (indicating that participants enjoyed the education), level 2 (indicating improved knowledge, skills, confidence and attitudes in participants) and level 3 (indicating changed behaviours as a result of the educational intervention). The strength of conclusions for the majority of the research studies were rated as either very clear and likely to be based on the results or reasonably clear and probably based on the results.

Themes: Themes emerged from the data which either acted as barriers or enablers to collaboration. The themes are presented below and will be discussed in detail in the review:

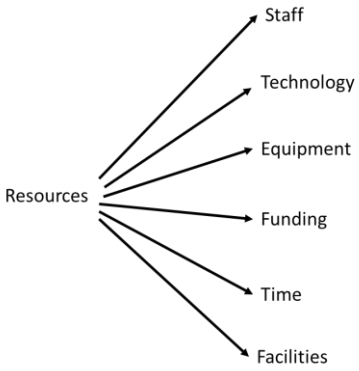
Barriers



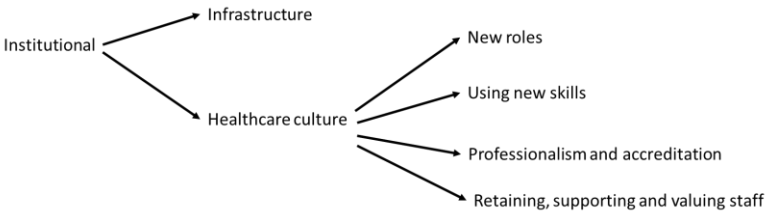
Barriers: Theme 2



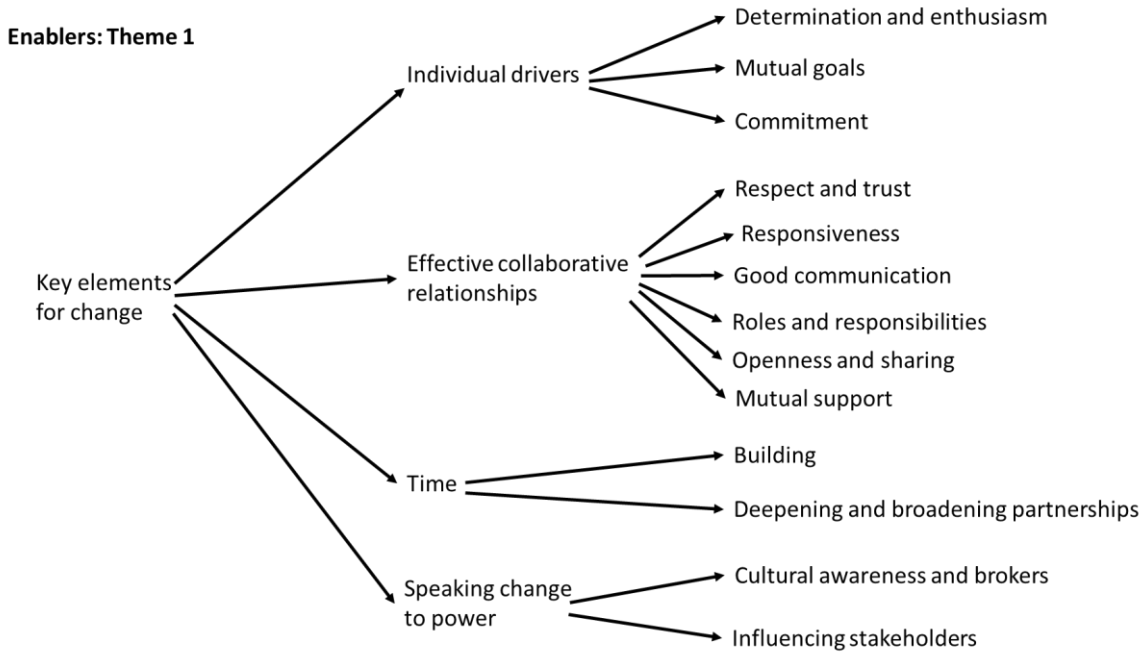
Barriers: Theme 3

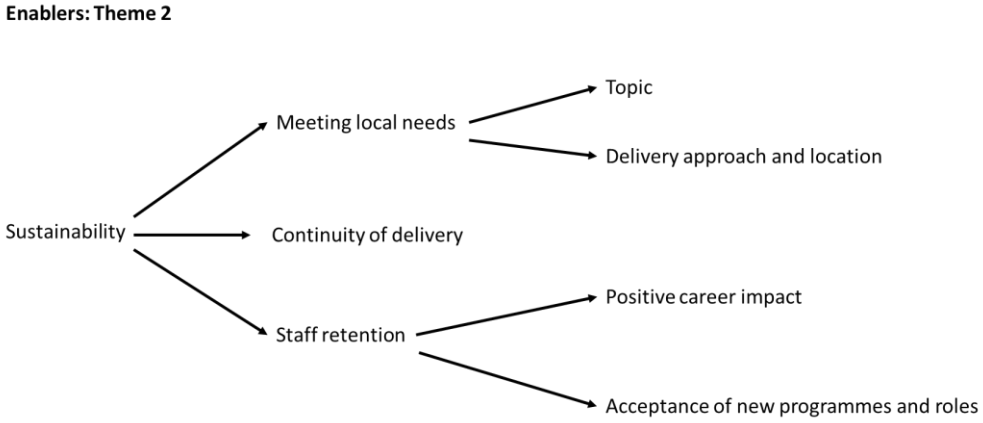


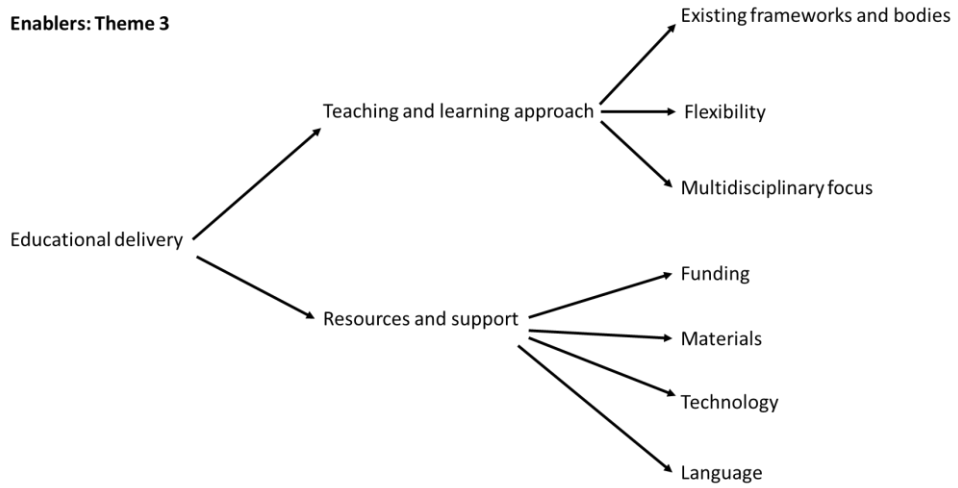
Barriers: Theme 4



Enablers


Enablers: Theme 1
Key elements for change
Individual drivers
Determination and enthusiasm
Mutual goals
Commitment
Effective collaborative relationships
Respect and trust
Responsiveness
Good communication
Roles and responsibilities
Openness and sharing
Mutual support
Time
Building
Deepening and broadening partnerships
Speaking change to power
Cultural awareness and brokers
Influencing stakeholders


Enablers: Theme 2
Sustainability
Meeting local needs
Topic
Delivery approach and location
Continuity of delivery
Staff retention
Positive career impact
Acceptance of new programmes and roles



Quality of studies: data has yet to be explored and analysed.

Attachments: data extraction tables for both research and commentary papers

Remaining work: all necessary data has now been extracted from the studies and more detailed analysis needs to be completed, including examination of data which is not mentioned in this report. Conclusions need to be drawn and the final report prepared and submitted by September 2020. It is anticipated that the majority of this work will be completed by the end of June 2020 and that the final report will be available ahead of the agreed submission date.