Nurse Education Today 75 (2019) 47–52

Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/locate/nedt

Learning about midwifery in another country from a distance: Evaluation of a virtual classroom learning session

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ARTICLE INFO

Keywords:
Midwifery education
Midwifery students
Distance learning
Online learning
Virtual classroom
Synchronous chat rooms
Cultural awareness
Content analysis

ABSTRACT

Background: Studying abroad promotes cultural awareness and understanding of different healthcare settings and practices but family or financial constraints prevent some students from taking advantage of these opportunities. We developed a virtual classroom learning session to give Danish and Irish midwifery students an opportunity to explore midwifery and maternity care in another country.
Objectives: To evaluate the content of midwifery students' chat room discussions about the differences in maternity and midwifery care during an international online learning session, and their opinions of the session.
Participants: 27 Danish and 37 Irish undergraduate direct entry midwifery students.
Methods: Content analysis of students' chat room discussions and post-session survey.
Findings: Students engaged enthusiastically in the chat room discussions throughout the session. Almost all of the interactivity was between students themselves, and questions raised by students from one country were answered by students in the other country. Discussions centred on the lecture content, rates of interventions and birth outcomes, but developed into broader issues relating to one-to-one midwifery care during labour, factors that facilitate normal birth, national data availability, staffing levels, and financial and cultural aspects of having children at earlier or later ages.

In the survey, students described the session as awakening curiosity and a fun way to learn. They found it 'cool' to talk with real students from another country, a memorable way of discussing differences between the two maternity care systems and expanding knowledge. Negative comments related to technological problems.
Conclusion: An international virtual classroom learning session can give midwifery students insights into midwifery elsewhere, stimulate curiosity and be an engaging way to learn. Our students' experiences show that it can offer a real, engaging and positive learning experience and enrich students' knowledge of cultural differences.

1. Introduction

Studying abroad offers midwifery students opportunities to learn about cultures and practices in other countries but family commitments or financial constraints prevent some students from taking advantage of these opportunities. To give Danish and Irish midwifery students an opportunity to learn about midwifery and maternity care in another country, we devised a virtual classroom (VC) learning session that comprised of a lecture with synchronous chat room discussions, and full and sub-group discussions. This paper presents an evaluation of the content of students' chat room discussions and their opinions of the session.

2. Background/literature

The benefits of studying abroad during pre-registration midwifery or nursing education programmes include personal and professional development and enhanced cultural competence (Goodman et al., 2008; Green et al., 2008; Milne and Cowie, 2013; Brown et al., 2016; Marshall, 2017), feeling empowered to initiate practice developments (Bohman and Borglin, 2014; Marshall, 2017) and enhanced professional identity and employment opportunities (Green et al., 2008; Kelleher et al., 2016). However, studying abroad can be prohibitively expensive (Goodman et al., 2008; Maltby et al., 2016). International online learning offers students alternative opportunities to learn about another country's healthcare system and culture from a distance, enables them to reflect on their own country's system and culture, and can

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https://doi.org/10.1016/j.nedt.2019.01.007
Received 8 December 2017; Received in revised form 12 December 2018; Accepted 21 January 2019

promote the development of cultural competence (Arbour et al., 2015). The midwifery, nursing and health education literature shows that online learning is used, mainly, to give students access to information and support face-to-face teaching but remains a peripheral part of their education (Moule et al., 2011). Web conferencing platforms enable the creation of a VC that is an effective teaching and learning strategy for, and popular with, undergraduate students because they can interact simultaneously in audio or text 'chat rooms' and discussions. Some students also feel more comfortable expressing opinions in a VC, and this increases their learning potential (McBrien et al., 2009). In nursing and midwifery education, VCs have promoted high levels of interaction, collaboration and academic engagement between students, primarily because interactions are synchronous i.e., in real-time (Andrew et al., 2015, O'Flaherty and Timms, 2015). From a midwifery perspective, synchronous interaction, enabled by web conferencing software, has been used for continuing professional development and learning in online conferences (Vilain and Stewart, 2012), to share knowledge and experiences internationally (Sidebotham et al., 2015) and create global learning networks (Stewart et al., 2012a; Stewart et al., 2012b). Despite these potential benefits, there is little research on synchronous online learning in VCs being used to enhance midwifery students' awareness of another country's culture, in an international context.

3. Midwifery in Denmark

Maternity services are free to all women resident in Denmark. In 2012, the population was 5.592 million (http://ec.europa.eu/eurostat/), and the birth rate was 10.2 per 1000. There were 24 hospitals with maternity facilities with annual births ranging from 770 to 6660 (Det Medicinske Fødselsregister, 2015), and homebirths accounted for 1.39% of all births. Midwifery education was regulated in 1672, and the Danish Midwifery School was established in 1787 with a direct entry programme (Cliff, 1997). The University College Copenhagen was established in 2008. The Bachelor programme is based on the national curriculum, established in 2001 and revised in 2009 (The Danish Midwifery Education, 2009), and practice placements take place in one of several hospitals. Midwives have a strong tradition as independent practitioners with a broad autonomous scope of practice (Sundhedsstyrelsen, 2001a; Sundhedsstyrelsen, 2001b).

4. Midwifery in the Republic of Ireland

Maternity services are free to all women resident in Ireland, although women may attend for care privately. In 2012, Ireland's population was 4.587 million (http://ec.europa.eu/eurostat/), the birth rate was 15.5 per 1000, there were 19 maternity hospitals/units with annual births ranging from 1400 to 8500, two along-side midwifery-led units and 0.2% of births took place at home. Following the enactment of the 1950 Nurses Act (Government of Ireland, 1950), midwifery struggled to regain independence from nursing, and the journey to legislative recognition as a separate profession (Government of Ireland, 2011) is well documented (Daly et al., 2006; Daly and OBoyle, 2010). Trinity College Dublin (TCD) was established in 1572, the School of Nursing and Midwifery was established in 1996 and the four-year BSc midwifery education programme was introduced nationally in 2006. Practice placements take place in one of two linked stand-alone maternity hospitals, both of which have ≥8500 births per annum.

5. Session aim, content and organisation

5.1. Aim

To offer Danish and Irish midwifery students an opportunity to explore the cultural differences in maternity and midwifery care in a VC learning session.

5.2. Lecture content and organisation

The session took place in March 2015. The 45-min lecture content was student-directed and included 2013 data, from both countries, on the maternity services and birth outcomes. The full 2-h session was moderated by AD (Denmark), the lecture was delivered by DD (Ireland), and AMR (Denmark) delivered the Danish data. The session's structure and lecture were shared with midwifery students in advance and planned to supplement students' core education on international midwifery issues. At the time of the session, the programme in TCD included a one-week elective placement, undertaken in Ireland or abroad, and the content on international issues was delivered in lectures. In Denmark, the session was part of a multidisciplinary module on the organisation of the health system and cooperation between professions. Midwifery students had an opportunity to undertake placements abroad and could apply for student exchange funding, but few students actually availed of these, primarily due to financial reasons.

Students in both countries identified the lecture content and were asked to prepare questions they would like to discuss with students in the other country.

During the lecture, midwifery students were asked to;

(i) identify and discuss the similarities and differences between the place and mode of birth in both countries
(ii) discuss their perceptions of how the maternity care system impacts on learning to be a midwife/midwifery practice
(iii) ask any other question of their choice to students in the other country
(iv) The lecture was followed by a 30-min full-group chat room discussion, then by sub-group chat room discussions.

5.3. Technology

We used the web conferencing software (Adobe Connect). Information on how to participate was shared with students in advance. The VC was designed with the lecture slides in the centre, and live videos of the lecturers, a list of attendees and a large chat room on either side. Students could ask and respond to questions in the chat room, and orally. Eleven chat rooms were designed for the sub-group work.

5.4. Post-session survey

The session was evaluated using an online anonymous survey which was shared with students in advance and incorporated their suggestions. Students were asked to identify (i) what they learnt, if anything; (ii) three things that were good; (iii) three things that were not so good, (iv) three things that would have improved the session, and (v) content for future sessions. The survey was administered in the English language on Survey Monkey®.

6. Methodology

We used a conventional approach (Hsieh and Shannon, 2005) to analyse the content of midwifery students' chat room discussions and a line-by-line approach to extracting key words and terms. Students' opinions of the session were evaluated using an online anonymous survey.

7. Ethics

According to the '*Danish Act on Research Ethics Review of Health Research Projects*', Section 2 (http://www.nvk.dk/english/act-on-research), this evaluation did not constitute a health research project and could be initiated without approval from the Committees on Health Research Ethics for the Capital Region of Denmark (confirmatory

correspondence available).

8. Recruitment and consent

Fifty four midwifery students attended the session. The 27 Danish students were in the second year of the 3.5-year bachelor programme, studying at the Metropolitan University College, Copenhagen (now University College Copenhagen). The 37 Irish students were in the third year of the 4-year BSc programme, studying at TCD.

Twenty-seven students completed the survey. The purpose of the anonymised survey was outlined at the start and end of the session, and students were assured that no individual information, only country of study, was requested. Individual student names were removed from the transcript of the chat room discussions prior to the analysis.

9. Data analysis

The chatroom discussion content resulted in 14 A4 pages of text and was analysed independently by two authors, DD and AD. Both authors read and re-read the text and, using a line-by-line approach, extracted keywords and quotations and identified emerging themes. DD and AD then compared and agreed findings and relevant verbatim quotations. The three themes that emerged were labelled using students' own words.

The survey was also analysed independently by two authors, DD and AD. Findings were compared and discussed, quotations agreed, and presented under the relevant survey headings.

10. Findings

10.1. Chat room discussions

Students' discussions focused on three key themes: (i) age of women birthing; (ii) data availability and transparency, and (iii) one-to-one midwifery care during labour.

10.2. Age of women birthing

In 2012, almost one in five first-time mothers in Ireland, and almost one in ten in Denmark, were aged 35 years and over. Students discussed the possible reasons for these age differences; Danish students suggested it was '*easier*' to have children at an earlier age, and while studying, because the State provided financial support. Irish students suggested that it was '*culturally*' acceptable to give birth later because (some) women wished to '*feel secure in their career*' before having babies and that many women '*put off having their family for financial and career reasons'*. During this discussion, students also asked and answered questions on availability, or not, of termination of pregnancy in each country.

10.3. Data availability and transparency

The availability of national data, definitions used, epidural anaesthesia and mode of birth rates generated the most discussion. In Denmark, the spontaneous vaginal birth (SVB) rate, defined as birth without epidural anaesthesia, episiotomy, third or fourth degree perineal tear etc., was 50.0%, the rate of SVB complicated by episiotomy, epidural anaesthesia, multiple births, preterm births etc., was 19.0%, the instrumental vaginal birth (IVB) rate was 7.0%, the caesarean section (CS) rate was 21.0% (planned CS = 10%, emergency CS = 11%) and the homebirth rate was 1.39%. National perinatal statistics data are publicly available in Ireland, but do not include rates of epidural anaesthesia, episiotomy, third or fourth degree perineal tear etc., therefore, data from the annual reports of TCD's two linked maternity hospitals were presented. The epidural rate for nulliparous women in these two maternity hospitals was 55.8% and 73.0% respectively, the national SVB rate, which includes births using epidural anaesthesia, episiotomy etc., was 40.5%, the IVB rate was 29.1%, the CS rate was 30.0% and the homebirth rate was 0.2%.

Danish data are accessible from the National Health Board's website, and Irish students expressed dismay that similar data were not publicly available, especially interventions rates. They described the Danish definition and SVB rate as '*awesome*'.

Danish students suggested the epidural rate was low because midwives '*focus on the natural childbirth…encourage women to move around and use alternatives such as showers, warmth etc.',* and that *'Entonox* [Nitrous Oxide] *alone is sufficient for many women'*. An Irish student commented *'yes we do use gas but epidural figures are higher than in Denmark - just curious why?'* A Danish student replied stating that they *'spend a lot of time talking with, preparing and informing women about risks of epidural anaesthesia antenatally'* and while the epidural rate is increasing, '*many women wish to have natural birth*'. Irish students said they also '*encouraged mobility and alternative pain management methods during labour'*, however, some suggested that epidural anaesthesia was perceived (by women) as '*great*' and that *'the first thing people say to pregnant women is to get an epidural because they won't feel a thing*'. Irish students concluded that they (and midwives) needed to rethink the way women are informed about epidural anaesthesia.

10.4. One-to-one midwifery care during labour

The discussion on mode of birth led onto discussions on intrapartum midwife-woman staffing levels/ratios. Danish students stated that women in active labour '*always*' have one-to-one care, and Irish students stated that while one-to-one care was '*usual*' (in one hospital), midwives might care for two women, especially if they have a student to help. They also discussed having a known midwife in labour, and staffing levels on antenatal and postnatal wards.

Most of these discussion topics were raised as questions in the chat room by a student from one country and answered by a student in the other country, with minimal interaction from the lecturers. By way of illustrating this dynamic conversation and discussion, an Irish student asked why epidural rates are so low in Denmark, another Irish student asked *'continuity of care I wonder?',* a Danish student replied *'In Denmark midwives focus on the natural childbirth and trying opportunities other than epidurals…',* another Danish student agreed stating *'I think you are right in the thoughts about how we inform pregnant women* [antenatally]', another Danish suggested that it may be *'a cultural thing - many women in Denmark wish for at natural birth*' while another Danish student suggested '*I also think midwives in Denmark might wait longer to propose epidural – we try almost everything else first'.* This prompted another Danish student to ask '*don't you talk to woman one to one in the antenatal time?',* and an Irish student responded *'yes we do. At booking and at clinics. Probably not enough of the right discussions'.*

When a Danish student stated *'when you are in active labour, you have one midwife for your own',* an Irish student replied *'wouldn't that just make such a difference in Ireland!'.*

10.5. Session evaluation

Twenty-seven students, 11 Danish and 16 Irish, completed the survey.

10.6. What students learnt from the lecture

Most students said they learnt from comparing the two countries' systems and data. One Irish student commented that '[it is] *better to be a midwife in Denmark! Cultural differences were apparent*', while a Danish student said '*that the system - both health and school - influences our education and the choices we make'* and that *'midwifery is nice in Ireland too!'*. Eleven students described the content as interesting because it compared systems and outcomes. Students said '[it] *awoke my curiosity'*

(Danish student); '*it was good to see differences between intervention rates, learn about their* [Danish] *hospitals*' (Irish student); '*there is quite some differences in the education and work of midwives in Ireland and Denmark, even though we're not that far apart*' (Danish student); '*it was very interesting to compare with the Irish students*' (Danish student), and that '*comparing and contrasting the two systems was a big eye opening experience*' (Irish student).

10.7. The difference between the two countries

The key differences identified were in relation to interventions and birth outcomes. One Irish student described Denmark's data as '*stuff we could only dream of at present'*, highlighting '*no forceps in Denmark, normal uncomplicated births, such a high rate for including no epidurals etc. - absolutely amazing considering Ireland's levels aren't as high and they include epidurals etc. Home birth rate - amazing figures from Denmark'*. Another Irish student listed specific differences in service configuration, intervention rates and birth outcomes, and qualified this by saying '*None the less both systems seemed to have a strong respectful and passionate desire for providing best care within the existing system to women'*. The impact on learning to be a midwife in these two different systems was described in terms of pros and cons: '*Danish students have more experience in SVDs, homebirth and woman centred care. Ireland is a lot more medicalised in nature and so the students may not be as skilled with natural techniques and methods as the Danish students. Similarly, Danish students may not be as experienced in abnormalities or medicalised birth'* and that '*both are catering for different requirements and systems*' (Irish student). One Danish student stated '*I think I remember an Irish student saying that they don't get to attend home births - and I think that is a very important part of learning how to be a midwife, so that's a very big difference between IE* [Ireland] *and DK* [Denmark]'.

The Danish system was described as appearing '*more holistic as it encompassed aspects like homebirth, less medial intervention and more woman centred care*' (Irish student), and that this may lead to Danish students being '*more relaxed, calm and skilled in certain areas compared to the Irish students who are exposed to medicalised birth and as a result may burn out quicke*r'.

10.8. Three things students said were good about the session

Seventeen students enjoyed being able to '*talk*', '*chat*' or '*communicate*' during the lecture; one Irish student described this as enabling her to '*discuss ideas as they happened*'. Others '*enjoyed meeting students from another country*' (Danish student), '*connecting with international students*' (Irish student) and found it '*cool to talk with midwife students from another country*' (Danish student). The session was '*a memorable way of talking about the differences*' (Irish student); '*expand*[ed] *our knowledge of difference settings from real active midwives/students*' (Irish student); '*a nice social exercise in learning*' (Irish student), and '*a great variation that makes studying fun*' (Danish student).

10.9. Three things students said were not so good about the session

Nineteen students commented on aspects that were *not so good*, almost all of which related to the technological problems; '*Getting the hang of how everything worked meant it took a while to get going*' (Irish student) and *'patience is necessary!'* (Danish student).

10.10. Three things that would have improved the session

Most said they would have liked more time in the groups, and a '*trial run with the technology'* might have prevented the delay at the start. Two students, one from each country, would have liked advanced *'preparatory work'* so that they could have *'prepared the answers at home before the session'* (Danish student) because '*this would have contributed to the discussion*'. Two students, one from each country, would have liked the data from both countries presented on the same slides and '*more time to discuss differences*'.

10.11. Suggested content of future sessions

Students were asked to suggest content for future sessions, should the possibility arise, and three clear topics/areas emerged: (a) midwifery and midwifery student-related issues; (b) intervention and birth rates, and (c) legislative issues.

10.12. Midwifery and midwifery student-related issues

Irish students would like content on the '*current challenges for students and midwifery*' and the '*difficulties students face studying midwifery'*. They would like more content on the role of the midwife in Denmark because '*they see primarily home births and midwifery-led care while we see primarily obstetric-led care!*' and how *'having home birth as part of the Danish student's training, enhances their training*'. One Irish student *'would have loved to have found out whether the students in Denmark see primarily home births or do they work in obstetric-led facilities for long as students*?' Another Irish student felt '*that Denmark had a much better normal birth rate compared to us and would have loved to discuss why the students feel they have such a good rate. I would have liked to find out if they get to assist at home births as part of their training*'. In general, Danish students would like content on '*how midwives work in Ireland (do they have independent midwives, are there independent clinics…)*'.

10.13. Intervention and birth rates

Most students would like content on intervention rates and birth outcomes, similar to the content in this lecture. One Danish student suggested '*…what you do to prevent tears, what you do to make the women comfortable, what you do for unmedical pain relief how many labours, and why labour is induced*'.

10.14. Legislative issues

Suggested legislative issues related to professional regulation, availability of abortion and surrogacy. Specific topics identified were; '*the values and virtues in midwifery* [and] *laws and regulations relevant to midwives in Denmark and Ireland*' (Danish student) and '*surrogacy, abortion, rates and limits in their country* [Denmark]' because '*Danish students asked about abortion in the larger group chat*' (Irish student).

11. Discussion

This VC learning session gave Danish and Irish midwifery students an opportunity to meet virtually and discuss cultural differences in midwifery and maternity care. From the students' perspectives it was a new and engaging learning environment. Students joined the chat room with a palpable enthusiasm and remained actively engaged throughout. In Christianson et al.'s (2002) study, staff felt there was more interactivity in their online course than in a conventional face-to-face classroom and this would seem to be borne out in our evaluation. Synchronous online systems, such as VCs, can empower students to interact and engage in conversations in ways not possible in face-to-face lectures (McBrien et al., 2009). In our session, almost all of the interactivity was between students themselves and lecturers were asked for clarification on just three occasions. Students in one country responded to the questions and chat room comments from students in the other country using a wide range of emoticons to express reactions. In the post-session survey, some students said they liked being able to raise questions as they thought of them, something that can be difficult to achieve in face-to-face sessions. Others have found that students, even shy students, engaged more readily in a VC environment that in face-to-face lectures (McBrien et al., 2009; Andrew et al., 2015). It was

apparent that the actual lecture was merely a starting point for discussions; students took ownership of the discussion, and described it as making learning '*real*', '*engaging*' and '*interesting*'. For example, when the slides containing data from each country were presented, students commented on the age of women birthing in each country. Without any prompting, this stimulated discussion on related cultural and financial issues as to why women may postpone motherhood. The slides on intrapartum interventions and mode of birth stimulated discussion on data available in each country. Data on the proportion of women who used epidural anaesthesia led to discussions on supporting women in labour, approaches used to help women avoid pharmacological interventions and one-to-one intrapartum midwifery care. Williamson et al. (2009) also found that web conferencing, such as the VC, was popular with midwifery students, while Arbour et al. (2015) found that VCs increased their sense of immersion into a community. It is possible that learning about another country's practices in the VC's synchronous real-time, discussions gave our students a sense of being part of a wider 'midwifery student' community and immersion in another culture, which might deepen their cultural and critical awareness.

12. Limitations

Limitations relate to technological problems, experienced on two levels; it took time to become familiar with the technology, and an internet outage occurred in the latter part of the session. The delay in starting the session arose because some students lost connection, could see but not hear the moderator or could not see the lecture content. TCD's midwifery students were on site and, while they were located in different areas, all used the university's WIFI which is less stable than a wired connection.

Without technological constraints, students may have established ongoing or stronger networks and exchanged contacts.

13. Recommendations

Lectures in virtual classrooms should be planned with periodic pauses so that students can discuss the content as it is delivered. Allocating time for group discussions, where students can exchange experiences, is vital. Having a moderator, i.e., a person whose sole role is to oversee the chat room discussions and questions, eliminates the challenges of delivering the lecture while simultaneously following students' discussions.

14. Conclusion

Students actively engaged in chat room discussions throughout the session, and their evaluations were positive. The virtual classroom offered opportunities to interact and learn collaboratively, and it was the combined audio, visual and written real-time interaction that students found engaging and enjoyable. Learning in a virtual classroom is not a replacement for real immersion in another country's system and culture, but our students' experiences show that it can offer a real, engaging and positive learning experience and enrich students' knowledge of cultural differences. Being able to discuss midwifery in an international context also allows students to reflect on their own developing identity as they become midwives.

Authors' contributions

All authors contributed to the design and content of the session and the online survey. AD moderated the session, and the chat rooms in the full and small group sessions.

DD and AD analysed the data from the chat room discussions and the online survey.

DD and AD drafted the manuscript, and all authors approved the final version.

Acknowledgements

We wish to acknowledge the midwifery students in both countries, and thank them sincerely for their input into identifying the lecture's and online survey's content, and for their enthusiastic participation.

Funding

This evaluation did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

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