

UNIVERSITY OF THE WESTERN CAPE

FACULTY OF COMMUNITY HEALTH SCIENCE

RESEARCH REPORT

Title: The development of a framework to align theory and practice to improve midwifery education in the Western Cape

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KEY WORDS

Alignment

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Practice

Professional nurse

Student

Theory



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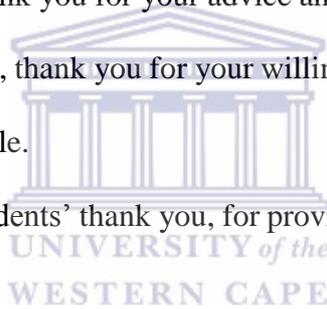
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Specifically, to all my nursing students' thank you, for providing me with the opportunity to teach you what I know and love!



DECLARATION

I declare that “The development of a framework to align theory and practice to improve midwifery education in the Western Cape” is my own work, that it has not been submitted for any other degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

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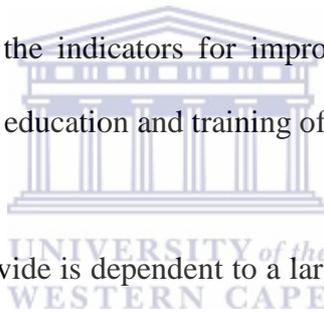
Date: April 2017

Signed:



ABSTRACT

Midwives play a critical role in the care of pregnant women from the first antenatal visit, through to the delivery and the postpartum period. The education of midwives has however become a concern, not only in South Africa but in many countries for a multitude of reasons. Evidence suggests that South Africa is devoted to reducing the maternal mortality rates as reflected in the Negotiated Service Delivery Agreement, signed in 2010, which identifies reductions in maternal and child/neonatal mortality rates as key strategic outcomes for the South African Health sector. However, by 2015 the set Millennium Development goals, specifically goal 4 (to reduce child mortality) and 5 (to improve maternal health) were not met and were replaced by Sustainable Development Goals, specifically goal 3 (to ensure healthy lives and promote wellbeing for all at all stages). This lag in meeting the indicators for improving the health of the population is associated in some respects to the education and training of health professionals.



The quality of care midwives provide is dependent to a large extent on the training they receive. The annual maternal deaths worldwide due to complications in pregnancy and childbirth are alarming. Midwifery education must be evaluated with the intention to identify the challenges and to implement improvement plans. A review of midwifery curricula, educational resources, and supervised exposure to clinical practice is warranted.

Thus the purpose of this study was to develop a framework to align theory and practice for improved midwifery education in the Western Cape. To achieve the purpose of the research the objectives focused on establishing the experiences of the community service practitioners regarding midwifery education and their perceived competence to provide safe maternal care; exploring the views and perceptions of nurse educators (lecturers and clinical facilitators) regarding the education of midwives to deliver safe maternal care; establishing the nurse educators

and professional nurses views on the community service practitioners' competence to provide safe maternal care and to determine possible gaps in the education of midwives that could preclude the provision of safe maternal care.

A qualitative exploratory, descriptive and theory generative research design was employed to meet the study purpose and objectives. The research was conducted in two phases. Phase one was the exploratory descriptive phase during which data was collected from two (2) focus group interviews with community service practitioners; and twenty nine (29) in-depth interviews with midwifery educators, (lecturers, and clinical facilitators) and professional nurses who were purposively sampled. Data was analysed inductively using the steps described by Thomas (2003). The themes generated from the data of all participant groups highlighted several challenges in the midwifery education programme which spanned both theory and practice. Lincoln and Guba's (2008) model for establishing trustworthiness was used, namely credibility, transferability, dependability and confirmability.

Phase two followed a theory generative design which culminated in the development of the framework by the following three steps. Step one -concept synthesis- focused on the identification, classification, and the definition of major concepts generated in phase one. A total of twenty one concepts were identified. These concepts were then further synthesized into five main concepts.

Step 2 - Statement synthesis - focused on the development of relational statements and Step 3 - Theory synthesis – focused on the process of framework development.

The context for which the framework was developed and the assumptions of the framework were discussed. An overview of the framework, its purpose, structure and the guidelines to operationalize the framework are described.

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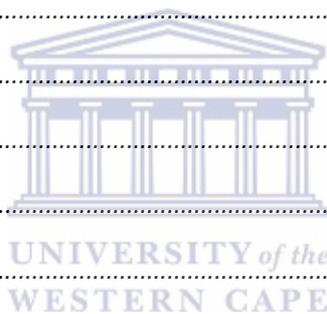


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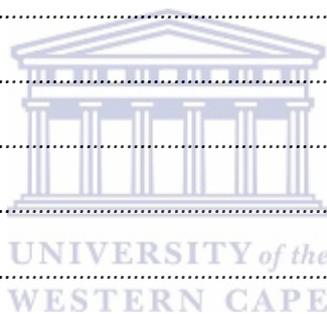


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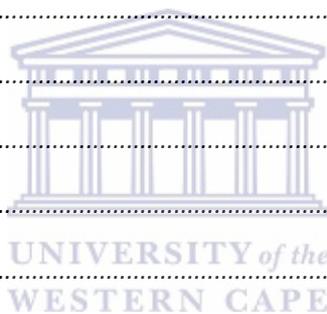
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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Maternal mortality is the health indicator with the most disparity between developed and developing countries, a woman in West and Central Africa is one hundred and twenty times more likely to die from pregnancy related complications than a woman in a developed country United Nations Population Fund (UNFPA, 2016). Recent evidence suggests that South Africa is devoted to reducing the maternal mortality rates as reflected in the Negotiated Service Delivery Agreement, signed in 2010, which identifies reductions in maternal and child/neonatal mortality rates as key strategic outcomes for the South African Health sector (Delivery Agreement, 2010). Globally, the Millennium Developmental Goals adopted in 2000 were instrumental in focusing resources in low and middle income countries to promote the health and well-being of both mothers and babies. In 2014, the United Nations highlighted (UNFPA, 2014) that even though both maternal and child mortality rates have declined significantly the set targets were not reached. Then, in 2015 the Millennium Development Goals were superseded by the Sustainable Goals of which goal number three to “Ensure healthy lives and promote wellbeing for all at all stages” is of significant importance (United Nations Development Programme, 2015).

Midwives play a critical role in the care of pregnant women from the first antenatal visit, through to the delivery and the postpartum period. The role of the midwife is multifaceted and it confers many advantages over obstetrical care, in that it is expected of midwives to:

- Understand and facilitate normal childbearing;
- Spread health and well-being to women and their families;
- Support, facilitate and implement the women's choice;
- Understand the range of normal maternal, foetal and neonatal well-being;
- Not to implement interventions not based on sound evidence;
- Critically appraise the evidence-base for midwifery knowledge and practice;
- Diagnose factors that may adversely affect maternal or foetal well-being;
- Locate appropriate support or interventions while providing sustained family support;
- Manage skilled emergency interventions;
- Assist during bereavement; and
- Be a resource for women and their families (Fraser, Cooper & Nolte, 2010).

Fundamentally, the quality of care provided by midwives is directly linked to the personal and professional development of student midwives. Data from several studies (ICM, 2008; WHO, 2015; Koblinsky, Chowdhury, Moran, & Ronsmans, 2012) have identified that midwives have a major effect upon the well-being of women as the practice of midwifery remains the core form of care-delivery to most women globally, particularly in poor and under-served areas. The announcement therefore by Black, Curzio, and Terry (2014), that higher educational institutions are failing to deliver skilled midwives for the modern health care system, dictates an enquiry into midwifery education programmes. This is crucial because midwives are the one group of health care workers that can impact on maternal patient outcomes.

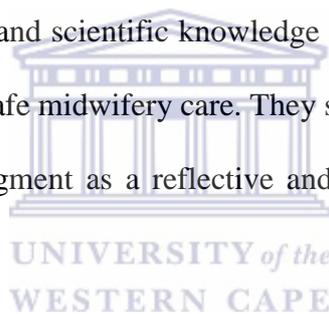
1.1.1 Midwifery education

Midwives have been part of the human experience for as long as we know. The midwife is mentioned in the Book of Genesis, 35:17: “And when she (Rachel) was in her hard labour, the midwife said to her, fear not for now you will have another son.”

The education of midwives has however become a concern, not only in South Africa but in many countries for a multitude of reasons. In some countries (Lopes, Nove, Hoop-Bender, de Bernis, Bokosi, Nester, Moyo, & Homer, 2015), as in South Africa, the education and training of midwives is currently offered as part of the integrated four year undergraduate nurse training programme, formulated according to Regulation 425, as promulgated by the Nursing Act 33 of 2005. This programme provides for simultaneous qualifications in general nursing, psychiatry and community health care nursing as well as midwifery. While there were good justifications for making it a practice to have health professionals doubly qualified and multi-skilled, there are also a number of drawbacks (Schoon & Motlometsi, 2012). Amongst others - the inclusion of midwifery into the nurse training programme can lead to it being viewed as an addition to nursing. Consequently, a student learning midwifery is afforded very little academic time for it within the curriculum. Currently, midwifery training at some institutions only extends a period of six months. In addition, by virtue of the structure of the Bachelor of nursing programme in which midwifery is one of the qualifications the student will be registered for on completion - midwifery education can be viewed as being indirectly forced upon students who may not have an interest or passion for working in a midwifery environment (Schoon, Motlolometsi, 2012 and Woods & Theron 2012). In this regard, Woods and Theron (2012) concur with Schoon and Motlolometsi (2012) who argue that the inclusion of midwifery into the education programme of nurses has a detrimental outcome on the quality of midwifery. They further argue that it is not guaranteed that

such nurses would hold and display the necessary motivation, passion and drive for midwifery practice.

Some global education practices which are dissimilar to that of South Africa, include New Zealand where midwifery education and nurse education are seen as separate professions (Schoon & Motlolometsi, 2012). In order to be registered as a midwife, students must complete a minimum of one thousand five hundred theoretical hours as well as a minimum of one thousand five hundred clinical practice hours, in a variety of clinical placements. Competence to practice as a midwife is evident when the student has attended to 30 – 60 births, demonstrating the ability to work in partnership with the woman throughout the maternity experience. The students are then able to apply comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care. They should also be able to demonstrate the ability to apply professional judgment as a reflective and critical practitioner when providing midwifery care.

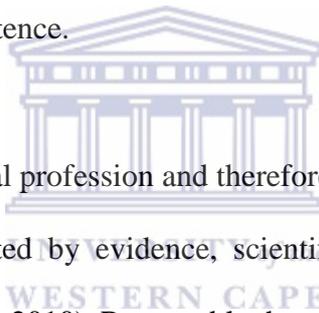


Canada is another example where the route of entry to the midwifery profession is through a Bachelor of Science in Midwifery, offered in both francophone and anglophone university settings (Fraser, et al., 2010).

In Japan however, the midwifery educational programme is similar to that of South Africa. Students who want to be midwives are required to take midwifery courses within the nursing curriculum. After successful completion of their training programme, they receive a nursing license and a nurse midwife license (Wang, 2016).

It should be noted however that global standards for the initial education and training of professional nurses and midwives sets specific benchmarks and standards for nursing and midwifery practice (WHO & STTI International, 2006).

Direct entry programmes are well established in countries such as France, the United Kingdom and Holland (Lopes, Nove, Hoop-Bender, de Bernis, Bokosi, Nester, Moyo, & Homer, 2015). It is perceived by many that such programmes offer a great opportunity for midwives to be acknowledged practitioners and true partners required for safe pregnancy and childbirth. Fraser et al (2010) draws our attention to the fact that direct entry programmes would allow more appropriate programmes to be developed based on a ‘fitness for practice’ model essential for the achievement of midwifery competence.

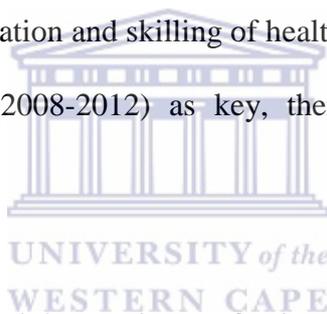


Midwifery is essentially a practical profession and therefore education and training must be skills based, where practice is supported by evidence, scientific principles, knowledge and sound practical application (Fraser, et al., 2010). Regrettably though, studies have shown that knowledge gained in the classroom may be perceived to bear little similarity to what is required in the practical setting. In a situation where knowledge and skills alone are all that is available to save a woman’s life, for example when faced with a woman having a severe haemorrhage after a delivery, a competent midwife should be able to apply aortic compression (Fraser,et al., 2010). The correct application of aortic pressure may be the only option available for a midwife to stem the flow of the haemorrhage until medical assistance is available (Fraser, et al., 2010).

However, literature also suggests that care received from nurses do not always reflect what they have been taught in class. Subsequently, in the transitional period from a student to a professional nurses, nurses do not perform competently in the clinical setting as they struggle to integrate theory

with practice (Hasani, Cheraghi, Yaghmaei, 2008). State of the World's Midwifery (2011) further posit that a health care system relying on midwives who are less than competent to provide care throughout their professional careers are dangerous to women, newborns, families and communities. This raises the question of how we can improve the education of our midwives to guarantee positive maternal nursing care.

The advanced diploma in midwifery is a new SANC qualification - which aims to produce graduates with a wide range of skills, knowledge and attitudes - that will enable them to make a meaningful and sustained contribution to health services (SANC Circular 15/ 2014). Taylor (2008) reported that countries such as Brazil, Mexico and Egypt has managed to half their under-five mortality rate. Appropriate preparation and skilling of health workers including midwives is seen by World Health Organisation (2008-2012) as key, therefore the need for this midwifery qualification.



Presently, health care provision and the nursing profession in South Africa are in the midst of an electrifying and stimulating phase. The SANC has developed new nursing qualifications that are registered on the National Qualification Framework (NQF). The initial plan was to implement these qualifications by June 2015 (Circular, 7/2012). The new Bachelor of Nursing and Midwifery Qualification Framework (R174) set out by SANC provides a changed structure in the undergraduate nursing programme leading to registration - with potential to change and improve the midwifery education programme. This means that the nurse will no longer be registered as a psychiatric nurse, community nurse and midwife. The new Bachelor's Degree in Nursing and Midwifery programme has prescriptive learning outcomes for midwifery. It becomes a crucial responsibility of curriculum designers to ensure that new curricula are underpinned by

transformative educational theory and teaching and learning approaches, to ensure that nurse midwives develop the necessary competence to guarantee positive maternal outcomes.

Currently, however, most institutions' new programmes have not yet been accredited by the Council on Higher Education (CHE) and SANC, which means that they have not met the 2015 implementation date. Subsequently, the date for implementation of new programmes has been extended to 2020 (SANC Circular 7/2016). Given that many institutions may only implement the new programme in 2020, the impact of the new Bachelor's Degree in Nursing and Midwifery will only be evident after 2023 when the first cohort from the new programme are expected to graduate. In the meantime, women and children are dying due to substandard care.

1.1.2 Midwifery competence

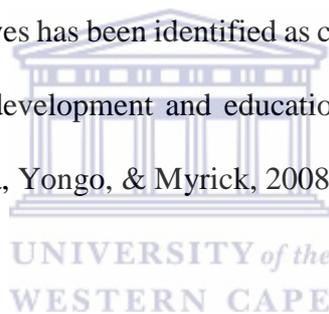
The main proof of competence in nursing is in the practical setting, where the highest risk of 'do no harm' and patient outcomes are directly linked to nursing activities. Evidence suggests that the influence of nursing competence has its effect on the health and safety of all patients (Axley, 2008).

Clark and Holmes (2007) reported findings that ward managers in England have low expectations of newly qualified nurses who, themselves, reported feeling poorly equipped for their new role.

Nursing students described factors such as motivation, a supportive environment for learning, teaching methods, curriculum design, previous academic success and the learning abilities of the facilitators of learning as educational barriers affecting nurse education (Lewis, 2010).

In South Africa, the establishment of the district health care system and the working practice of midwives changed from hospital based to primary health care focused approach, affecting the way in which maternal health care is provided . As a result new models of woman-centred care have

emerged such as midwifery-led stand-alone birth units in Macassar, Elsies River, Kraaifontein, Bishop Lavis and Retreat Midwifery Obstetric Units (MOU) in the Western Cape as well as the introduction of publicly-funded birth services such as at the Mowbray Maternity Hospital in the Western Cape. These changes require a midwife to practice independently whilst providing antenatal services during pregnancy and labour as well as when conducting deliveries on her own for a normal healthy baby. Schoon and Motlometsi (2012) reported that newly qualified midwives are not competent in obstetric skills; they lack knowledge and values which may contribute to poor maternal outcomes. This is linked to general debates about the competence of community service practitioners – which is mostly based on personal involvement, deeply seated opinions and anecdotes (Holland, Roxburgh, Johnson, Topping, Lauder & Porter, 2010). Therefore, assessing the competence of student midwives has been identified as crucially important in attaining nursing standards, identifying areas for development and educational needs, and ensuring that nursing competence is achieved (Luhanga, Yongo, & Myrick, 2008).

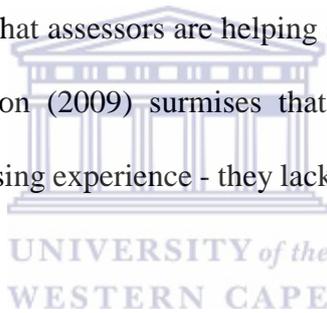


1.1.3 Assessments and competence

Assessment of students' competency is a worldwide matter of concern to all practice-based professions as diverse as teaching, accountancy and medicine (Whiteford, 2007). Determining midwifery competence for practice involves students fulfilling theoretical, practical and professional criteria as laid down by the SANC and by each individual educational institution providing nursing education. However, the situation is far from simple; students seem to be more successful in the practical component of their education than in the theoretical component of their education. A lack of formative feedback has been identified as one of the reasons for this situation (HEFCE, 2010). Furthermore, it is suggested that students may experience more meaningful

learning from clinical facilitators in practice where insights into previously poorly understood aspects of nursing can be found (Bradbury-Jones, Irvine & Sambrook, 2010).

Conversely, many writers have challenged Bradbury-Jones, Irvine & Sambrook's claims on the ground that reports consistently identified that clinical facilitators were not dependable gatekeepers for the nursing profession, resulting in inept students passing and registering as midwives. The reasons cited for this situation are numerous and include assessment protocols being too complex (Gainsbury, 2010), attempts to fail students are sometimes thwarted by university processes (Luhanga, Yongo & Myrick, 2008), intimidation by students and threats of legal action may also discourage assessors from failing students (Cleland Knight, Rees, Tracey & Bond, 2008) as well as reluctance to jeopardize the student's future just prior to graduation (Gainsbury, 2010) and the belief that assessors are helping students by giving them the benefit of doubt (Cassidy, 2009). Anderson (2009) surmises that though these assessors have much knowledge from their clinical nursing experience - they lack specific education, skills and support to succeed as educators.

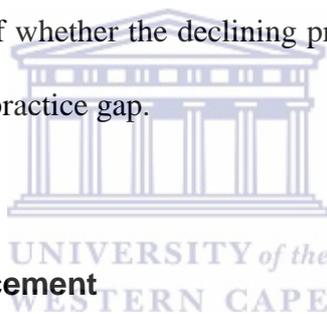


1.1.4 Clinical supervision and mentoring

Fowler (as cited in Bruno and Stein –Parbury, 2011) defined clinical supervision as the process of professional support and learning in which nurses are assisted in developing their practice through regular discussion time with experienced and knowledgeable colleagues. This concept can be traced back to Florence Nightingale who instructed that nurses should be trained under the direct supervision of experienced nurses who were educated to train nurses.

As a result of moving nursing and midwifery into the higher education sector, the clinical role of the nurse educator has diminished and therefore clinical facilitators were appointed as an auxiliary to the educator as a means of incorporating clinical practice into the academic role (Murray,

Murray, MacIntyre, & Teel, 2011). A clinical supervisor/clinical facilitator, who is a trained nurse, is responsible for assessment and supervision, organizing learning opportunities, and has either to sign off or provide evidence of students' competency. Severinson and Sand (2010) state that the ability to apply theory to practice in an educational environment will result in giving the academics clinical credibility. Furthermore, Murray, et al (2011) argues that nurse educators need to be aware of the clinical realities that can affect the application of the theory they teach. This is supported by Elliot and Wall (2007), who argue that educators need to be aware of the knowledge and skills students require in a constantly changing midwifery environment. The importance of a clear purpose for clinical site visits by clinical supervisors will enable them to explore in-depth, with students and preceptors, the factors that influence student learning (Sedgwick & Harris 2012). Therefore it raises the question of whether the declining presence of the educator in the clinical setting contributes to the theory–practice gap.



1.1.5 Student clinical placement

The significance of student clinical placement is one of the oldest and most written about aspects of teaching and learning in regard to assisting students in bridging theory and practice. It is during their clinical placement that students are expected to apply relevant knowledge and develop the essential skills and competence. Gaberson and Oerman (2007) reported that practical experience is the most important component of nursing education. In order for students to gain practical experience, educational institutions are reliant on the health sector for providing experiential learning opportunities - while the health sector is reliant on the educational institutions for a supply of competent midwives. Clearly, clinical placement environments do not only play an important part in developing students' clinical skills for integrating theory with practice, applying problem-solving skills, developing interpersonal skills, becoming socialized into the formal and informal

norms, protocols and the expectations of the midwifery profession but also in developing students' confidence.

Hence in order to prepare student midwives to acquire the necessary skills for practice, the South African Nursing Council (SANC) requires students to be placed in the midwifery clinical locale for a minimum of one thousand hours of Clinical teaching strategies in nursing. Students undertake various placements, such as hospital and MOU placements, and have to adjust as they move from one placement area to the next. Having to fit into the social and professional environment of the clinical locale and be accepted as part of the team can be challenging and increase the pressure that students face. Levitt- Jones and Lathean (2009) found that students' perceptions of belonging in clinical settings were related to how staff treated them.

Papastrarou (2009) stated that student nurses perceived grave deficits in clinical learning, not only did they report negative experiences and dissatisfaction in the practice setting but they also anticipated hostility and difficulties in communicating with staff. Midwifery students have no choice of whom to work with and they recognize their dependence on health care providers to make opportunities available for them to learn. Nevertheless, nurses felt that there was no time for “nursing” during their education and indicated that the time spent as students did not sufficiently prepare them for the realities of nursing and indicated a theory-practice gap (Mooney, 2007).

The question is: What are the factors affecting teaching and learning, and what is the role of education in ensuring that competency in midwifery is achieved? Teaching and learning are very important in ensuring the integration of theory and practice as well as the achievement of competence, therefore both clinical and theoretical components of the programme must be fulfilled and passed to be regarded as competent to be registered as a midwife.

1.1.6 Teaching methodology

Literature powerfully maintains that evidence-based education should be implemented for undergraduate midwifery teaching and learning (Stevens, 2009). However, it is concerning how little the teaching is evidence-based - given the regularity of educators' reference to students that clinical learning should be evidence based.

Many teaching and learning actions have been documented in the context of 'competency for practice' and one of the most prominent is competency-based education. Ryan (2011) outlines the value of competency-based education for competence in midwifery. Competency-based education is outcomes based instruction which is adaptive to the changing needs of students, educators and the community. It is based on a set of outcomes derived from an analysis of tasks typically required of students in life-role situations (Weddel, 2006). Stevens (2009), reported positive results for the graduates of their education programme in respect to the indicators for which they were testing – however, the indicators did not include most of the required skills and abilities recommended by the World Health Organization.

The researcher, a midwifery educator at a higher education institution, became aware of national and local efforts to improve and expand maternal and newborn health care services through the improvement and expansion of a midwifery workforce (Tillet, 2007, Weeks, 2008). Findings from several studies suggest that when midwives receive a firm educational foundation for practice, improvements in maternal and newborn health follows. The researcher observed whilst working with professional nurses in the clinical environment that much was done to improve the skills of the community service practitioner who was placed there. This study was consequently conducted to gauge the experiences of the community service practitioner, midwifery educator and professional nurse vis-à-vis midwifery education and the influence it has on the competence of the

community service practitioner. To develop a framework within which theory and practice are aligned in order to improve midwifery education and ultimately maternal patient outcomes.

1.2 PROBLEM STATEMENT

The well-being of the foetus, mother and family should be ensured by midwives; the quality of care midwives provide is reliant on the training they receive. Each year an estimated number of 350 000, or more, women die worldwide due to complications in pregnancy and childbirth (World Health Organization, 2010). A report by State of the World's midwifery (2011) announced that curricula, staff, educational resources and supervised exposure to clinical practice needed strengthening to ensure that government's obligation to protect the community was met. There is, however, very little evidence regarding studies conducted to explore the influence of midwifery training on the competence of midwives. As yet, the views of midwifery educators and the experiences of community service practitioners have not been explored in relation to midwifery education and its influence on the competence of community service practitioners. Neither have the views of the professional nurse, regarding midwifery competence of community service practitioners and possible gaps in midwifery education, been identified and documented. In addition, there is no framework within which theory and practice are aligned in order to improve midwifery education and maternal patient outcomes.

1.3 RESEARCH PURPOSE

The purpose of this study was to develop a framework within which theory and practice are aligned in order to improve midwifery education.

It is founded on an exploration of the experiences of community service practitioners, professional nurses and midwifery educators regarding the midwifery education programme as well as their perceptions of the competence of the community service practitioners to provide safe maternal care.

1.4 RESEARCH OBJECTIVES

To achieve the purpose of the research the following objectives were formulated:

- i) To establish the experiences of the community service practitioners regarding midwifery education and their perceived competence to provide safe maternal care.
- ii) To explore the views and perceptions of nurse educators (lecturers and clinical facilitators) regarding the education of midwives to deliver safe maternal care.
- iii) To establish the nurse educators (lecturers and clinical facilitators) and professional nurses views on the community service practitioners' competence to provide safe maternal care.
- iv) To determine possible gaps in the education of midwives that could preclude the provision of safe maternal care.
- v) To develop a framework, based on the findings of the study, to align theory and practice for improved midwifery education in the Western Cape.

1.5 RESEARCH QUESTIONS

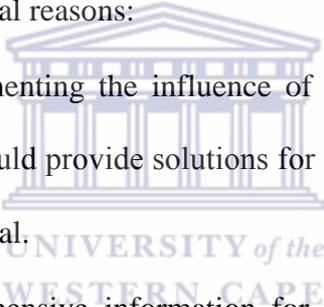
The questions to be answered by this research were:

- What are the views, experiences and perceptions of community service practitioners, midwifery educators (lecturers and clinical facilitators), and professional nurses regarding the education of midwives to deliver safe maternal care?

- What are the views of midwifery educators (lecturers and clinical facilitators) and professional nurses in maternal care settings regarding community service practitioners' competence to provide safe maternal care?
- What are the possible gaps in the education of midwives that would impede the provision of safe maternal care?
- What are the concepts forming the framework to align theory and practice to improve midwifery education?

1.6 SIGNIFICANCE OF THE STUDY

This study is noteworthy for several reasons:

- 
- This first attempt at documenting the influence of a midwifery training programme on midwives' competence should provide solutions for identified problems and thus improve midwifery training in general.
 - It should provide comprehensive information for midwifery educational planners and educators on how to assist students to reach their potential.
 - The developed framework for the improvement and alignment of theory and practice for midwifery education should, with implementation locally and nationally, standardise midwifery training and thereby improve midwifery training and maternal patient outcomes in the country. This will contribute to the Government's undertaking to maintain Sustainable Development Goal 3.
 - It is anticipated that through the involvement of all participants and the implementation of the framework, collective ownership in midwifery training would improve midwives' competence and positive results should be evident in maternal patient outcomes.

1.7 PARADIGMATIC PERSPECTIVE

It is mandatory for midwives to be competent at the point of registration as a professional nurse to ensure positive maternal patient outcomes. The South African Nursing Council defines the concept competence as the ability of a practitioner to integrate the professional attributes including but not limited to, knowledge, skill, judgment, values and beliefs required to perform as a professional nurse in all situations and practice settings (Nursing Act 33 of 2005).

The holistic view of competence include clinical tasks e.g. physical assessment of the antenatal patient, principles of health education, advocacy and empowerment strategies for women, responsible and accountable for clinical decisions and actions, engage in health education discussions with and for women and their families, and take leadership role in policy arena are understood as skill elements within a more complex unit of competence (International Confederation Of Midwives, 2010). According to the National Health Workforce Task Force Report (2010). Conversely, while these perspectives were developed for Australia it can also be transferred to a South- African situation, - the main underpinning assumptions and theoretical perspectives, to which the researcher subscribes, are that:

- Pregnancy, labour, birth and parenting are significant and meaningful life events. Women have the right to access quality maternity care. This should be reflected in the content of curricula and its assessment processes.
- Maternity services provide care that is individualised, continuous, evidence-based and women-centred. This ought to be supported by competency standards, curricula and continuous professional development.
- As maternity services are provided by different providers in a variety of settings, educational curricula should value and support inter-professional learning and

collaborative practice to assist in creating a competent and flexible workforce to ensure safe maternity services.

- Women may experience a change in their health during childbearing. Some women need access to a higher level of care. The maternity care provider needs to recognise when complexities arise and ensure that appropriate consultation and referral occurs (National Health Workforce Task Force Report, 2010).

Assumptions which originate from the meta-theoretical statements include:

- The midwifery educational programme was developed by nurse educators with knowledge and expertise in both midwifery content and educational design.
- The education meets government and SANC expectations for accountability.
- The public is assured that community service practitioners working in the health care facility have successfully completed an accredited midwifery educational programme.

The above summarized assumptions and theoretical perspectives of midwifery competence and midwifery education should create the educational experience through which community service practitioners attain midwifery competence, determine appropriate learning and assessment strategies and create achievement standards with the intent to improve maternal patient outcomes.

1.8 CLARIFICATION OF CONCEPTS

1.8.1 Assessment

Assessment refers to all processes employed by academic staff to make judgments about the achievements of students in units of study and over a course of study. These processes include making decisions about what is relevant evidence for a particular purpose, how to collect and

interpret the evidence, and how to communicate it to intended users (Harlen, 2005). For the purpose of this study, assessment refers to all formative and summative assessments related to midwifery education.

1.8.2 Clinical facility

Clinical facility means a continuum of services to promote health and provide care to individuals and groups used to teach learners (SANC, Notice No R173).

1.8.3 Clinical placement

Clinical placement refers to the period spent by a learner in clinical and other experiential learning sites, to ensure that the purpose of the professional nurse education and training programme is achieved (Nursing Act 33 of 2015). For the purpose of this study, clinical placement refers to the placement for clinical learning and the achievement of the SANC requirement of 1000 hours of clinical learning.

1.8.4 Clinical supervisor

The Clinical supervisor is a trained/experienced person with clinical supervision and should have a minimum of five years' experience in a maternal nursing care setting (Nursing Act 33 Of 2015). In this study, the concepts clinical supervisor and clinical facilitator may be used interchangeably. It refers to the professional nurse employed at a maternal nurse care setting (primary, secondary and tertiary) and who is tasked with providing supervision to the student midwives during clinical placement.

1.8.5 Clinical supervision

Bastable (2008) define clinical supervision as a process that encourages personal and professional growth within a caring relationship that is formed between equals. It aims to promote high clinical standards and to develop professional expertise by supporting staff and helping to prevent problems in busy stressful practice settings. In this study, clinical supervision refers to the visitation of student midwives by the clinical supervisors during clinical placement for the purpose of supervising student midwives' clinical learning, organizing learning opportunities, conducting assessments and either authenticating evidence of clinical learning or the achievement of competence.

1.8.6 Community service practitioner

A community service practitioner, according to SANC, should have completed the R425 nursing programme and have met the minimum requirements prescribed for the education of a Nurse (General, Psychiatry and Community) and Midwife. The Department of Health must have allocated the practitioner to a designated establishment where the practitioner will perform community service for a period of one year (Nursing Act 33 of 2005). In this study, a community service practitioner refers to a nurse who has successfully completed either a Bachelor degree in Nursing or a Diploma in Nursing, and is placed for community service in a maternal care setting for a period of at least six months.

1.8.7 Competence

The ability of a practitioner to integrate the professional attributes including - but are not limited to - knowledge, skill, judgment, values and beliefs required to perform as a professional nurse in

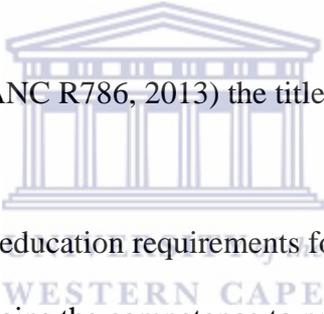
all situations and practice settings (Nursing Act 33 of 2005). Competence in this study refers to the meeting all requirements in both theory and practice, for the successful completion of the nursing programme.

1.8.8 Educator

Educator will refer, for the purpose of this study, to one trained in teaching - a specialist in the theory and practice of midwifery education (TheFreeDictionary.com). In this study, an educator collectively refers to lecturers and clinical supervisors employed at the university.

1.8.9 Midwife

According to the SANC R786 (SANC R786, 2013) the title midwife may only be used by a person who:

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- has met the prescribed education requirements for registration as a midwife
 - has acquired and maintains the competence to practice as a midwife, and
 - is registered as a midwife in terms of the Nursing Act 33 of 2005.

1.8.10 Professional Nurse

The title of Professional nurse may only be used by a person who

- has met the prescribed requirements education requirements for registration as a professional nurse and midwife
- has acquired and maintained the competencies to practice as a professional nurse and midwife

- is registered as a professional nurse in terms of the Nursing Act 33 of 2005 (SANC R786, 2013).

1.8.11 Programme

A programme is defined as a purposeful and structured set of learning experiences which lead to registration as a professional nurse (Nursing Act 33 of 2005). The programme referred to in this study is related to Regulation 425.

1.9 RESEARCH METHODS

The study adopted a qualitative approach and an exploratory, descriptive and theory generative design. Concept synthesis, statement synthesis and theory synthesis was key to the development of the framework and was based on Chin and Kramer (2015) and Walker and Avant (2014). The research methodology is described in detail in chapter 3.

1.10 DATA ANALYSIS

Data was analysed inductively. Tesch's (1999) eight steps in the data analysis process were followed. The findings which emerged from phase 1 were used in phase 2, which focused on the development of the framework. A more detailed description of data analysis process is provided in Chapter 3.

1.11 OUTLINE OF THE THESIS

The layout of the chapters is as follows:

Chapter 1: An overview of the study is provided.

Chapter 2: The theoretical framework which forms the basis of this study is presented.

Chapter 3: The methodology used in the study is discussed in detail.

Chapter 4: A presentation and an in-depth discussion of the findings of the study are provided.

Chapter 5: The process for the development of the framework to align theory and practice is presented.

Chapter 6: Conclusions and limitations of the study are discussed and recommendations based on the findings of the study are presented.



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1.12 SUMMARY

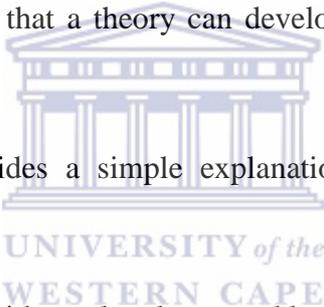
Chapter one provided the introduction and background to the study. The problem statement, purpose and objectives of the study were stated together with the interview questions. The significance of the study was also described, as was the paradigmatic perspectives. Concepts used in the study were clarified which was followed by a brief discussion of the research methods. Lastly, an outline of the six chapters in the thesis was given. Chapter 2 describes the theoretical framework used in this study.

CHAPTER TWO

THEORETICAL FRAMEWORK

2.1 INTRODUCTION

Meleis (2007) purports, a theory are a set of interrelated concepts, definitions and propositions which presents a systematic view of phenomena by specifying the relations among the variables. It postulates specific relationships among concepts and takes the form of a description, explanation, prediction or prescription for action. Similarly, Meleis, Sawyer, Hiffinger, Messias and Schumacher (2000) explains that a theory can develop scientific knowledge by using the following criteria:

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- Firstly, the theory provides a simple explanation about perceived relations to the phenomena;
 - Secondly, it is consistent with an already created body of knowledge;
 - Thirdly, it facilitates a process for verification and revision of the phenomena; and
 - Fourthly, it stimulates further research in areas needing investigation.

In this study, theory was used to:

1. Provide the necessary insight necessary to design a framework to align theory with practice for midwifery education in order to bring about the desired changes.
2. Improve the quality, effectiveness and efficiency of the midwifery education programme to ensure the provision of safe maternal care.
3. Examine the relationship between the programme activities and the observed consequences.

4. Guide the selection of significant data to interpret, and to propose interpretations of the underlying reasons or effects of perceived phenomenon (Zinovieff & Rotem, 2008).

Based on the study's purpose and objectives, a theoretical framework for this study should centre on educating (teaching and learning) competent midwifery students to provide safe maternal care. This chapter presents some theories considered in the selection of the theoretical framework used in the study, which is also described in detail.

2.2 DEFINING THE CONCEPT LEARNING

Psychologists (Field, 2000) define learning as a change in behaviour or probable behaviour that transpires as a result of experience. While educationalists on the other hand see learning as the development by which people obtain skills, knowledge, understanding and attributes. Atkin (1994), for example, explains that learning occurs most commendably when whole-brain processes are engaged, and in particular when the process of learning moves from experience to reflection on experience, so that a pattern or framework enables the learner to grasp the meaning of learning in the mind's eye - and finally learning moves onto an aptitude to use language, rules, laws and principles for precision and efficiency in thinking, doing and further learning. Houwer, Barnes-Homes and Moors (2013) concurs, claiming that the presence of learning similarly requires evidence about the causes of changes in behaviour and should therefore provide an explanation for those changes. Therefore, it is the goal of all educators to enable students to transfer their learning from the classroom to the practice setting (Lauder, Sharkey & Booth, 2004).

Human learning might transpire as part of an educational process, via own development, schooling or training. Also learning can be deliberate or without conscious responsiveness. The challenge however, is for the educator to understand how people learn, and more importantly to be able to

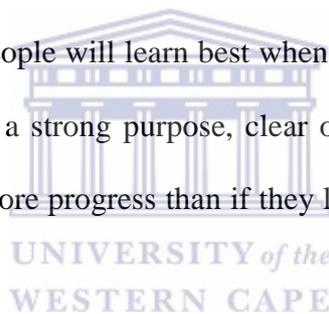
apply that knowledge to the learning environment. Even though psychologists and educators are not in complete agreement, most do agree that learning may be explained by a combination of two basic approaches, namely behaviourism and cognitive theories (Gagne, 2007).

2.3 THORNDIKE'S LAWS OF LEARNING

The following laws of learning as identified by educational psychologist Thorndike (1932) provide additional insight into what makes people learn more effectively (Thorndike's Laws of learning, 2010).

- **Readiness**

According to this psychologist people will learn best when they are ready to learn. He continues to say that should students have a strong purpose, clear objectives and a definitive reason for learning something, they make more progress than if they lack motivation (Thorndike's Laws of learning, 2010).



- **Exercise**

Students learn by applying what they have been told and illustrated better every time practice occurs and learning continues. According to Thorndike (1932) the mind can rarely retain, evaluate and apply new concepts or practices after a single exposure (Thorndike's Laws of learning, 2010).

- **Effect**

The law of effect is based on the emotional reaction of the student. Learning is strengthened when it is accompanied by a pleasant feeling, but if it is associated with a negative feeling then learning is weakened (Thorndike's Laws of learning, 2010).

- **Primacy**

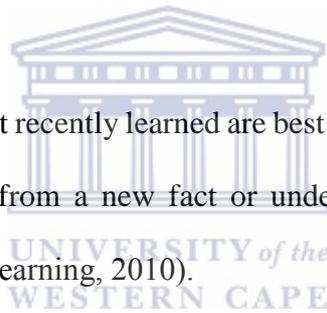
Primacy relates to being first, meaning what is taught must be right the first time. The first experience should be positive for the students. According to psychologists un-teaching what went wrong is more difficult than teaching (Thorndike's Laws of learning, 2010).

- **Intensity**

The law of intensity implies that a student will learn more from the real thing than from a substitute. A student will gain greater understanding of midwifery skills when performing them rather than merely reading about it. The classroom imposes limitations on the amount of realism that can be brought into teaching (Thorndike's Laws of learning, 2010).

- **Recency**

Recency states that the things most recently learned are best remembered, meaning that the further a student is removed time-wise from a new fact or understanding, the more difficult it is to remember (Thorndike's Laws of learning, 2010).



2.4 THEORIES AND MODELS OF LEARNING

2.4.1 Behaviourism theory

Behaviourism employs mechanisms as a fundamental metaphor which assumes that behaviour is directed by a restricted set of physical laws. In this view behaviour should be explained by observable experiences and not by mental processes (Owusu-Banhene, 2006). Behaviourist such as Watson and Skinner argued that it is not probable to accurately observe or quantify what occurs in the mind and that scientific theories should take observable indicators such as stimulus-response sequences into account (Skinner, 1976).

Cognitivist psychologists share the belief with the behaviourist that the study of learning should be objective and that learning theories should develop from the results of empirical research. However, for the cognitivist not all learning occurs as a result of shaping and changing of behaviour, information rather comes in as an input and then it is processed in the mind for the time being, then stored away to be retrieved later. This cognitive view of learning is thus teacher centred, and information must be presented in an organized manner to achieve the most efficient learning.

2.4.2 Andragogy: Adult learning theory

Higher education, including the education of nurses, relates to adult education. Knowles (1913-1997) labeled this as andragogy, which involves the development and implementation of learning activities for adults. According to Knowles, Holton and Swanson (2011) - Andragogy is based on the following six assumptions of the adult learner:

- Adults need to know the reason for learning.
- Adults draw on their experiences to aid their learning.
- Adults need to be responsible for their decisions on education.
- As a person learns new knowledge he/she wants to apply it immediately in problem solving.
- Learning readiness of adults is closely related to the assumption of new social roles.
- As a person matures motivation is received from internal factors.

2.4.3 Conditions/ environment theory of learning

The condition of the learning environment has been identified as crucial to the outcome of learning. Research has shown that an environment can either promote or discourage learning based on the organizational structure (in the case of this study, the programme structure), positive or negative environmental conditions and time constraints. Weber and Berthoin Antal (2003) allude to a very important fact, that learning which requires practice (such as nursing) are much slower than those that do not require practice. Therefore, the time it takes for students to learn is an important factor to consider in the learning process.

Furthermore, McLeod (2007) argues that learning created as a result of involuntary associations between an environmental stimulus and a naturally occurring one is significant to note for the learning process. McLeod (2007) continues by saying that the learned response that is created as a result of this association is then transferred to the neutral or environmental stimulus after repeated pairings. It is therefore important for nurse educators to think about ways to improve their teaching through the use of associations.

According to McLeod (2007), the condition/environment theory fails to take into account the role of inherited and cognitive factors during learning and therefore it is an inadequate description of the learning process. Weiten (2007) explains this by claiming that personality structure only focuses on stimulus-response associations. Weiten (2007) continues to argue that there is an overdependence on animal research and it therefore denies the existence of free will and the importance of cognitive processes.

2.4.4 Experiential learning theory

The concept of experiential learning explores the cyclic pattern of all learning - from experience through reflection and conceptualization to action and onto further experience. Scholars in the field of education have two contrasting opinions concerning the concept of experiential learning. The first opinion defines experiential learning as learning that enables the student to apply newly acquired knowledge in a relevant setting. The other school of thought defines experiential learning as education that transpires as a direct participation in the events of life. Baker, Jansen and Kolb (2002) further developed the second view of experiential learning by creating an experiential learning model which consist of four basic elements, these elements are:

- Concrete experience,
- Observation and reflection,
- Forming abstract concepts, and
- Testing in new situations.



According to Kolb and Fry (1975), the adult learner can enter the process at any one of these points and moves to the next step once their experience has been processed in the previous step.

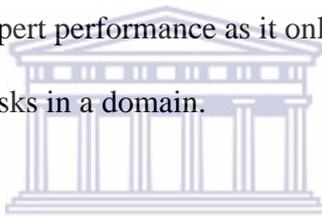
The experiential learning theory does not take differences in cultural experiences or conditions into consideration. There is some confusion about where elements of learning such as aims, purpose and intentions fit into the experiential learning theory (Orey, 2010).

2.4.5 Cognitive apprenticeship model

The cognitive apprenticeship model is a pedagogic approach based on the assumption that knowledge is constructed by learners as they attempt to make sense of their experiences. It is

founded on a variation of the traditional and historic model of teaching and learning through apprenticeship, derived from the Situated Learning Theory. The notion of a cognitive apprenticeship includes purposeful demonstration of skills, coupled with assistance and coaching (Collins, Brown, & Newman, 1989). The apprentice observes the master then copies the actions on a similar task, with the master coaching the apprentice through the task by providing hints and corrective feedback (Johnson, 1992). The cognitive apprenticeship model has four main features namely content, method, sequencing and sociology (Brown, Collins & Duguid, 1989).

Content refers to concepts, facts and procedures related to a specialized area also known as domain knowledge. Domain knowledge, according to the cognitive apprenticeship model, is necessary but not sufficient for expert performance as it only provides enough clues about how to solve problems and accomplish tasks in a domain.



Methods are ways to promote the growth of expertise. The cognitive apprenticeship model embraces six teaching methods. These teaching methods help students attain an integrated set of skills through a process of observation and guided practice.

Sequencing refers to clearly defined knowledge and goals with the anticipation that students do their work over time through repeated exposure to text genres, procedural strategies and the use of important concepts/powerful ideas.

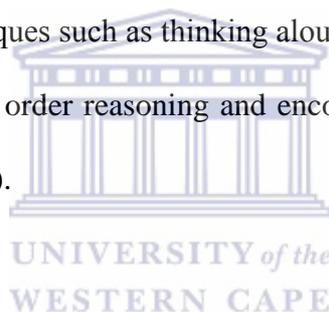
Sociology refers to ensuring that apprentices learn their skills in the context of their application to real life problems, within a culture defined by expert practice (Collins, et al, 1989). Within this social apprenticeship organization certain aspects inspires productive beliefs about the nature of

learning and the expertise important to learners' motivation, confidence, and their orientation towards problems encountered as they learn.

Cognitive apprenticeship encourages authentic activity and assessment. The most significant characteristic of this model is the emphasis on situated learning and the culture of expert practice (Collins & Newman, 1989). Practices of cognitive apprenticeship are motivating and engaging for learners. It provides students with authentic tasks and encourages them to think and be treated like experts (Collins, et al, 1989).

Hill and Smith (1998) posits that students are engaged in contextual, situated learning that enhances their ability to transfer their newly acquired skills and knowledge through their instructor's use of specific techniques such as thinking aloud modeling and scaffolding.

It may therefore facilitate higher order reasoning and encourage greater levels of retention and transfer (Hogan and Tudge, 1999).



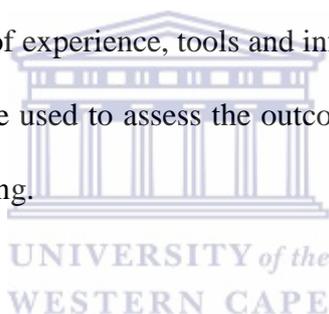
This method may require highly facilitative teaching skills, sometimes requiring sourcing experts. In addition, the student's self-sufficiency level is reliant on the success of the coach and the scaffolding rendered by the teacher. Difficulty in comprehending the process and construction of a mental model modeled by the experts can overwhelm the student, resulting in frustrated and anxious students who are afraid to explore tasks on their own.

Students may require more time to explore different areas of learning, working in groups, making discoveries and creating their products. Additional and more sophisticated resources, which are not readily available in educational institutions, may be required (Orey, 2010).

2.4.6 Kirkpatrick's four-level framework selected for the study

The Kirkpatrick four-level framework was selected for this study because it provided a framework within which concerns, strengths and weaknesses related to the midwifery education programme could be explored. Furthermore, the framework was fittingly suited for supporting analysis since it provided a systematic model for managing and mapping data.

Literature on the utilisation of the Kirkpatrick framework to investigate the effectiveness of an education programme spans multiple professional disciplines, fields and contexts. Yaw (2005) utilised the framework to design a safety training programme. Bersin and Associates (2002) used the Kirkpatrick framework and discovered that thirty training organizations failed to measure their training effectively due to a lack of experience, tools and infrastructure. Oerman (2013) proposed that the Kirkpatrick framework be used to assess the outcome level of an educational study and whether it is appropriate for nursing.



2.4.6.1 Kirkpatrick's levels for appraising education interventions

Kirkpatrick and Kirkpatrick (2006) purports that training can be evaluated using four levels namely reaction, learning, behaviour and results. Furthermore, the Kirkpatrick framework is categorized in nature and the levels are chronological. Level one reaction focuses on the learner's perceptions about the programme and its effectiveness, Level two focuses on what the learner has learned, Level three behaviour focuses on the extent to which learners' changed attitudes, improved knowledge and increase in skill as a result of attending the programme, and Level four focuses on on-the-job behaviour.

2.4.6.2 Application of Kirkpatrick's levels to education

Level 1: Reaction

Reaction as defined by Kirkpatrick and Kirkpatrick (2006) relates to how well learners like a particular educational programme. It measures the students' direct reaction to the programme and it might involve anything, for example – from the relevance of the course/programme content to their job duties to how comfortable the classroom chairs were. This is significant because a positive reaction to an educational programme may encourage attendance of future education programmes. However, negative reactions about an education programme may discourage attendance and/or completion of the programme. A programme's existence is threatened if participants uniformly and consistently claim that a particular education programme is of little or no value to them. Favourable reactions, according to Kirkpatrick and Kirkpatrick (2006), however do not guarantee that learning (level two) has occurred.



Level 2: Learning

According to Kirkpatrick and Kirkpatrick (2006), learning is the assessment of the level of knowledge or skills acquired from the programme. The aim of this level is to ascertain the efficacy of the education. It is evident from literature that level two is the most popular form of evaluating the effectiveness of training programmes (Berlin, 2003). Conversely, according to Kirkpatrick, it is important to be aware of the distinction between learning and performance – only the performance can be measured and learning can be inferred through the observable performance. Kirkpatrick and Kirkpatrick (2006) suggest that it is important to determine whether performance is a true reflection of learning and not due to some other reason. They further highlight that the evaluation of learning is important since without learning no change in behaviour will occur.

Level 3: Behaviour

This level relates to how effectively students have applied the new knowledge or skills on the job. For an education programme to be effective, it is critical that skills and knowledge acquisition has to be translated into appropriate changes in job behaviour. This transfer of education on the job must be a demonstration of the skill acquired after learning. According to Kirkpatrick and Kirkpatrick (2006), learning that positively influences job behaviour will be translated into beneficial effects in the organization within which the trainee works.

Level 4: Results

The result level relates to the extent to which the education programme contributed to meeting the organisational objectives for the programme. This is also the most challenging level to assess (Werner & Simone, 2005).



Shelton and Alliger (1993) purported that the Kirkpatrick framework can be used to address the training need of professionals to understand training evaluation in a systematic way. The popularity of this framework, according to Bates (2004), can be ascribed to the simplified way in which the complex process of training can be evaluated. This is because the framework symbolises a straightforward guide regarding the kinds of interview questions that should be asked as well as the possible appropriate criteria for the research.

The model also eliminates the need to measure the complex and numerous factors surrounding and interacting with the training process (Bates, 2004).

Despite the valuable contributions that the Kirkpatrick framework makes in training evaluation, according to Bates (2004) there are some limitations in this framework. Several professionals have

commented on the simplicity of the model and that it slipped-up in suggesting that evaluations can be conclusive, replicated and generalised to a larger group (Galloway, 2005).

One of the most documented criticisms is Kirkpatrick’s implied correlation between reaction learning (Level 1) and changed behaviour (level 3) in the workplace. This criticism is based on Kirkpatrick’s supposition that to achieve behavioural change in the workplace learners must react favourably to the training programme in order to learn the required knowledge, skills and attitudes. However - Bates, Holton, and Carvalho (2002) has shown that there is very little correlation between a learner’s reaction to training and learning, and even less between reaction and performance or behavioural change.

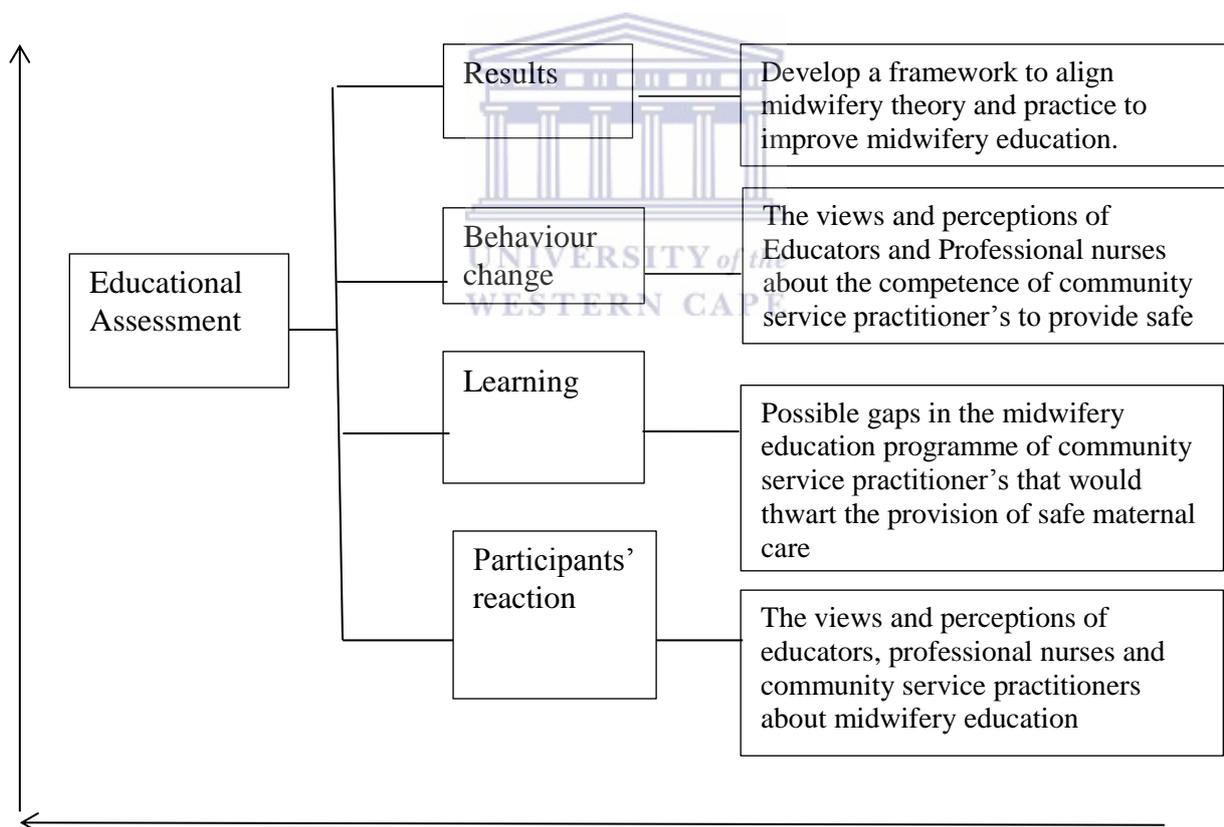


Fig 2.1 Diagrammatic representation of Kirkpatrick’s four levels of assessment

2.4.6.5 Application of the Kirkpatrick Framework in the study

Based on Kirkpatrick's (2006) framework and the literature review, this study was guided by the following interview questions and objectives. The following table shows how the interview questions and study objectives are linked to the Kirkpatrick framework.



Table 2.1: Alignment of research objectives and question with Kirkpatrick’s framework

Level of Kirkpatrick framework		Purpose	Objective	Research questions
Level 1	Participant reaction	To explore participants’ reaction with reference to their satisfaction with the midwifery education programme	<ul style="list-style-type: none"> • To explore the views and perceptions of educators (educators and clinical facilitators) regarding the education of midwives to deliver safe maternal care • To determine the experiences of the community service practitioner’s regarding midwifery education and their perceived competence to provide safe maternal care 	What are the views, experiences and perceptions of community service practitioners, midwifery educators (lecturers, clinical facilitators), and professional nurses regarding the education of midwives to deliver safe maternal care
Level 2	Learning	To determine learning, participants were asked to indicate the possible shortcomings in the existing education programme which impeded the increase in knowledge and competency of the community service practitioner’s when back on the job, after completion of the midwifery education programme	To determine possible gaps in the education of midwives to provide safe maternal care	What are the views of midwifery educators (lecturers and clinical facilitators) and professional nurses in maternal care settings regarding community service practitioners’ competence to provide safe maternal care?
Level 3	Behaviour	To establish the extent to which the behaviour and competence of the	To establish the nurse educators (educators and	What are the views of midwifery educators (lecturers and clinical

		community service practitioner's improved, as well as the implementation/ application of skills and knowledge when back on the job	clinical facilitators) as well as professional nurses' views on the community service practitioner's competence to provide safe maternal care.	facilitators) and professional nurses in maternal care settings regarding community service practitioners' competence to provide safe maternal care?
Level 4	Results	Based on the results of exploring the experiences of midwifery educators, professional nurses and community service practitioner's, a framework to align theory and practice was developed	To develop a framework to align theory and practice for improved midwifery education in the Western Cape, based on the findings of the study 	What are the possible gaps in the education of midwives that would impede the provision of safe maternal care? What are the concepts forming the framework to align theory and practice to improve midwifery education?

2.5 SUMMARY

Learning theories - namely andragogy, conditions/environment and experiential learning; the cognitive apprenticeship model and the Kirkpatrick framework were discussed in this chapter, based on their relevance to learning which is central to this study. These theories, model and framework were assessed for suitability to be used in this study. Based on their strengths and limitations, the Kirkpatrick framework was selected to guide the exploration and description of the participants' views as well as their perceptions of the midwifery education programme in preparing community service practitioner's to provide safe maternal care.

Chapter three focuses on the research methodology.



CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The purpose of this study is to explore community service practitioners, professional nurses and midwifery educators' perceptions of the midwifery educational programme and the influence it has on the competence of the community service practitioner in maternal care settings. The researcher believes that a better understanding of this would guide midwifery educators in terms of the design and facilitation of midwifery education programmes which, if informed by the framework to align theory with practice, would improve midwifery education. The ultimate purpose is to improve the competence of community service practitioners to deliver safe maternal care towards positive patient outcomes. In seeking to understand this phenomenon, the study addresses the following three interview questions:

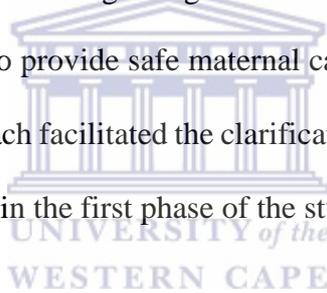
1. What are the views and perceptions of participants regarding the education of midwives to deliver safe maternal care?
2. What are the views of participants regarding community service practitioners' competence to provide safe maternal care?
3. What are the possible gaps in the education of midwives that should be addressed to ensure the provision of safe maternal care?

This chapter describes the research methods adopted for this study to achieve the purpose stated in chapter one which was:

To develop a framework to align theory and practice in order to improve midwifery education based on an exploration of the experiences of community service practitioners, professional nurses and midwifery educators regarding the midwifery education programme as well as their perceptions related to the competence of the community service practitioners to provide safe maternal care.

3.2 RESEARCH APPROACH

The qualitative approach was adopted in this study, since it allows the logical exploration and analysis of the perceptions and experiences of lecturers, clinical facilitators, professional nurses and community service practitioners regarding midwifery education and its preparation of community service practitioners to provide safe maternal care. Furthermore, as described later in this chapter, the qualitative approach facilitated the clarification of central concepts and constructs of the study which were analysed in the first phase of the study.



Qualitative research involves the study of participants in their natural settings where the researcher conducts a systematic enquiry into meanings, attempting to interpret and make sense of phenomena and the meanings people attribute to them (Burns & Grove, 2011). Recently, qualitative research has experienced an upsurge in the nursing field of inquiry; it has increasingly found favour with researchers as an adjunct to quantitative empirical research, and more importantly as a research approach in its own right. Qualitative research on human experience has specific strengths and is powerful and sometimes more gripping than quantitative research.

Some of these strengths include: that issues can be investigated in depth, taking into account the many complexities surrounding a research topic; the research framework and direction can be revised as new information emerges because interviews are not restricted to specific questions and can be directed and re-directed by the researcher; and although data from a few participants cannot be generalised to a larger population, findings can be transferred to another setting if the research was well executed (Anderson, 2010).

Despite its strengths, qualitative research has a few limitations which the researcher remained cognizant of to avoid issues of bias and lack of scientific rigor (Burns & Grove, 2011).

3.3 RESEARCH DESIGN

A research design refers to all the decisions a researcher makes in the planning of a research study. It is also referred to as the blueprint or working plan for actions to reach the intended research goal by answering the interview questions formulated for the study (Wood & Ross-Kerr, 2011). An exploratory, descriptive and theory generating design is used in this study.

3.3.1 Exploratory design

Polit and Beck (2012:87) postulate that explorative studies are undertaken when a new area is being investigated or when little is known about an area of interest. Exploratory studies answer the “what” question (Mouton, 2001 in de Vos et. al., 2011). In this study the exploratory design is used to gain insight into the perceptions and experiences of lecturers, clinical facilitators, professional nurses and community service practitioners regarding midwifery education. Further on it is used to clarify the main concepts of the study which forms the basis of model development in the second phase of the study.

3.3.2 Descriptive design

Burns and Grove (2011), postulate that descriptive research is designed to provide a picture of a situation as it naturally happens. A complete and accurate description of a particular situation, social setting or relationship is garnered through descriptive research by asking the “how” and “why” questions (Fouche & De Vos, 2011). This design is appropriate for this study as a description of the perceptions and experiences of lecturers, clinical facilitators, professional nurses and community service practitioners regarding midwifery education could be given. The descriptive dimension allowed the researcher to describe, analyse and divide the descriptions made by the participants into meaning-laden statements in phases one and two of the study. Furthermore, it allowed for interpretations and linkages relating to the findings of previous research.

3.3.3 Theory generative design

The framework to align theory with practice, in order to improve midwifery education with the intent of improving maternal patient outcomes, was developed following the Chinn and Kramer (2011) theory generating process. Based on Chinn and Kramer’s definition, this study focuses on generating empiric theory which they define as “a creative and rigorous structuring of ideas that projects a tentative, purposeful and systematic view of phenomena” (Chinn & Kramer, 2011: 157). This design is appropriate for the study as it refers to knowledge which is based on perceptual experience (exploratory descriptive), derived through naturalistic research methods. This part of the study’s research design is therefore dependent on the knowledge generated through the exploratory descriptive designs described above.

The study was conducted in two phases. The complete research method for each phase is described in the following section of the chapter.

3.4 PHASE 1: DATA COLLECTION

3.4.1 Research design

Phase one employed an exploratory descriptive design.

3.4.2 Study population

A study population comprises all individuals who possess specific characteristics related to the research in which the researcher is interested (de Vos, 2011). The participants were therefore selected based on their knowledge and expertise in midwifery or their expertise in the midwifery education programme.



The population of interest for this study included:

- i) The population of interest included all 2012 nurse graduates from both the university and college. The total graduate population of interest from the university was seventy-six (76); and fifty-five (55) were from the college. These graduates were all employed as community service practitioners in a midwifery setting at either a tertiary, secondary or primary level of care within the Cape Metropole.
- ii) All midwifery educators (lecturers and clinical facilitators) employed at both these nursing education institutions. The total educator population of interest at both education institutions was fourteen of which eleven participated.
- iii) All professional nurses employed at the tertiary, secondary and primary levels of midwifery care within the Cape Metropole. The population of professional nurses relevant to this study was one hundred and forty-eight (n-148).

3.4.3 Sampling strategy and sample size

Through sampling the researcher selects a subset of the population to gain an idea of what could be expected in the total study population (de Vos, Strydom, Fouché & Delpont, 2011).

In qualitative research, selection of the research sample is purposeful (Burns & Grove, 2005).

The sensibleness of purposeful sampling lies in selecting information-rich cases, with the aim of gaining insight and understanding of the phenomenon under investigation (Speziale & Carpenter, 2007). Four research populations were sampled purposively as follows:

3.4.3.1 Community service practitioners

The following inclusion criteria were applied:

- Community service practitioners had to be 2012 graduates from either the university or college selected for this study.
- Employed as community service practitioners at either a primary, secondary and/or tertiary level at a maternal care setting for at least a period of six months.

The researcher requested a list of community service practitioners employed at maternal care settings which met the inclusion criteria, one for each educational institution.

The researcher contacted one or two community service practitioners on each list and explained the purpose and objectives of the study to them, and thereafter enquired whether they were willing to gather a group of at least four to five community service practitioners for a focus group interview.

The community service practitioners were co-operative and agreed to participate in the study. Each of the community service practitioners who were approached contacted the researcher when they

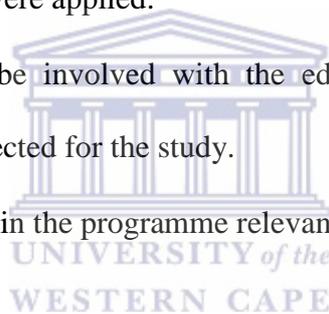
had four to five willing participants. A total of ten community service practitioners participated in the two focus group interviews.

3.4.3.2 Educators

The researcher contacted each institution and requested a list of names, telephone numbers and e-mail addresses of all midwifery lecturers. Six lecturers were employed at the university and the college under study. The researcher contacted them to explain the study and to ascertain their willingness to participate. A total of four lecturers agreed to participate: one at the university and three at the college.

The following inclusion criteria were applied:

- Midwifery educators to be involved with the education of student midwives at the university and college selected for the study.
- Participation of educators in the programme relevant to the 2012 graduate cohort.



3.4.3.3 Clinical facilitators

Seven clinical facilitators were employed at the education institutions included in the study.

All of them agreed to participate in the study: three at the university and four at the college.

The following inclusion criteria were applied:

- Clinical facilitators to be involved in the midwifery education of students at the university and college selected for this study.
- Participation of facilitators in the programme relevant to the 2012 graduate cohort.

3.4.3.4 Professional nurses

The researcher contacted the managers at the various maternal health care settings, where the community service practitioners were employed, for a list of names and telephone numbers of all the professional nurses who matched the inclusion criteria. The researcher then contacted the professional nurses to explain the study and to ascertain their willingness to participate. A total of eighteen (n-18) professional nurses were interviewed.

The following inclusion criteria were applied:

- Professional nurses should have been employed at the primary, secondary or tertiary level of midwifery health care; and
- Participated in the training of the student midwives.

The sample size for all groups was determined by data saturation during the focus group interviews and in-depth interviews. Data saturation was reached after two focus group interviews with community service practitioners and twenty-nine individual interviews with midwifery educators and professional nurses. Data saturation was evidenced by the examination of data that yielded only recurrence of information that had already been discovered, coded and integrated.

Table 3.1 summarizes the study sample per participant group at each of the education institutions.

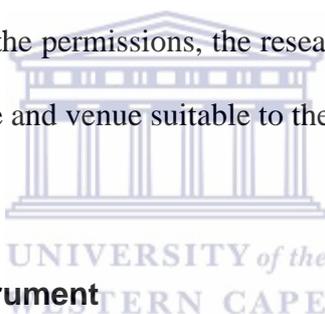
Table 3.1: Study sample

Participant group	University	College	Total sample size
Community service practitioners	5	5	10
Lecturers	1	3	4
Clinical facilitators	3	4	7
Professional nurses			18

3.4.4 Access to research sites

To honour the requirements for access to the research settings and the participants, as described by Green and Thorogood (2009), the researcher sought permission from the management of the institutions involved in the study. Access to research sites was requested in writing from the Department of Health in the Western Cape and the relevant nursing managers at the clinical sites for access to the tertiary and secondary hospitals, and primary maternal health care settings (See Appendix: 14).

Formal written permission was obtained from the Heads of Department at the nursing education institutions for access to the educators (lecturers and clinical facilitators). (See Appendix: 11). Subsequent to the granting of all the permissions, the researcher telephonically arranged with all participants to meet at a time, date and venue suitable to them.



3.4.5. Pre-testing the instrument

Pre-testing is the administration of the data collection instrument with a small set of participants from the population. The purpose is to identify problems with the data collection instrument and to find possible solutions (De Vos et al, 2008).

A pre-test of the instrument was conducted with a professional nurse, midwifery lecturer and midwifery student. Based on the pre-test, no change was made to the questions.

3.4.5.1 Data collection methods

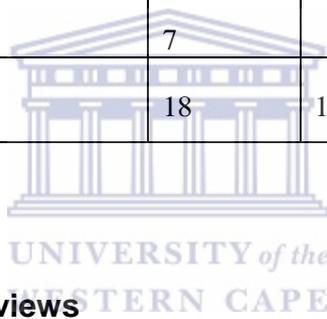
Data was collected using focus group interviews and in-depth interviews.

These methods were chosen because it allowed the researcher to pose open-ended questions, to gain insight into the experiences of the participants, appropriate for exploratory research (Creswell, 2009).

The sample size for each data collection method used in the study is presented in the table below.

Table 3.2 Sample size per data collection method

Participant Group	Focus Group	In-depth Interview	Total no. of participants
Community Service Practitioners	2		10
Lecturers		4	11
Clinical facilitators		7	
Professional nurses		18	18



3.4.5.2 Focus group interviews

Focus group interviews were utilised to obtain information from the community service practitioners regarding their midwifery education programme experiences.

The focus group method, unlike person to person interviewing, is a more active and dynamic social discussions, and thus a cumulative understanding of the identified problem can be achieved (Gillis & Jackson, 2002). The open response format allowed participants to discuss their experiences in their own words (Bickman & Rog, 2009).

i) Data collection instrument

The development of the data collection tools was influenced by the Kirkpatrick model (See Appendix 2, 3, 4). The research objectives also assisted in framing the broad interview questions.

The broad research question posed to the community service practitioners was: "What were your experiences of the midwifery education you received and your perceived competence to provide safe maternal care?" A follow-up question was posed: "What were the gaps in the education of midwives to provide safe maternal care?"

Probes and follow-up questions were used to deepen the responses to questions posed, to increase the depth of responses, to maintain control over the flow of the interview (Greeff, 2011) and also to verify or clarify what the participants were saying (De Vos, 2008). The probes used were the basic "who", "what", "where", "when", and "how" questions to obtain a complete picture of some activity or experience. Elaboration probes such as "tell me more about it" were used to keep a participant talking. While clarification probes were used to check the accuracy of the researcher's grasp of what was said by participants, or to restate the question (Niewenhuis, 2007).

ii) **Focus group process**

The researcher, who acted as the facilitator, conducted two focus group interviews with community service practitioners during the month of April 2015. One focus group interview, for ease of access, was held at a secondary maternal health care setting and the second was conducted at a tertiary maternal health care setting.

Each focus group comprised of five participants from the different levels of maternal health care settings - namely primary, secondary and tertiary.

The participants were contacted and informed about the focus group interviews via telephone, as indicated earlier.

Prior to starting the group interviews the researcher established a rapport with the participants by welcoming them and facilitating introductions, providing an overview of the topic to be discussed, outlining the ground rules as well as obtaining consent and permission for the use of the tape-

recorder (See Appendix 6). Participants were reminded that they could withdraw, should they wish to do so, from the group at any time. Participants were allowed an opportunity to ask questions related to the research before the focus group commenced. Anonymity of the participants was assured by using pseudonyms, e.g. participant one to participant five - according to the seating arrangements, as a substitute for their real names. The focus group discussion lasted about one hour. At the end of the discussion, group members were thanked for their participation and informed regarding the use of the information gathered in the discussion. The researcher also recorded field notes that captured her thoughts, impressions and the events, as well as the context and processes of the group.

Challenges with focus group interviews

As with most research methods, focus group discussions pose some difficulties.

Holloway and Wheeler (2006) emphasize the following limitations of focus group discussions:

- Data analysis can be daunting because of the amount of information gathered.
- Recording data can present problems, and it is not practical to take notes when many people are talking at the same time, also audiotape recorders may record only those that are closer to the recorder.
- Group climate can inhibit or fail to stimulate the individual's participating.
- Some participants may be introverts while others dominate the discussion and influence the outcome, or perhaps even introduce bias.
- Focus group interviews are not replicable, also the validity and reliability of findings are difficult to ascertain on their own.

The above difficulties were addressed by ensuring that the group is homogenous in terms of education and experience. As mentioned earlier participants were made comfortable and

introduced to each other, the research purpose and objectives of the study were explained and made clear. The tape recorder was tested beforehand and because the group was small, recording of all participants was effective. Participants were encouraged to express their views and to respect the views of the other participants.

3.4.5.3 In-depth interviews

In-depth interviews are described as a form of conversation which produces knowledge about a phenomenon (Creswell, 2009).

This method of data collection is frequently used in exploratory and descriptive research (Creswell, 2009). The researcher conducted twenty-nine (29) in-depth interviews with midwifery educators (lecturers and clinical facilitators) and professional nurses during September 2014 to March 2015.



i) Data collection instrument

An interview guide with one broad question for each of the participating groups (lecturers, clinical facilitators and professional nurse) was developed in line with the research objective and used during the in-depth interview (See Appendix 2, 3, 4). The broad research question for the lecturers and clinical facilitators was:

“What are your views on the education of midwives and the competence of community service practitioners to deliver safe maternal care?” The researcher also determined, as a follow-up question, the participant’s views regarding possible gaps in the education of midwives that could preclude the provision of safe maternal care.

The research question used to initiate the interview with professional nurses was: “What are your views on the community service practitioner’s competence to provide safe maternal care?” The researcher posed the same follow-up question to the professional nurses, as was posed to the nurse educators, regarding the views about the possible gaps in the education of midwives which could preclude the provision of safe maternal care. Probes, similar to those used in the focus group discussions, were used to enhance the necessary depth in the discussion.

ii) In-depth interview process

The researcher informed participants telephonically that the data collection would be conducted on-site on a date suitable for participants. Prior to starting the interview the researcher provided an overview of the topic (See Appendix 5), participants were granted the opportunity to ask questions related to the research process. Consent to participate in the study and also permission to use a tape recorder was obtained from participants (See Appendix 6).

Each interview lasted between 30 minutes and an hour. Participants were interviewed until data saturation was reached and no new information was yielded from participants even with further probing (Polit & Beck, 2012).

iii) Challenges with in-depth interviews

Boyce and Neale (2006) identified the following limitations, which the researcher were aware of, for in-depths interviews:

- It requires well-qualified highly trained interviewers.
- Interviewing is expensive and time consuming.
- Inconsistencies can result across the interviews.

- Interviewee may distort information through recall error, selective perceptions and a desire to please the interviewer.

The researcher avoided some of these challenges by thoroughly preparing herself for the interviews. Pilot testing the interview guides improved the researcher's confidence to conduct the interviews.

The researcher was safeguarded against voicing any personal opinions by ensuring that the interviewee was comfortable. The purpose of the research was explicated to the participants.

3.4.6 Data analysis

According to Polit and Beck (2008) qualitative data analysis is the process of fitting data together, of making the invisible obvious, of linking and attributing consequences to antecedents, it also has a process of conjecture and verification, of correction and modification, of suggestion and defense.

Data analysis was conducted according to the inductive approach proposed by Thomas (2003) and mapped by the Kirkpatrick framework. The following are the steps of analysis used:

- Data voice files were filed according to interviewed participant groups. A back-up of each voice file was made.
- The voice files were listened to, to get a sense of what was said by the participants.
- The voice files were then transcribed verbatim. Thereafter the transcripts were read several times by the researcher to identify common threads in the participants' contributions.
- The transcripts were also read by the promoter.
- The transcripts were coded, and as new codes emerged the coding frame changed. The transcripts were then reread according to the new structure.

- This process was used to develop fifty-six categories from which fifteen broader themes emerged.
- Emerging themes were developed by studying the transcripts repeatedly, considering possible meanings and how these corresponded with developing themes.
- The transcripts were also read horizontally which involved grouping text segments by theme.
- Towards the end of the data analysis no new themes were identified, which suggested that the major themes had been identified.

A discussion between the researcher and the supervisor was held to refine and confirm the themes.

3.4.7 Rigor

Rigor is a measure of the overall quality of research reflected in the data collection and analysis processes (Macnee & McCable, 2008). Lincoln and Guba's (2008) model for establishing trustworthiness was used, namely credibility, transferability, dependability and confirmability.

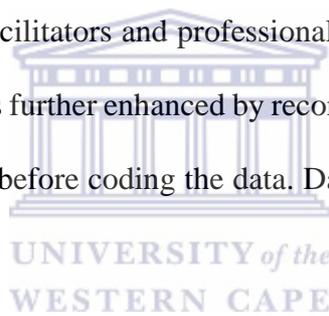
3.4.7.1 Credibility

Credibility refers to the extent to which data and data analysis are believable and trustworthy. To ensure credibility the researcher rephrased, repeated or expanded questions on different occasions. Peer review was ensured by discussing the findings with the supervisor who has extensive experience with qualitative research methods. The researcher had also been a midwifery lecturer for five years; it was therefore important for her to be aware and to reflect on the influence of her own background, perceptions and interests.

Thus a field journal was kept to describe and interpret her behaviour and experiences within the research context in order to detect any biases and preconceived assumptions she may have. If any preconceived assumptions were revealed, the method of data collection would have been amended by, for example, using an independent person to collect the data and thereby enhance the credibility of the research.

Furthermore, triangulation of data gathering methods (focus group and in-depth interviews) further ensured the trustworthiness of the data.

Data was also obtained from four different groups of participants - namely community service practitioners, lecturers, clinical facilitators and professional nurses - in order to cross-check data and interpretation. Credibility was further enhanced by recording the interviews on a tape recorder and then transcribing it verbatim before coding the data. Data thus obtained was also verified by the researcher and supervisor.



3.4.7.2 Transferability

Speziale and Carpenter (2007:39) posits that transferability or ‘fittingness’ refers to the likelihood that the study findings have meaning to others in similar situations. Therefore to ensure transferability the researcher provided a substantial description of the background information about the participants, the research context and the findings - to allow for the comparison of this context to other possible contexts in which transferability might apply.

3.4.7.3 Dependability

According to Polit and Beck (2008:539) dependability refers to the stability of data over time, over conditions and over occasions. In order to achieve dependability the researcher provided a detailed description of the research process, thus enabling a future researcher to repeat the process. In this study the official examination of data was made by the researcher, the participants and the supervisor.

3.4.7.4 Confirmability

Lincoln and Guba (2008) indicate that confirmability is a neutral criterion for measuring trustworthiness in a qualitative study. Thus an audit or decision trail was used to ensure that the conclusions, interpretations and recommendations could be traced to the source of the data. Furthermore, actual participant quotes during the focus group and in-depth interviews were presented to substantiate the findings. The researcher thus ensured that the findings reflected the participants' voices and the condition of enquiry, and not the biases, motivations or perspectives of the researcher (Polit & Beck, 2008: 539).

3.4.7.5 Reflexivity

Qualitative researchers are interested in how meaning is created within a particular social, cultural and relational context. Interviewing is recognized as one such process of inter-active meaning-making.

This however necessitates reflection on the research process. Parahoo (2006) defines reflexivity as the continuous process of reflection by the researcher on his or her values, preconceptions, behaviour or presence and those of the participants, which can affect the interpretation of

responses. The researcher believes that by exposing preconceptions and developing an awareness of situational dynamics the researcher and participants are involved in knowledge creation. Reflexivity was therefore used by the researcher to understand the experiences of participants in regard to the midwifery education programme, and how the programme affects the ability of the community service practitioner to provide safe maternal care. It required the researcher to remain aware of her insights on the programme being researched, as she had also been a lecturer in the midwifery programme.

For this research the researcher was the sole investigator who interacted with all participants, she therefore had to ensure her personal experiences did not influence the way in which data was collected, analysed or interpreted. The following practices were put in place:

- A field journal was kept in which all awareness of influences on the interpretation of data and the relationship to the research topic and participants was noted. The aim was to capture thoughts that otherwise might have been forgotten.
- Data was recorded, transcribed and typed by the researcher, facilitating a deepening of insight throughout the research process.

The table below provides a summary of the methodology of Phase 1. The table reflects the number of participants, namely community service practitioners as well as lecturers, clinical facilitators, and professional nurses who participated in the study.

The interview questions probed how the Kirkpatrick framework informed the data analysis process and the data analysis reasoning strategies, which were applied during data analysis.

Table 3.3: Summary of Phase 1 methodology

Data sources	Research design	Research question	Probes	Framework	Data analysis
Community service practitioners (n-10) focus group interviews	Exploratory descriptive	1. What are the views, and experiences of community service practitioner regarding the education of midwives to deliver safe maternal care?	Probes such as when, how, what and where were used to probe for specifics	Kirkpatrick levels <ul style="list-style-type: none"> • Reaction • Learning • Behaviour • Results 	Inductive analysis
Lecturers (n-4) In-depth interviews	Exploratory descriptive	1. What are the views of midwifery educators regarding the education of midwives to deliver safe maternal care? 2. What are the possible gaps in the education of midwives that would impede the provision of safe maternal care?	Probes such as when, how, what and where were used to probe for specifics	Kirkpatrick levels <ul style="list-style-type: none"> • Reaction • Learning • Behaviour • Results 	Inductive analysis

		3. What are the concepts forming the framework to align theory and practice to improve midwifery education?			
Clinical facilitators (n-7) In-depth Interviews	Exploratory descriptive	1. What are the views of clinical facilitator regarding the education of midwives to deliver safe maternal Care? 2. What are the possible gaps in the education of midwives that would impede the provision of safe maternal care? 3. What are the concepts forming the framework to align theory and practice to improve midwifery education?		Kirkpatrick levels <ul style="list-style-type: none"> • Reaction • Learning • Behaviour • Results 	Inductive analysis
Professional nurses (18) In-depth interviews	Exploratory descriptive	1. What are your views on the competence of community service practitioners to provide safe maternal care?		Kirkpatrick levels <ul style="list-style-type: none"> • Reaction • Learning • Behaviour • Results 	Inductive analysis

		<p>What are the possible gaps in the education of midwives that would impede the provision of safe maternal care?</p> <p>3. What are the concepts forming the framework to align theory and practice to improve midwifery education?</p>			
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3.5 PHASE TWO: THEORY GENERATING PROCESS

A description of the process used for the development of the framework to align theory with practice for improved midwifery education, using the theory generating process, is described in this phase. However, the application of this process is described in detail in chapter five. Theory generation requires creative and rigorous structuring of concepts which are defined and have some logical relationship with each other.

Synthesis was used as the approach to model development in this study. It involves using information based on observation to construct new concepts, statements or a new theory (Walker & Avant, 2011).

3.5.1 Step 1: Concept synthesis

Walker and Avant (2011) consider concept synthesis as the process of developing concepts from empirical evidence. Chinn and Kramer (2015: 160) define a concept as a “complex mental formulation of experience”. In other words, concepts or words represent an experience or phenomena which form the basis of theory. The experience is therefore perceptions of the world and is regarded as empiric. In this study, synthesis began by identifying concepts that emerged from empirical evidence generated through the exploratory descriptive study in phase 1.

3.5.1.1 Identification of the concepts and main concepts

Once data analysis had been done, the researcher used inductive reasoning to identify the main concepts of the framework. This is in line with Chinn and Kramer’s (2015) suggestion that the selection of concepts is guided by the purpose of the study and the researcher’s values, such as beliefs and attitudes about nursing. These authors caution that the selected concepts should not be

too broad so that they lose meaning and cannot be contextualized with the necessary detail. Likewise selected concepts should not be too narrow and concrete (Chinn & Kramer, 2015). A total of twenty-one concepts were identified from the four concluding statements developed from horizontal themes, which emerged from the analysis of the in-depth and focus group interviews. Concept synthesis was done by examining the similarities and differences of the selected twenty-one concepts, which resulted in five main concepts. These five main concepts were used to develop the framework to align theory with practice for improved midwifery education.

3.5.1.2 Classification and definition of concepts

In order to give meaning to a concept it must be classified and defined. Chinn and Kramer (2015) advise that to effectively clarify concepts it is essential to read widely on materials related to the concept. According to Meleis (2012) the goal of concept clarification is to refine existing definitions, to sharpen theoretical definitions, consider inter-relationships between the different elements of the concept, to discover new relationships and to discuss these relationships in order to resolve existing conflicts about meanings and definitions.

Concepts were classified according to the survey list of Dickoff, James and Wiedenbach (1968), which highlights the following six questions:

- Agency (Who or what performs the activity?)
- Recipient (Who or what is the recipient of the activity?)
- Framework (In what context is the activity performed?)
- Terminus (What is the end point of the activity?)
- Procedure (What is the guiding procedure, technique or protocol of the activity?)
- Dynamics (What is the energy source for the activity - whether chemical, physical, biological, mechanical or psychological?)

Several strategies were used to define the concepts including dictionary definitions, literature and the input of experts in the field of midwifery education - to determine whether the concepts were fit for purpose. Various definitions of the concepts from the different sources were then synthesized to arrive at a definition which could be contextualised and which could give meaning to the framework to align theory and practice in midwifery education.

3.5.2 Step 2: Statement synthesis

Statement synthesis is the process of extracting one or more statements from the data (Walker & Avant, 2011). Concepts are not viewed in isolation but in relation to one another. Chinn and Kramer (2015) assert that relationship statements describe, explain or predict the nature of the inter-relationship between the concepts. The statements were supported by empirical evidence (Walker & Avant, 2011). The relationship statements can be uncomplicated where only two concepts are linked or more complex where multiple concepts are interrelated. Chinn and Kramer (2011) maintain that specific attention must be given to substance, direction, strength and the quality of the interaction between concepts when developing relational statements.

3.5.3 Step 3: Theory synthesis

Walker and Avant (2011) contend that this is the process of developing theory from a set of empirical statements. The process of framework development included the use of concepts which were identified and defined in step two. Relational statements which link the concepts were then developed. Synthesis was used to bring about cohesiveness in the data from phase one, to facilitate the process of framework development since the data that emerged from phase one need to be connected for the development of the framework (Walker & Avant, 2011).

3.5.4 Framework description

This involved describing the framework for the alignment of theory and practice to improve midwifery education in the Western Cape. This was to ensure that the concepts and their relevance and links were understood and clear and that the framework as a whole had meaning.

The following questions were used to structure the description of the framework for the alignment of theory and practice to improve midwifery education:

- What is the purpose of this framework or why was it developed? It provides clarity regarding the circumstances and context for which the framework was developed.
- What are the concepts underpinning the framework? This provides an understanding of the ideas that are structured and related in the model.
- How are the concepts defined within the framework? This shows how concepts are linked and gives structure to the framework.
- What is the nature of the relationships within the framework? It shows how concepts in the framework are linked together.
- What is the structure of the framework? This illustrates how the structure of the framework is based on the conceptual relationships within it.
- On what assumptions does the framework build? This addresses the basic truths underpinning the theoretic reasoning (Chinn & Kramer, 2015).

3.5.5 Guidelines to operationalize the framework

The developed framework will be used by midwifery educators to improve midwifery education.

Chinn and Kramer (2015) state that deliberative application of the model / framework has the following subcomponents:

- Selecting the clinical setting - the clinical setting for deliberate application of this research will be higher education institutions and maternal health care settings, where students are placed for clinical practice.
- Determining outcome variables for practice - the outcome variables for this study would be to ensure that midwifery education meets the need to provide safe care to patients in need of maternal care.
- The framework will not be implemented or tested as part of this study. Specific guidelines have been developed to operationalize the framework.

The table below summarises the approach to theory building used in this study.

Table 3.5: Synthesis as an approach to theory building (Walker & Avant, 2011)

Strategy	Use
Concept synthesis	To extract or pull together concepts from a body of data
Statement synthesis	To extract or pull together one or more statements from a body of data
Theory synthesis	To pull together a theory from a body of data or a set of empirical statements

3.6 RESEARCH ETHICS

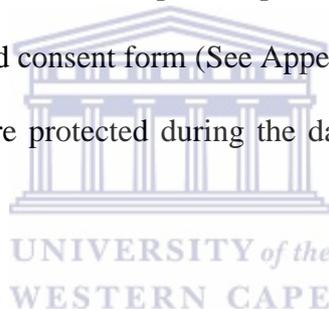
3.6.1 Gaining permission to conduct the study

Ethics clearance, prior to conducting the study, was obtained from the Research Grant and Study Leave Committee of the University of the Western Cape. The proposal was also submitted to the Higher Degrees Committee of the University of the Western Cape for approval. In addition,

approval to conduct the study was obtained from the Department of Health of the Western Cape. Written approval was obtained - from the education institutions' Heads of Department and Executive Managers of the primary, secondary and tertiary midwifery services - for access to study participants (See Appendix 9, 10, 12, & 13).

3.6.2 Informed consent

Informed consent (See Appendix 6) was sought from community service practitioners' midwifery educators, clinical facilitators and professional nurses who were provided with explicit information (See Appendix 5) about the research. Facts were presented in a manner that was understandable to the participants. Therefore, prior to participation in the research it was required of participants to sign an informed consent form (See Appendix 6). This form acknowledged that the rights of the participants were protected during the data collection process (Polit & Beck, 2012).



3.6.3 Voluntary participation

To ensure that participants did not feel obliged to participate, it was emphasized that they were under no obligation to do so; whether they participated or not, would not affect their rights as employees. They were also made aware of their right to withdraw from the study at any time.

3.6.4 Confidentiality

The researcher also had a responsibility to give participants the assurance of confidentiality and anonymity (Polit & Beck, 2012). The participants' identity was protected - participants were addressed using pseudonyms during the interviews, e.g. participant no 1 or no 2 etcetera. They

were made aware that although quotes would be used in the write-up for the thesis and journal article, no identifying information would be made known. The data was kept in a locked cabinet that only the researcher had access to. Five years after the conclusion of the research, the data will be destroyed. In addition, the participants in the focus group interview were required to sign a binding confidentiality form (See Appendix 7).

3.6.5 Beneficence and non-maleficence

These are two of the most fundamental principles when conducting research and it relates to the concept of “do no harm”. In assessing the potential effects, risks or hazards for research participants, it is acknowledged that the recollection of their midwifery education might have been distressing. However, it could be argued that research investigating the experiences pertaining to midwifery education does not fulfill the criteria of a sensitive topic although it might arouse strong emotional responses. Informing the participants in advance about what the study would involve, as well as the topics that would be covered, assisted them in making informed decisions regarding participation. Participants were informed that they could request a break at any time and could also refrain from answering certain questions, if they so wished, during the interview process. Arrangements for debriefing sessions with psychologists at the participants’ institutions of employ were made lest the need arose.

3.7 SUMMARY

This chapter described in detail the research methodology used in the two phases of the study. Research ethics and trustworthiness related to the study were also discussed. The findings of phase one is presented in chapter four.

CHAPTER FOUR

PRESENTATION OF RESULTS AND DISCUSSION

4.1 INTRODUCTION

This chapter presented and discussed the results of analysed data collected from participants in phase one of the study in response to the following research purpose:

- To develop a framework within which theory and practice are aligned in order to improve midwifery education.

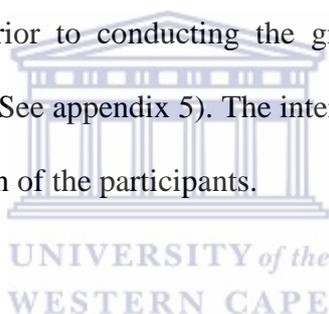
This was based on an exploration of the experiences of community service practitioners, professional nurses and midwifery educators regarding the midwifery education programme as well as their perceptions on the competence of the community service practitioners to provide safe maternal care. Data collection was conducted between November 2014 and May 2015.

4.1.1 Focus group discussions

Two focus group discussions, each comprising of five community service practitioners, were conducted. The participants in the focus group discussions had at least six months' experience as community service practitioners. To ensure that group members would be comfortable with each other and also to facilitate an open discussion without any reservations, the researcher interviewed the community service practitioners from the different education institutions separately.

The researcher visited each clinical placement facility and explained the purpose and objectives of the research in depth to the managers. She requested their co-operation with the selection of

community service practitioners who would be willing to participate in the study. Once the list was compiled, it was conveyed either telephonically or by e-mail to the researcher. The researcher then contacted the practitioners on the list to explain the purpose and objectives of the study. Thereafter she requested that they compose a group of community service practitioners who met the inclusion criteria and were willing to participate in the study. Once five willing community service practitioners were recruited, the researcher was contacted and a date, time and venue which suited all the community service practitioners were set for conducting the focus group discussion. One focus group discussion was conducted in the training venue at a secondary maternal care facility in April 2015; the other focus group discussion was conducted in the training venue at a tertiary maternal care facility in May 2015. The researcher obtained written consent from all participants prior to conducting the group interviews and after providing information regarding the study (See appendix 5). The interviews were all recorded on an audio-tape recorder, with the permission of the participants.



4.1.2 In-depth Interviews

Eleven in-depth interviews were conducted with lecturers and clinical facilitators, referred to as educators, employed at the two education institutions in the Western Cape offering the undergraduate midwifery programme in accordance with SANC R425. The data collected through the in-depth interviews addresses objective two and three of the study:

Midwifery educators were contacted telephonically by the researcher to set up interview dates and times. All interviews were conducted and recorded in offices at the campuses where the educators were employed. The educators matched the inclusion criteria described in chapter three and informed written consent was obtained prior to the interviews.

Eighteen in-depth interviews were conducted with professional nurses employed at either a primary, secondary or tertiary maternal care setting where students were placed for midwifery clinical practice. The group of professional nurses was diverse in terms of the posts they held, age, professional education and experience. They were purposively sampled and interview appointments were made, this was done in the same manner as described above. The interviews with the professional nurses were conducted in their offices.

4.1.3 Data analysis

Data analysis was conducted simultaneously with data collection. The large amount of information was reduced to themes and categories by implementing Thomas's (2003) inductive analysis steps, these steps are described in detail in chapter three.

Descriptive narratives are used to describe the research findings. Every category and theme were authenticated by quotes from raw data, compared and differentiated by relevant, current literature, and researched to establish current knowledge about the perceptions and experiences of community service practitioners, lecturers, clinical facilitators and professional nurses regarding the midwifery education programme. However, in order to convey an inductive design the researcher used literature frugally. Kirkpatrick's framework, which is described in chapter two and is the theoretical framework used in this study, had guided the analysis by assisting to establish a system of categories which were later developed into themes.

Data was analysed and structured under the following levels, according to the Kirkpatrick framework:

Level 1: Participant's reaction - this level focused on the views and experiences of participants about learning, teaching methods and aspects of the quality of clinical instruction.

Level 2: Learning - this level relates to changes in learners' attitudes or the perception of learners about education practice. It also relates to the change in learners' knowledge and skills. In addition it relates to students' acquisition of midwifery concepts, principles, cognitive and psychomotor skills.

Level 3: Behaviour - this level relates to the transfer of learning to the workplace.

Level 4: Results - this level was used in phase two of the study and relates to the development of the framework to align theory with practice to improve midwifery education, the ultimate aim being the improvement of maternal patient care in the Western Cape.



4.2 PRESENTATION OF RESULTS

The results are presented and discussed in four sections as follows:

Section 1A presents the vertical themes and categories obtained from the analysis of the focus group discussions with community service practitioners.

Section 1B presents the vertical themes and categories obtained from the in-depth interviews with lecturers and clinical facilitators.

Section 1C presents the vertical themes and categories obtained from the in-depth interviews with professional nurses.

Section 2 presents a summary of the themes and categories for all participant groups, in tabular form, as well as the horizontal themes which cut across the vertical themes of all participant groups presented in section one; this is followed by a discussion of data from the focus group discussions and in-depth interviews.

4.2.1 Section 1A: Results of community service practitioners' focus groups

The results in section 1A respond to the following research objectives in line with the Kirkpatrick framework:

- Establish the experiences of the community service practitioners regarding midwifery education and their perceived competence to provide safe maternal care.
- To determine possible gaps in the education of midwives that could preclude the provision of safe maternal care.

Level 1: Participants' reaction - this level focused on the views and experiences of participants regarding learning, teaching methods and aspects of the quality of clinical instruction. Table 4.1 presents the themes and categories generated from the focus group discussion data.

Table 4.1: Community service practitioners themes and categories

Themes	Categories
Kirkpatrick framework – Level 1	
<p>Theme 1:Duration and structure of the midwifery education programme negatively affected learning and the attainment competence by community service practitioners</p>	<p>1.1: The midwifery education programme was too short to ensure learning and achievement of competence to provide safe maternal care</p> <p>1.2: Time allocated for the achievement of theoretical knowledge was insufficient which made learning stressful and negatively influenced the achievement of competence</p> <p>1.3: Structure of the placement programme was incongruous, allowing limited exposure of high risk placement which adversely affected learning and the achievement of competence</p>
<p>Theme 2:Preparation for clinical placement was adversely affected by the lack of relevance and synchrony between theory and practice, the focus on learning for assessment, the timing of written assessments and the exposure to ideal situations during skills laboratory sessions negatively influenced learning</p>	<p>2.1: The lack of synchrony between theoretical preparation and clinical placement as well as the use of outdated policies in the theoretical preparation, made students feel unprepared for clinical placement which negatively influenced learning</p> <p>2.2: The process of delineating content for assessment purposes only, hinder comprehensive learning and achievement of competence</p> <p>2.3: Written assessments were untimely as they were often written before clinical placements and did not assist in the synergy of theory and practice which negatively impacted on the student’s performance in assessments</p> <p>2.4: The ideal situations provided during skills laboratory sessions compared to the real experiences in clinical practice, which was experienced stressful, affected their performance</p>

<p>Theme 3: Clinical learning was adversely affected by the lack of synergy between theory and practice, clinical learning requirements, assessments by the professional nurses, ineffectual clinical supervision and differing techniques for demonstrating competencies</p>	<p>3.1: Some of SANC’s clinical requirements were unattainable since it was no longer conducted in practice, this adversely impacted on the achievement of the required competencies</p> <p>3.2: Assessments by professional nurses in the clinical area were often opportunistic, which negatively influenced learning and the attainment of competence</p> <p>3.3: Ineffective clinical supervision by professional nurses and educators, negatively impacted on learning and the attainment of competence</p> <p>3.4: Differing techniques for competencies used by educators and professional nurses evoked confusion amongst students, which adversely impacted on learning</p>
<p>Theme 4: Learning in the clinical setting was adversely affected by personal attributes of professional nurses and ineffectual communication between educators and professional nurses</p>	<p>4.1: Personal attributes of professional nurses such as a perceived knowledge deficit and lack of English language proficiency played a role in learning and the attainment of competence</p> <p>4.2: Ineffective communication between role players stifled learning and the attainment of competence for community service practitioners</p>

4.2.1.1 Discussion of themes and categories for community service practitioners

Theme 1: Duration and structure of the midwifery education programme negatively affected learning and the attainment of competence by community service practitioners

This theme and ensuing categories narrates the difficulties community service practitioners experienced whilst attempting to consolidate and build their midwifery knowledge and skills, due to the nature and duration of the midwifery education programme.

Category 1.1: The midwifery education programme was too short to ensure learning and achievement of competence to provide safe maternal care

Community service practitioners believed that the time spent in the clinical practice setting as student midwives was too short to assist them to construct a professional identity as a midwife or to demonstrate midwifery competence to provide safe maternal care. One community service practitioner remarked that *“it was way too little to prepare me to become a competent midwife”* (focus group 1 participant 4). Another participant noted that even after completing the programme and having at least six months’ experience of working as a community service practitioner, she *“still feel[s] uncomfortable working in a labour ward”* (focus group 1, participant 2). One more community service practitioner summed it all up when she said: *“The programme was just 6 months. I think we had 3 weeks normal and 3 weeks abnormal, that was just the theory and it was too short for me, and then plus minus how many months in the wards just to gain experience”* (focus group 1, participant 2). Literature proposes that developing a professional identity and an aspiration to learn are influenced by the length of the clinical practice (Levett-Jones, Lathlean, Higgins & McMillan, 2009). Short-term placement has been shown to offer students less opportunity to participate in the social interactions that go into making them future professionals (Levett-Jones & Lathlean, 2008). Miller (2014) concurred stating to provoke meaningful learning for students in practice the length of a practice learning experience will need to be considered.

Given the community service practitioners desire to consolidate and build their knowledge and skills base, it is therefore not surprising that the majority of them acknowledged that a longer period allocated for the education of midwives would assist them in meeting their goals. The present duration is extremely stressful, as attested to by this participant’s comment: *“I felt I was under pressure because the time was like very short”* (focus group 1, participant).

Category 1.2: Time allocated for the achievement of theoretical knowledge was insufficient which made learning stressful and negatively influenced the achievement of competence

Leading on from their expressed need for an extended duration of the midwifery programme, participants voiced their opinion regarding the time allocated for theoretical teaching being insufficient to consolidate the information. *“The time period or the duration is much too short for all of that information”* (focus group 2, participant 7). Learning had to be authentic and meaningful for the participants, they felt that they - *“just studied to pass that time”* (focus group 1, participant 1). Another participant commented that *“we are not only studying to pass, we should study to have something to put into our pockets, which are our brains because we know we are going to a place”* (focus group 1, participant 3).



Category 1.3: Structure of the placement programme was incongruous allowing limited exposure of high risk placement which adversely affected learning and the achievement of competence

The duration of the clinical placement or rotation was another aspect frequently commented on. Adequate clinical exposure was linked with community service practitioners' gaining competence. A community service practitioner mentioned *“I feel at low risk it was enough”* (focus group 1, participant 3). Community service practitioners were of the opinion that frequent rotation of student nurses hampered effective clinical learning. The need for longer placement and less frequent rotation were strongly emphasized by community service practitioners, to practice their high risk maternal care skills and improve their competence for practice.

It became clear that the majority of community service practitioners identified a set of specific areas and clinical skills that they considered would assist them to practice as competent midwives. “*But when it came to high risk we were only there placed for 7 days and we had to rotate within that 7 days*” (focus group 1, participant 3). These commonly included high-risk areas such as the labour wards, as noted by this community service practitioner: “*I felt I needed to be placed more in the labour ward to get exposure*” (focus group 1, participant 3). Knowledge of skills such as preparing patients “*for caesarean section, episiotomies for which we did not get exposure of*” was also identified (focus group 1, participant 3).

Community service practitioners were of the opinion that midwifery educators did their best within the time period provided for training and education, but that their efforts were weakened by the short duration of the programme. “*There was nothing wrong with the lecturers; it was only the shortness of the programme*” (focus group 1, participant 1). Additional time may be needed by students to facilitate the acquisition of basic midwifery skills and to incorporate complex concepts into the provision of safe maternal care.

Theme 2: Preparation for clinical placement was adversely affected by the lack of relevance and synchrony between theory and practice, the focus on learning for assessment and the exposure to ideal situations during skills laboratory sessions negatively influenced learning

This theme highlights the lack of synchrony between the offering of the theoretical component of midwifery and the actual clinical placements. It furthermore alludes to the clinical skills laboratory reflecting an ideal situation as opposed to what is the real life situation in clinical practice.

Category 2.1: The lack of synchrony between theoretical preparation and clinical placement, as well as outdated policies made students feel unprepared for clinical placement which negatively influenced learning and the achievement of competence.

Community service practitioners clearly acknowledged the underlying value of theoretical preparation for clinical placement “*My training, I think, did prepare me theoretically*” (focus group 1, participant 1). However, it became evident from the data that there was a great deal of theory to cover - which they understood much better when they could synchronize it with practical experience. These results were consistent with Morgan’s (2006) opinion that there were perceived differences in student nurses regard of the reality of practice idealism and theory. The researchers mentioned that the existence of the theory-practice gap can delay student learning. The examples provided indicate that the majority of interviewed students had difficulty in achieving synchrony between theory and practice.

“*It was very difficult, it made us so stupid* (focus group 1, participant 3). “*Now I didn’t do the abnormal, I only knew the normal*” (focus group 2, participant 6). The following excerpt portrays the amount of anxiety the students were experiencing due to the misalignment of theoretical preparation and practice placement. The community service practitioners had varying reactions ranging from ineffectiveness to distress to overwhelming emotion. “*I was in shock and the patient was in shock, she was pale and I was - like what I was - just standing. I didn’t do nothing! I was just there occupying the space; I didn’t know what to do*” (focus group 1, participant 3). Consistent with the findings of this study, Ousey and Gallagher (2007) assert that the theory-practice gap from the student’s perspective has been noted as demanding; it has left students confused and uncertain about their roles in practice. There were, however, some instances where community service practitioners felt that clinical placement corresponded with- and strengthened

theoretical preparation. *“Some were lucky to have been placed at places relevant”* (focus group 1, participant 2).

Despite the emphasis on sufficiency and relevance of the content, several responses indicated that participants believed that *“they can’t teach you everything; you know you must get orientation at the hospital”* (focus group 2, participant 9). Community service practitioners also expressed the need to be acquainted with essential things like the latest policies and guidelines, in order to gain a better understanding of care-decisions made in practice and to deal with the policies in theory before being involved in care in the clinical settings. As summed up by this participant: *“Policies and guidelines, let’s say the PMCT (prevention of mother to child transmission), it was different in the facilities than the one in the class”* (focus group 2, participant 10). *“It was confusing, something else in class and when we come to practical, this thing that we got in class it is not the latest”* (focus group 2, participant 7).



Category 2.2: The process of delineating important content for assessment purposes was hindering comprehensive learning and achievement of competence

SANC (2008) asserts that the rationale of assessments is to determine whether the person being assessed is a competent, informed and compassionate midwifery practitioner who is able to perform the dependent and autonomous functions. Whilst written assessments were relevant and helped to synchronize theory and practice as voiced by this participant: *“Everything that was done was related to what was expected to [of] us as sisters”* (focus group 1, participant 2); it did not support the practice of delineating important theoretical content for assessment purposes, as it was seen as hindering comprehensive learning which was necessary for safe practice. It was summed up by this participant: *“It’s a disadvantage because there is so many things in the book*

that you don't go to, because myself I'm not gonna [going to] go through something that is not in the test (laughing); because now you are only going through this and leaving out all the other things that was also important, that we are finding out now is also important" (focus group 1, participant 3). Carrick (2011) asserts that students have difficulty discerning what is important and thereby creating a situation for failure.

Category 2.3: Written assessments were ill-timed and did not assist in the synergy of theory with practice, which negatively impacted on learning and achievement of competence in order to provide safe maternal care

Leading on from the expressed need for synchrony between theoretical preparation and clinical placement, was the timing of written assessments. Gaberson, Gaberson and Oerman (2010) asserted that those not in favour of assessments argued that assessments could result in emotional and psychological harm to students. Community service practitioners felt that they would have had better reinforcing and sense-making of theoretical knowledge, if they were allowed to experience the application of theory to practice and be assessed thereafter. *"How can you write the normal and you didn't go to the services and you didn't see the normal midwifery"* (focus group 1, participant 5). Another participant noted: *"We went to the practical area afterwards, now I see all those things that we were writing about in the paper"* (focus group 1, participant 5). A participant summed it up as: *"I mean in midwifery the prac [practice] and the theory, it must go together"* (focus group 1 participant 2).

Category 2.4: The dissimilarity between skills laboratory sessions and clinical practice was confusing and stressful, which adversely influenced the achievement of competence

Another implication of an increased number of nursing students is difficulty in finding clinical placement (Ganley & Sheets, 2009). This compels nursing education institutions to substitute bedside patient-care experiences with clinical simulation, in order to accommodate the increased student numbers. Skills laboratory sessions are commonly utilised to create experiential learning opportunities for midwifery nursing students through activities and mock-ups of genuine nursing experiences. Newton and McKenna (2007) in their study revealed that graduates reported that experiences in the university simulated laboratory environments do not accurately reflect the complexities, challenges, emotions and conflicts that are the reality of the clinical environment. Participants similarly acknowledged the pivotal role the skills laboratory sessions played in their preparation for clinical practice placement, but to make the experience more real they preferred the skill be demonstrated on a real patient as well. *“My tutor, I don’t remember her demonstrating that procedure with me on a patient only on the doll. So, I feel if it was done on the patient it would make it feel like the real thing”* (focus group 1, participant 1). Another participant said: *“With the dummy, the experience is not the same although they tell you anatomically it is the same”* (focus group 1, participant 6). Similarly, Gaberson, Gaberson and Oerman (2010) postulates that practice in the clinical setting exposes the student to realities of professional practice that cannot be conveyed by a textbook or a simulation.

Participants noted that learning in the skills laboratory setting was more context-specific and did not focus on the reality of the practice setting. The dissimilarity between these two environments was distressing as demonstrations in the skills laboratory were mainly performed on relevant anatomical body parts. This made the implementation of clinical skills more challenging in practice reality as explained by this participant: *“demonstrations in the skills lab were done using*

only a pelvis, they could turn that pelvis. So, with the real patient you would then know to turn yourself and not the dummy” (focus group 2, participant 6).

Participants commented that they were often caught between their lecturers’ demands to implement what they had been taught in theory and the pressure from professional nurses to conform to the constraints of the real practice setting - since the patient and practice were different in practice reality: *“so when you get to the facility there’s a sister telling you, you are supposed to know and you are supposed to do that; and now you are standing there and you are thinking what am I doing”* (focus group 1, participant 2). Conversely, in a research study containing 125 student midwives participants recognized that evidence based practice in clinical placements was not always employed in practice nor always chosen by the midwife (Armstrong, 2010). Leaving students frustrated by the way things are being done (Armstrong, 2010).

However, in a study conducted by Chan and Yuan (2013) - at a nursing school in Macao with eighty-five Baccalaureate nursing students, to ascertain how students’ health assessment skills changed in a simulated setting - it was found that using simulation in a skills laboratory helped to transform student’s knowledge, develop their potential and encourage them to keep their determination to learn.

Despite the recognition and value of linking theory with practice, the clinical experience was deemed most important. Examples were provided which highlights the tension community service practitioners experienced between the academic and practice settings in relation to theoretical preparation for practice placement. Their feelings arose out of their preconceived perceptions regarding how the patient should be treated, which was informed by the theory of midwifery practice taught at the education institutions. An example of this is provided by the following participant: *“I have never seen an episiotomy done, but they did explain why they don’t do the*

episiotomy at the MOU [midwifery obstetric unit]. But I see now that at the MOU's they declare the patient as delayed only to find out that if a episiotomy was done on the patient, the baby would have just popped out. The outlet was not big enough to allow the baby through" (focus group 2, participant 10). An episiotomy is an incision made in the perineum during childbirth to help deliver the foetus or to prevent the muscles and skin from tearing. Moreover, Jordan and Farley (2008) postulates the clinical learning environment significantly influence student's competency as well as socialization into the profession.

In addition, community service practitioners recognized that they had to make re-adjustments between what they have been taught in the classroom and the midwives who had their own way of doing things, as provided by the following illustration: "*They declare that the patient's labour are delayed only to found out that if an episiotomy was performed on this patient they could not have referred the patient, the baby would have just popped out. It was not actually a delayed second stage, the outlet was not enough for the baby to pop-out*" (focus group 2, participant 9).

The handling of this circumstance ignored the learning-role of the student as well as the wonderful learning opportunity that existed.

In a study on student nurses' experience of clinical practice, conducted by Sharif and Masoumi (2005), it was reported that students experienced confusion in the wards because of discrepancies between what is taught in the classroom and what is actually implemented in the clinical environment. Kaphagwani and Usch (2013) assert that theory forms the basis for students learning what to apply in the clinical practice in order to make meaning of the theory.

Theme 3: Clinical learning was adversely affected by clinical learning requirements, assessments by professional nurses, ineffectual clinical supervision, and differing techniques for demonstrating competencies

Community service practitioners mentioned that they experienced the greatest pressure from the demanding programme during clinical placement, as they would be working and having to complete academic assignments: “...we have to be in the services, we have two assignments to do and there is not enough time” (focus group 1, participant 4).

Category 3.1: Some of SANC’s clinical requirements were unattainable since it was no longer practiced, this adversely impacted on the achievement of competence

Participants stressed that some of SANC’s clinical requirements, particularly the pelvic assessment which is performed on a pregnant patient to determine whether her pelvis is large enough to accommodate the safe vaginal delivery of the baby, were no longer performed at some facilities; a participant summed it up as follows: “Not all of them, the pelvic assessment that one the sisters [midwives] they don’t do it at the MOU [midwifery obstetric unit]” (focus group 2, participant 8).

Participants claimed that their adverse experiences were exacerbated when large numbers of students were placed at one placement facility. It made the attainment of those identified objectives more difficult as there were not enough learning opportunities available for all the students placed at the facility. “Nursing is a very big class, there was [were] not enough learning opportunities” (focus group 1, participant 3).

Nursing students from the two different education institutions were posted to one ward; the students then needed to compete with each other to complete their procedures in order to achieve their targets. Therefore students shared procedures on patients when there were limited opportunities - or else some students would not have had an opportunity to practice their clinical skills, as explained by this participant: *“We would share procedures, if someone needed to cut a [n] episiotomy then you would call your friend to cut. And if someone else needed just to suture and then she will be called to suture”* (focus group 2, participant 10). Another participant noted: *“...but if we’re not friends then we will fight for procedures, or if it is close to the end of placement periods”* (focus group 2, participant 3). Mattila, Pitkajarvi and Eriksson (2010), in their study conducted with international nursing students in the Finnish health care sector, stated in their findings that most nursing students did not experience meaningful learning outcomes because they were prevented from participating in the daily ward routines.

Some of the participants, however, claimed that working shifts helped to ease the congestion - as reported by this participant: *“And the other thing that helped us was to work 7/7 [from 07h00 – 19h00]. I think that is the other thing that helped us because some of the other students at the other institutions, they worked 7/4’s [from 07h00 – 16h00]. So we were staying behind and by that time we were learning more of that stuff because we were not that crowded”* (focus group 1, participant 5). Large numbers in clinical practice appears to be a common phenomenon, hindering clinical teaching and the attainment of competence (Mabuda, Potgieter & Alberts, 2008).

Category 3.2: Assessments by professional nurses in the clinical area were often opportunistic, which negatively influenced learning and the attainment of competence

Clinical assessment in the clinical area is conducted by the clinical facilitator and/or professional nurse (Gopee, 2008). In clinical assessments, it must be ensured that students in the practice settings have the appropriate professional behaviour, establish appropriate interaction with the patient, prioritize the problems, have the basic knowledge about clinical methods, perform the care procedures correctly and apply critical thinking (Leung, Mok, & Wong, 2014). Furthermore - assessments have a gatekeeper function in that those qualified practitioners who have the ability to assess a student's competence to practice, regulate entry to the Register of Midwives. Numerous problems associated with the assessments of nursing students' clinical skills in the practical environment, have been highlighted and recorded in the literature (Jervis & Tiki, 2011). Similarly, whilst the process of assessing clinical learning had positive aspects, several concerns were raised by community service practitioners. Some eye-opening statements regarding the assessment of clinical learning were made: "*We had to ask the sisters to sign for us without the pelvic assessment being done*" (focus group 1, participant 4). These statements could question the transparency and significance of the assessment process for the stakeholders. However, because this procedure is one of the core objectives in their practical workbook required for successful completion of the midwifery education programme, participants said, as mentioned by this participant: "*So they must just keep up to date because we will end up signing for each other, or ask the sister [midwives] to sign for us (laughing)*" (focus group 1, participant 5). Another participant noted: "*The sister told me she doesn't know how to do it but she will just sign off the pelvic assessment for me, they don't evaluate you they only sign-off procedures*" (focus group 2, participant 10). These findings seem to be consistent with reports from recent Nursing and Midwifery reports, which responded to concerns about unsafe students passing practical

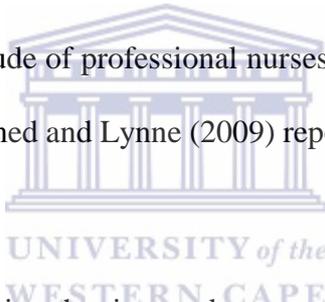
assessments (Nursing and Midwifery Council, Australia 2008). Similar concerns have been expressed in a range of recent studies such as Price (2007), Fitzgerald (2010), as well as Ross, Mahal, Chinnappenn, Kolar and Woodman (2014). The consequence of students' competencies being signed-off as a pass without thorough assessments of the student's ability to perform the psychomotor skill are poor nursing practices and risky as well as futile care, which possibly will cause harm to a patient's health (Gopee , 2008).

Category 3.3: Ineffective clinical supervision negatively impacted on learning and the attainment of competence to provide safe maternal care

The relationship with their supervisors in the clinical setting was an important factor for participants who acknowledged their supportive roles, in sharing knowledge and inculcating confidence in preparation for clinical practice. In a study conducted by Licqurish and Seibold (2008), students indicated that midwifery supervisors can either be helpful or unhelpful. Carr (2008) wrote on the perception of a good and bad supervisor, she states that a good supervisor is a nurse who is willing and committed to facilitate students' development by enabling them to practice learnt skills with reducing supervision. In contrast, she refers to a bad supervisor as a nurse who is not only unwilling to engage in students' learning but also evaluates their clinical competencies against personalities instead of knowledge. Community service practitioners noted that they preferred working with caring midwives who enjoy teaching, answer their questions fairly and have a philosophical orientation that is similar to theirs. Community service practitioners valued the relationship with professional nurses, recognized their supportive roles and valued their contributions, in the clinical setting. Participants disclosed that they primarily learned everything about the practice of midwifery in the clinical setting: "*The midwives and they*

taught us everything” (focus group 2, participant 10). The support provided by the professional nurses contributed to significant and genuine learning, allowing participants the opportunity to be actively involved in the practice of midwifery. *“The staffs were so friendly, they teach us everything, I almost got all my deliveries at the MOU at Vanguard”* (focus group 2, participant 8).

However, community service practitioners also recognized that their presence put the professional nurses under pressure as verbalized by this participant: *“the professional nurse[s] are sometimes very unapproachable, they have their own work,[and] they have doctors coming straight down on them, so there is no time for that student really”* (focus group, 1 participant 3). Consistent with this finding, Simms (2009) reported that students in the clinical learning environment often blame themselves for the opposing attitude of professional nurses towards them that lead to inadequate functioning. Similarly Kroll, Ahmed and Lynne (2009) reported that students felt that “they were thrown in at the deep end”.



Many students expected that having the time and opportunity to consolidate and develop skills would have a positive impact on their confidence by the end of their placement: *“Treated as a midwife and not as a student made me reach all my objectives; I cut my first episiotomy with the doctor”* (focus group 1, participant 3).

Whilst many of the issues were related to the theoretical preparation of the community service practitioner for clinical practice, their negative experiences were exacerbated by the lack of uniformity between lecturing staff. The conflict between the expectations of nursing school personnel and clinical personnel in hospitals, highlighted by Melender, Jensen and Hilli (2013), is one of the factors that can negatively influence the clinical experience of student nurses as

explained by this participant: *“They always had some arguments about things”* (focus group 2, participant 7).

Category 3.4: Differing techniques for competencies demonstrated by educators and professional nurses invoked confusion amongst students, which adversely impacted on learning

Professional nurses’ practices within the placement settings were influenced by their ethical standpoint, hospital guidelines and workload issues. It is evident from the data that students were exposed to dissimilar midwifery practice techniques in the various midwifery settings associated with education institutions. This applies to both organizational and individual midwifery practice. Students were aware of these differences and were required to practice in the manner outlined in unit guidelines, for example the use of an electronic monitoring device recording document called a partograph. There appeared to be inconsistency in the recording of this document which caused confusion for students and therefore affected the attainment of competence negatively, as expressed by this participant: *“It was due to the fact that they were not agreeing to what must be placed there, so for instance latent phase, where is the latent phase, some were taught no you are supposed to put this there”* (focus group 2, participant 10).

A partogram is used to monitor the progress of labour, once labour has been established, and is utilised in a labour ward. A participant conveyed the following about it: *“cause [because] now it can also cause some medical legal hazards, or I mean create problems for the patients”* (focus group 2, participant 7). The use of the partogram was thus perceived as standing in the way of learning and the accomplishment of competence to provide safe maternal care.

Time was a major issue for community service practitioners whilst in the clinical placement setting. Professional nurses were busy and under pressure to provide quality care to a large number of patients, which affected the time they had to teach students. Community service practitioners expressed their concerns about the learning strategies demonstrated to them not always exposing them to best practice, as summed up by this participant: *“The sister doesn’t have the time to teach the students the proper way of doing things, because they are also taking shortcuts in the wards”* (focus group 1, participant 3).

Theme 4: Learning in the clinical setting was adversely affected by personal limitations of professional nurses and ineffective communication between educators and professional nurses

Challenges in teaching and learning are negatively affected when those in senior position are perceived as lacking the relevant knowledge. The actions of professional nurses meaningfully impacted students’ learning and experiences. In addition the collaborative responsibility of education and practice is requires effective communications regarding the education and training of students. Educational institutions, professional nurses and clinical facilities are important contributors to the midwifery education process. Their mutual bond with education is a commitment to the profession.

Category 4.1: Personal limitations of professional nurses such as a perceived knowledge deficit and lack of English language proficiency played an adverse role in learning and the attainment of competence

Community service practitioners expressed concern when they did not receive adequate clinical teaching from professional nurses to help them link theory to practice. “The *ward sisters don’t have the knowledge, they don’t know the theory we are taught in class*” (focus group 1, participant1). Mabuda et al., (2008) found in their study that the ward staff or professional nurses could not teach student nurses because they did not have any education qualification, were not remunerated for teaching students and due to heavy workloads. The result of a study done by Magobe (2010) indicated that some clinical supervisors lacked the necessary knowledge, due to not having the required qualifications and consequently could not improve student clinical competence. Hughes and Fraser (2011) described that some midwives do not want to work with student midwives possibly because their practice may be under scrutiny. While, Longworth (2013) in his study found that learning was enhanced when the student recognized that their theoretical understanding was shared by the professional nurse.

Whilst clinical support and skills development are important, the community service practitioners also indicated that their own attitude played a role in aiding them to achieve their goals. Maintaining a positive personal attitude and believing in oneself was an important and interesting concept. “*People don’t trust themselves, if you trust yourself you make sure that you do the things you were taught and you practice*” (focus group 2, participant 10).

Category 4.2: Ineffective communication between role players stifled learning and the attainment of competence for community service practitioners

A number of participants indicated that occasionally poor communication was an obstacle in student supervision. It seemed that nursing students' learning and practice was stifled by professional nurses who refused to speak English, as expressed by this participant: "*Or they don't want to speak English*" (focus group 1, participant 4). Wilkes (2006) postulated that effective communication is the key to forming relationships between professional nurses and nursing students. Wilkes (2006) furthermore stated that not all nurses use the appropriate forms of communication during clinical teaching.

Another key issue for community service practitioners in relation to their clinical experience was discovering that they were responsible for their own learning and were often left to work alone. They perceived it as adequate support and supervision: "*The supervisors or the tutors that follow us up when they go to us in the placements, they practice with us what we are supposed to do. They try most of the times to practice because sometimes we don't*" (focus group 2, participant 9).

4.2.2 Section 1B: Results of lecturers and clinical facilitator interviews

The results in sections 1B respond to the following research objectives in line with the Kirkpatrick framework:

- To explore the views and perceptions of nurse educators (lecturers and clinical facilitators) regarding the education of midwives to deliver safe maternal care.

- To establish the nurse educators (lecturers and clinical supervisor) [*and professional nurses] views on the community service practitioners' competence to provide safe maternal care. [* this is addressed in section 1C]
- To determine possible gaps in the education of midwives which preclude the provision of safe maternal care.

The table below presents the themes and categories generated from in-depth interviews with the educators which are aligned to the three levels of the Kirkpatrick framework: Reaction, Learning and Behaviour.

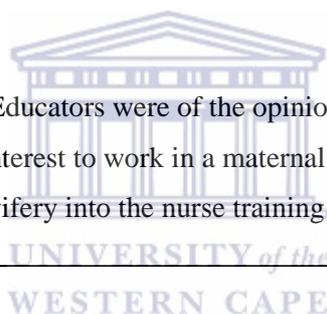
Table 4.2 Themes and categories of lecturers and clinical facilitators

Themes	Categories
Kirkpatrick framework - Level 1: Reaction	
<p>Theme 1: The timing, duration, nature and inclusion of midwifery as part of the qualification in the R425 programme has negatively affected learning</p>	<p>1.1: The offering of the midwifery component too early in the programme and the short duration of the midwifery clinical component, inhibits the integration of theory and practice resulting in limited attainment of appropriate midwifery knowledge and skills</p> <p>1.2: The inclusion of midwifery as part of the qualification in the R425 programme, meant that students with no interest in it had no other option and therefore impacted adversely on the attainment of competence for community service practitioners</p> <p>1.3: The concurrent offering and allowing a student to drag second year modules, was a challenge for the student which negatively affected learning</p> <p>1.4: The student selection and admission process was ineffectual and impacted on teaching and learning</p>
<p>Theme 2 Learning in the clinical setting was</p>	<p>2.1: The range of clinical competencies included in the clinical workbook and SANC's clinical requirements, limited the students' overall competence development in midwifery practice</p>

<p>adversely affected by clinical requirements, limited clinical learning opportunities, assigned student duties, lack of synergy between theory and practice, and the unsupportive environment in which students were placed for clinical practice</p>	<p>2.2: Limited clinical exposure and the limited availability of learning opportunities for the large student numbers, negatively influenced the learning and participant satisfaction with the programme</p> <p>2.3: Assigning students to the same routine duties in the clinical facilities, did not facilitate learning and the acquisition of midwifery specific skills</p> <p>2.4: Clinical placement experience was negatively affected by the lack of synchrony between theoretical preparation and clinical exposure, which adversely affected teaching and learning</p> <p>2.5 : Dissimilarity between the simulated learning environments and the real life environment affected learning</p> <p>2.6: Too many interruptions during clinical teaching time, hindered learning for the community service practitioners</p> <p>2.7: Lack of dedicated learning space at the clinical facilities impacted negatively on learning</p> <p>2.8: Clinical placement in areas prone to violence also adversely affected student learning</p>
<p>Theme 3 Ineffective supervision, role modelling and communication between educators and professional nurses were negatively perceived, as it adversely impacted on the professional development of community service practitioners</p>	<p>3.1: Ineffectual clinical supervision by lecturers who focused more on assessments, negatively affected the alignment of theory with practice</p> <p>3.2: Limited mentoring, supervision and the illustration of poor professional conduct of professional nurses in the clinical setting - adversely affected teaching, learning and the attainment of competence to provide safe maternal care</p> <p>3.3: Ineffective communication between educators and professional nurses, negatively affected teaching and learning and the achievement of competence for community service practitioners</p>
<p>Theme 4 Educator and student attributes – including the lack of educators’ clinical experience, professional</p>	<p>4.1: The lack of lecturing staff’s clinical experience was viewed as negatively affecting the community service practitioners’ achievement of competence</p>

<p>nurses' lack of interest to teach, students' readiness and motivation for teaching methodology and their feelings of being overwhelmed were perceived negatively, as it affected the attainment of competence</p>	<p>4.2: The professional nurses' disinterest to teach students was impeding learning and the attainment of competence</p> <p>4.3: The students were not ready for the outcomes based teaching methodology used in one programme</p> <p>4.4: The students' lack of interest affected their learning and the achievement of competence to provide safe maternal care</p>
<p>Theme 5 The quality and effectiveness of assessment were capricious which affected learning and the students competence to provide safe maternal care</p>	<p>5.1: The theoretical component focused greatly on what the students already knew, this limited the time to teach the management of midwifery specific practice and it adversely impacted on the students' competence</p> <p>5.2: The need to incessantly re-teach clinical skills is overwhelming for the educators, causing more pressure due to limited available time which impacts on the practice of midwifery specific skills</p> <p>5.3: Providing a scope for learning in preparation for assessment limited the students' competence</p> <p>5.4: The low pass criteria for the midwifery module affects safe practice</p> <p>5.5: Reluctance to fail students prevents learning and competence</p>
<p>Kirkpatrick framework - Level 2: Learning</p>	
<p>Theme 6: Learning and the attainment of competence were negatively affected by ignoring students' supernumerary status, students' motivation, slow accreditation process, the short duration and rapid rotation of the placement programme, the inclusion</p>	<p>6.1: Ignorance of students' supernumerary status impacted on the achievement of programme objectives, which negatively affected learning</p> <p>6.2: Students' lack of interest in clinical learning impacted negatively on teaching and learning</p> <p>6.3: The slow accreditation process of clinical placement sites influenced clinical placement space, limiting clinical exposure and adversely affected the attainment of competence</p> <p>6.4: The short duration and rapid rotation placement programme impacted negatively on the attainment of competence</p>

<p>of midwifery in the nurse training programme, and the low pass mark</p>	<p>6.5: The inclusion of midwifery in the nurse training programme left students with no choice, which negatively impacted on the attainment of competence</p> <p>6.6: The low midwifery pass mark adversely affected learning, the attainment of knowledge and competence</p>
<p>Kirkpatrick framework - Level 3: Behaviour</p>	
<p>Theme :7 Community service practitioners were perceived as poorly prepared midwifery practitioners who could not be trusted to work as independent midwives, since they lacked basic midwifery skills and displayed no interest to work in a maternal care setting</p>	<p>7.1: Community service practitioners were perceived as poorly prepared midwifery practitioners due to the short duration of the training programme</p> <p>7.2: Community service practitioners were perceived as being unreliable to work in a maternal care setting</p> <p>7.3: Community service practitioners were perceived as lacking basic clinical skills</p> <p>7.4: Educators were of the opinion that community service practitioners had no interest to work in a maternal care setting because of the inclusion of midwifery into the nurse training programme</p>



4.2.2.1 Discussion: Educators (lecturers and clinical facilitators)

Currently in South Africa, midwives are mainly educated through integrated nursing programmes as nurse-midwives. The undergraduate midwifery education programme is designed to prepare midwifery graduates for current professional practice, also to enable community service practitioners to learn and appreciate the art and science of the midwifery discipline. Furthermore, the community service practitioner is prepared for practice within the scope of practice, according to professional guidelines as proposed by the SANC.

Educators were probed on their views and perceptions pertaining to the current undergraduate midwifery education programme, preparing midwifery students to become competent midwives capable of providing safe maternal care. Their responses were grouped into five overarching themes; these five themes will now be discussed in more detail.

Level 1: Participant's reaction - this level focused on the views and experiences of participants on learning, teaching methods and aspects of the quality of clinical instruction.

Theme 1: The timing, duration, nature and the inclusion of midwifery as part of the qualification in the R425 programme, negatively affected learning

The researcher observed that educators were very keen to share their midwifery education programme related experiences. They appeared to be honest in sharing their experiences. The lecturers and clinical facilitators came from the two education institutions offering the undergraduate nurse midwife training in the Western Cape; therefore their experiences are mostly similar but also varied.

Category 1.1: The position and structure of the midwifery component in the nurse training programme inhibited the integration of theory and practice resulting in limited attainment of knowledge and skills which negatively affected learning

Educators agreed that the midwifery education component was placed too early in the nurse training programme. The excerpt below indicates that participants had certain expectations of the

students: “A lot of these students are not emotionally, psychologically ready for midwifery, never mind academically,” (educator 8).

Another participant indicated that even more was expected from the students in the clinical setting, influencing the perceptions of community service practitioners’ competence to provide safe maternal care; “They [students] tend to shift midwifery to the back of their minds and forget about it. So now they go back into the practice [after completion of the nurse training programme] and they are expected to just know everything, which is difficult” (educator 11).

Sufficient time was a perceived fundamental issue with educators. Educators felt that the six months allocated for the education and training of midwifery students were insufficient: “And the six months is not enough for these students to assimilate the theoretical knowledge and to hone the skills, never mind to incorporate these” (educator 8).

Another participant related her experience regarding the limited time available for the preparation of the students: “There’s only so much you can do” (educator 11). This is congruent with the recommendation from the Saving Babies report of 2008 (MRC Research Unit for Maternal and Infant Health Care Strategies, PPIP Users and the Saving Babies Technical Task Team, 2011), which proposes that the clinical skills of midwives must be improved by placing them in maternity wards for six months. Furthermore, educators were of the opinion that students found it difficult to integrate theoretical knowledge imparted to them in the classroom to the clinical practice setting, due to the short duration of the education programme. A study conducted by Ayo (2006) revealed that midwifery students did not meet the hours of experience as prescribed by SANC, which is the statutory body. The body prescribes a minimum of one thousand hours of midwifery clinical practice for midwifery students (SANC: 1985, as amended by No 1312).

Learning takes place if students are given sufficient opportunity to constructively engage with what they have been taught. Participants noted that there was no time for students to consolidate knowledge and skills because learning had to transpire very fast: *“So because they are in a hurry to finish with their procedures, I think they don’t really learn”* (educator 4).

Similar concerns have been repeatedly articulated by participants throughout the interview process. *“They get the theoretical work within 3 weeks and that can’t cover all the work because most of the students going out of that classes not with any understanding, not knowing. You know it is big words; it is strange that they find for the first time and they don’t actually know”* (educator 1).

Clinical placement settings not only play a significant role in the development of students’ competence but also students’ confidence, organizational skills and preparedness for practice (Chuan & Barnett, 2012). The clinical learning environments consist of in-patient hospital, out-patient as well as the community setting. These settings are classified according to the level of care they provide and the degree of obstetrical difficulty they are able to manage. Primary level (MOU’S) provide care to low risk pregnant women, secondary level (Karl Bremmer Hospital, Mowbray Midwifery Hospital) provide care to women experiencing low risk and moderate risk pregnancies and tertiary level hospitals

(Tygerberg Hospital, Groote Schuur Hospital) provide care to women experiencing high risk pregnancies.

Furthermore, students were allocated to a specific discipline within this setting for a short period of time and then rotated to the next discipline - for example antenatal care, labour ward, post-natal care. This short rotation does not allow them to get to know their environment well enough, which is important for the development of their professional identity as midwives. *“So they are*

placed there for seven weeks, and in that time period they work Monday, Tuesday and then they have class for one day and skills for two days per week, so it is actually five days per week” (educator 5). The practical exposure of community service practitioners as students, are perceived as being inadequate to prepare competent midwives. *“So what is your exposure? What is the possibility of exposure when you are a student and your exposure is so little? Sixteen hours? It depends also if they work from 7 to 7 [from 07h00 – 19h00], so that will be 22 hours. So some of them 16 hours and some of them 22 hours over that whole 5 week period”* (educator 7).

One clinical facilitator laughed, saying that instead of being exposed to the clinical area students were kept busy doing journal articles: *“They keep themselves busy with journals”* (educator 4).

Their concern was exacerbated by the lack of continuity in placement for clinical exposure, resulting in the student not being able to consolidate theory with practice. *“I mean it makes a difference between the student’s learning and their assimilation of the knowledge and their sense of that I mean it is disruptive”* (educator 7).

With the clinical practice area being so unpredictable, the fragmented and rapid rotational programme did not allow for the planning of well-organized learning opportunities, resulting in limited clinical exposure which was perceived as negatively affecting learning. *“So the only exposure they have now is of admission and labour, and the antenatal. It’s your history takings and abdominal assessments, so what they basically do is SF [Symphysis Fundus] measurements, the whole time”* (educator 6). Another participant noted: *“So what is the possibility of them getting perhaps a patient with hypertension, diabetes or a breech or twin pregnancy, things like that”* (educator 5).

One clinical facilitator described how the placement programme made it difficult for her to provide students with extensive learning opportunities. *“To be there Monday, Tuesday and then*

I don't see them in the facilities for another week or more sometimes, or when they go back then they must start over" (educator 7). The excerpts from participants, which are presented above, provide an insight into the issues of perceived dissatisfaction that midwifery educators have with the undergraduate midwifery education programme. It is apparent from data that the student selection and admission requirements process, students' own motivation, nature, timing and duration of the programme - have a drastic impact on the learning and achievement of competence for the community service practitioners to provide safe maternal care.

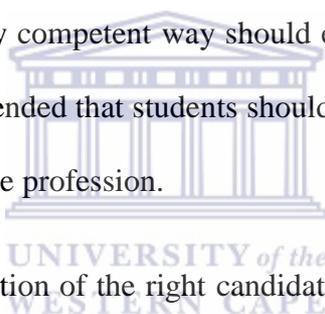
Furthermore, educators were of the opinion that the method of midwifery module presentation was perceived as creating a barrier between the midwifery component and the other nurse training components within the nurse training programme, as is described by this participant: *"There is definitely [a] separation from previous year levels to the third year level. So it is a big problem not to use the student in general nursing because that student thinks she is only there for midwifery alone and cut[s] off everything outside of midwifery"* (educator 1). Another participant noted: *"And then it (theoretical content) is given in compartments - normal labour, normal pregnancy, normal, normal, normal"* (educator 4). The midwifery module is broken down into principles, thereby teaching student midwives to deliver babies and to treat healthy mothers and babies in the ante-natal, delivery and post-natal periods; this is called normal labour and normal pregnancy. The principles of the midwifery module is to teach student midwives to recognize maternal and foetal complications, refer mothers and babies with complications during the ante-natal, delivery and post-natal periods; this is called high risk midwifery/ abnormal midwifery

Category 1.2: *The inclusion of midwifery in the nurse training programme meant that students with no interest in it had no option, which negatively affected the attainment of competence for community service practitioners*

As mentioned in chapter one, the midwifery training module is offered in the third year of the nurse training programme and leaves students with no choice. Several studies have noted that even when idealistic and traditional views of nursing have drawn students to the profession, these ideals often become a source of dissonance as they seek to be recognized for more than caring (Porter, Edwards & Granger, 2009). Similarly, the inclusion of midwifery into the nurse training programme was seen as having an adverse effect on students' attainment of competence. Participants reported that students were only doing the midwifery component because they did not have a choice and that those students choose to never work in a midwifery setting ever again. *"But because it is all included there is no choice for them. And it is not everybody who really enjoys doing midwifery, like most of the students they are not really enjoying it. Even when you talk to them they will admit and tell you they are only doing midwifery as part of the course but [that] they will never work in this set-up again"* (educator 7).

In addition, traditionally nursing has been seen as a professional career with caring at its core (Williams, 2009). The growth and sustainability of the nursing profession, however, depends on the ability to recruit and retain students in the profession (Nursing Summit, 2011). Whilst nursing recruitment is of documented national and international significance, perceptions of nursing as a career, however, revealed that the career desirability for nursing was lower than described in previous research on career aspirations in nursing (Neilson & McNally, 2010). Recently, the recruitment of student nurses with the right qualities has come under the spotlight (Karozi, 2005). Negative headlines such as - "Nurses told you're too posh to wash a patient: Minister orders student nurses back to basics to improve compassion" (Chapman & Martin, 2013). Admission

into the nurse education programme is based on a selective point system process. Applicants are required to meet the qualifying scores determined annually by the nursing faculty. Choosing the right candidate therefore plays a significant role, as midwifery is seen *“as a specialised area, you need to select candidates who have the cognitive ability, meet the criteria and has a passion to be a midwife”* (educator 3). Educators commented that the selection process *“sucks big time, ahmm they keep on selecting people with no attitude, with no [any] passion - so out of all the options this is the easiest one that would give me a bursary”* (educator 5). *“They don’t meet the criteria of the programme but they are chosen because there must be a certain amount, when they do the selection of the students”* (educator 1). Consistent with the findings, Fry and Johnston (2008) purports that only people with the knowledge, skills and commitment to practice nursing in a clinically, culturally and ethically competent way should enter the profession. Conversely, The Nursing Summit (2012) recommended that students should undergo a rigorous selection process to attract suitable candidates to the profession.



Whilst the recruitment and selection of the right candidate was deemed important, participants also identified that English language proficiency of students is a requirement for entrance into the nurse training programme. Educators, however, reported difficulties in communicating with students, they noted a lack of verbal English proficiency among students in both the academic and clinical setting. They questioned how these students were allowed to commence with the nurse training programme when their English skills put them at risk: *“So you get students, for example, in the third level of training that can’t even speak proper English. So, it is very difficult now to reach that student, to get that student competent to do something because there is a lack of understanding in between you and the student because of [the] language also. They also, they always need someone next to them to speak to the patient, they cannot speak to the patient”* (educator 1).

Rosenberg, Perraud and Willis (2007) emphasized that it is incumbent on colleges of nursing to make the best possible admission decisions, those that result in the highest possible retention rates of students well-suited to the profession.

Furthermore, political pressure seems to play a significant role in choosing candidates for the programme. Politics refers to the process of influence used for decision making and allocation of resources (Mason & Levitt, 1998), as reported by this participant: *“And then the department demands some numbers that the college had to take in certain number of students. Then they don’t find that number, then they just push the students in so that they can show the department that, [that] is the amount of students; you will take in that amount and you will go on with that amount”* (educator 1).



Category 1.3: The concurrent offering and allowing of students to drag second year modules was a challenge for the students, which negatively affected satisfaction with the programme

When exploring this point in more detail, it emerged that simultaneously with the midwifery component another component, namely unit management is offered. *“The other issue is [that] they are not just only doing midwifery; together with the midwifery they are doing unit management”* (educator 11). This was perceived as adversely impacting on time allocated for the practice of midwifery skills: *“[A] lot of the frustrations from the facility side is [are]) that the students tend to leave the wards because they have a unit management assignment to finish”* (educator 11).

Furthermore, there appears to be tension around the issue of students being allowed to drag second year level modules to the third year level, which interferes with teaching and learning of

the midwifery component. *“Then we have those students who come with second year modules which they did not pass, human biology...introduction to mental health, that [those] types of things that they bring with them to third year, and on top of the unit management. And then that becomes problematic because they need to go to classes for those modules and then those [it] clashes with either their clinical placement or with their midwifery classes”* (educator 11).

Theme 2: Preparation for learning in the clinical setting was adversely affected by clinical learning requirements, limited clinical learning opportunities, assigned student duties, lack of synergy between theory and practice and the unsupportive environment in which students were placed for clinical practice

This theme and subsequent categories relate to the community service practitioner’s experience in the clinical learning environment. The clinical learning environment, also known as the clinical setting, is an environment where students can learn and develop clinical skills in relative safety (Bruce, 2011). It is a place where students synthesise the knowledge gained from the classroom and apply it to practical situations. It is in this environment that student midwives learn what it means to be a real midwife. Educators’ perceptions regarding the clinical learning environment was mostly negative, as it did not contribute to the awareness of community service practitioner competence to provide safe maternal care.

Category 2.1: The range of clinical competencies included in the clinical workbook as well as SANC's clinical requirements, limited students' overall development of competence in midwifery practice

To empower students to develop a range of midwifery practical skills necessary to provide safe maternal patient care and for students to function in the maternal care setting, education institutions developed a range of clinical skills in the form of a booklet which is called the Practical Workbook/Portfolio of Evidence. The Practical Workbook/Portfolio of Evidence consists of a collection of the evidence to demonstrate skills, knowledge and achievements. The aim of this workbook/portfolio is to demonstrate a student's competence for practice and provide evidence of rational decision making and clinical judgments. Educators felt that the range of clinical skills reflected in the workbook/portfolio of students were insufficient to prepare community service practitioners to become competent practitioners who are able to deliver safe maternal care. As expressed by one participant: *"They have only a specific amount of clinical procedures but in the general midwifery they expect quite a few other things, not just the ones that we are finding them competent in. And this [these] other ones that they [are] exposed to in the clinical set-up but unfortunately they don't get enough theoretical background on that (those)"* (educator 5). Another participant said that *"not all the procedures that are in the service or community or whatever they have to master, that appear in their practica [practical] book. They have only a specific amount of clinical procedures that they have to [be] competent (in) for their practical book to be handed in as part of their training"* (educator 1).

Category 2.2: Limited clinical exposure and availability of learning opportunities for the large number of students, negatively influenced learning and participant satisfaction with the programme

Nursing education institutions are struggling to find sufficient clinical places for their undergraduate students to gain clinical experience. Institutions have therefore increased the number of student placements in the practice setting. The pressure was increased when students were all seeking particular practice experience in the clinical environment, to apply their skills and knowledge. “*They struggle to get their procedures because they have to wait for procedures*” (educator 10). Fitzgerald, Gibson and Gunn (2010) pointed out clinical skills strengthen midwives professional practice and therefore students need effective opportunities to learn, develop and master their skills.

The following excerpt from one of the clinical facilitators outlines the difficulties they experience in the clinical learning environment: “*So we are having a lack of models to teach the student[s] in the Sim lab [simulated learning environment] on the practica [practical] procedures*” (educator 1).

Category 2.3: Assigning students to the same routine duties in the clinical facilities did not facilitate learning and the acquisition of midwifery specific skills

The practice of assigning students to the same routine duties during placement practice was seen as obstructing the attainment of midwifery specific skill competence, as summed up by this participant: “*All the observation tasks, yes, they are not given the opportunity to practice their skills*” (educator 9). In support of the above statement, similarly Mabuda, et al. (2008) found that students spent most of their time in the clinical practice doing routine and menial tasks, as

the Professional Nurse did not delegate them according to their level of training and scope of practice. Hickley (2010) concurs with the findings of this study which suggest that learning in the clinical practice for student nurses to become competent, is reliant on the availability of thought-provoking opportunities which inspires students to ask questions and reflect on their experiences therefore becoming critical thinkers and be able to make clinical judgments.

The process of allocating students is difficult and requires a number of factors to be considered, i.e. working with the demands of the partner services, the allocation staff and the programme requirements of the students. Although this process is necessary, it was also perceived as hindering the attainment of competence to provide safe maternal care by the community service practitioner, as noted by this participant: *“The students come and say they want to do a certain procedure because they still need to complete their practical workbook but they are assigned to maybe [do] observations. But there is a delivery taking place, so they want to go and do the delivery because it is something that they need. So I think that also hinders them in a way, in getting there they waste time. They’re wasting time on doing observations when they could be completing their procedures”* (educator 10). Zaighami, Faseleh, Jahanmiri and Ghodsbin (2006) reported that the main challenge for student nurses in the clinical setting was unspecified task orientation. This is congruent to what Meyer, Naude, Shangase and van Niekerk (2009) postulates that the professional midwife needs to allow students to participate actively and enhance professional socialization, delegate to the students some responsibilities under supervision and not take all students as irresponsible.

Category 2.4: Clinical placement experience was negatively affected by the lack of synchrony between theoretical preparation and clinical exposure, which adversely affected teaching and learning

Professional education traditionally promotes a theory-practice hierarchy in which basic science is taught first, followed by practical implementation (Lange & Kennedy, 2006). Prior to clinical placement, community service practitioners are theoretically prepared in the classroom to assume responsibility and accountability for health promotion, assessment, diagnosis and management of patient problems, including the use and prescription of pharmacological and non-pharmacological interventions. Theory, as defined by the dictionaries, is a set of statements or principles devised to explain a group of facts or phenomena. Those that have been repeatedly tested or are widely accepted can be used to make predictions about natural phenomena. The term practice as defined is the act or the process of doing something, performance or action. These terms appear to be at odds with each other but when considered in terms of a professional set-up, they have to enable the application of applying the theory to practice (Ajani & Moez, 2011). The theory-practice gap occurs when theory taught in the classroom and the experiences of clinical practice do not correlate and seem to differ. The gap that is created put students in a predicament when they attempt to apply their newly gained knowledge in practice (Allen, 2008). Longworth (2013) emphasized that the clinical team should appropriately manage allocations and the workload of team members to assist learning, guide established needs of students and facilitate the requisite learning. Clinical facilitators however, described how students were perturbed by the imbalance between their theoretical preparation and clinical placement area. *“They are placed in high-risk places, [placement areas where maternal complications are treated] and maybe they just did the normal”* [placement areas where uncomplicated midwifery care is delivered]. *“Sometimes they are placed in the labour ward and they did not even get the theory yet and then the student don’t*

[doesn't] *have a clue of what is going on there because they don't have the background of theory of that. So now you need to teach the student in that area that she don't [doesn't] have the background of theory of that. So, then it is difficult then to reach that student - and for that student it is difficult to become competent because she had the theory of the normal pregnancy and now she is in the abnormal situation*" (educator 1).

Preparation for practice was considered as not only about how theoretical knowledge supported the student's placement experience but it appeared also to be a bonus to help students apply their theoretical knowledge to their placement experience.

Conversely, educators commented about students having to make re-adjustments between what they were taught in the classroom and what they saw being practiced in the clinical area. *"Students told me that 'yes, we will do what you say, what you taught us but once we get out there we are going to do the same as what they are doing'. And I ask[ed] them why, and they said 'because they are doing it that way and we don't want to be difficult'"* (educator 11). An example - *"The sister on night duty comes late for work, she arrives at about 21:00 in the evening. She comes on duty in plain clothes and [that] means she is not identifiable as the sister who is supposed to be on duty, that [is the] type of example that is being set"* (educator 11). Mather, McKay and Allen (2015) asserted that professional nurses have the responsibility to create a psychological climate which is conducive to learning and this will automatically create a safe environment for learning.

The importance of providing an appropriate clinical learning environment which compliments theoretical classroom preparation has been highlighted in several studies (Murray & Williamson, 2009). However, aligning student practice placement to theoretical preparation proves to be a daunting task, as available placement space is limited. Lecturers had no other option available to them but to place students in areas for which no theoretical preparation was done, impacting on

the learning of the community service practitioner. *“So we end up placing students in a labour ward. Now that student doesn’t have any theoretical knowledge or practiced any skills with regard to the labour ward, only covered the first antenatal visit. And the sister in the labour ward is now expecting that student to perform”* (educator 10). Stated by another participant this practice is: *“Because of the way our programme is run, it is a module programme - you can’t place all the students in the antenatal ward to start off with”* (educator 2).

The asynchrony between theoretical preparation and practice placement were found to have a major effect on teaching and practicing of midwifery skills, which impacted on learning for community service practitioners to attain competence to provide safe maternal care. Some of the facilitators expressed positive experiences of having to transfer theoretical information first before performing a practical demonstration: *“For me, I can’t teach practica and not teach theory. I want to make sure they understand why and how it will be before I even do the demonstration. So, I can’t do one without the other”* (educator 3). However, for others it was time consuming and frustrating as the expectation was that students should have received this information before clinical placement: *“So, it means [that] you have to go back and focus more on theory before you can actually join the two together in the clinical. I mean the theory or practice where the student[s] are actually placed, so then it is difficult to reach that student or it is difficult for her to become competent because she doesn’t have a clue of what is going on around her. She only had the theory of normal, of normal pregnancy, now she is in an abnormal situation”* (educator 4).

Category 2.5: Dissimilarity between simulated learning environments and real life environment affected learning

Educators felt that sessions in the skills laboratory did not sufficiently equip the community service practitioner with enough knowledge and skills to safely practice in a labour ward. *“We can show them the simulation or an example of a normal birth but it will not really prepare them for the actual delivery because they are still afraid to touch the patient”* (educator 7).

In addition to this perception because of the dissimilarity between the simulated environment and the real clinical environment, the clinical experiences of students were denuded. *“I find that they are in a situation [where] they are almost traumatised but they hold back, and stand back so far because of what they have learned and what they have seen are two completely different things”*(educator 7.) Another participant said: *“The student that is crying and running around the setting - I’m here, the patient is here. She is willing, she is able and you are going to be here, I’ll guide you through it”* (educator 2). This endorses what Moez and Ajani (2011) purports in their study. It was conducted amongst nursing students to establish the gap between knowledge and practice in nursing; they found that students become anxious and confused if they practice something different from what they learned in the classroom, negatively affecting their performance in the clinical area.

Category 2.6: Too many interruptions during clinical teaching time hindered learning of the community service practitioner

A contributing factor that affected students’ learning experience adversely, was the constant interruptions during clinical instruction to such an extent that it became difficult to accommodate

students to practice their newly acquired skills; which is essentially to help students to become competent to deliver safe maternal care. *“There is no the time for practica [practical] to let the students practice the practica (practical) because there is so much other interference in the programme. Then you must attend some meetings, you must come for teaching, helping with the teaching at the college...”* (educator 1). Another person said because practical skills are demonstrated to students on real patients, it was difficult to finish the demonstration of a skill without being interrupted. These were seen as impacting on community service practitioners learning to become competent to deliver safe maternal care. *“There is always this interruption, you are lucky if nobody come[s] and interrupt[s] you or the patient doesn’t have a visitor that wants to come in”* (educator 7).

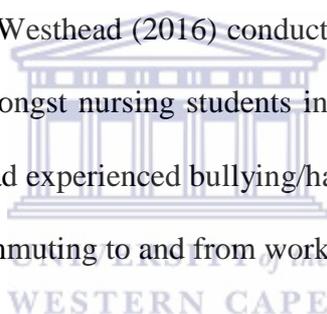


Category 2.7: Lack of dedicated learning space at the clinical facilities impacted negatively on learning

Participants believed that students may have a better clinical learning experience if a dedicated venue at clinical facilities be allocated for teaching and practicing midwifery skills. *“One of our main major problems there is no room where we can work in and sometimes you think you have found a spot, and like a room and you take your students in, and then five minutes later somebody come[s] knocking at the door and then they say this space is reserved for whoever”* (educator 4).

Category 2.8: Clinical placement in areas prone to violence adversely affected students learning

The isolation of students was exacerbated by violence, verbal abuse and discrimination experienced from the community in which they were placed to obtain clinical exposure. This was a reported ongoing issue that educators had to deal with. As phrased by this participant: *“The environment, the clinic that you send them out into [where] they get discriminated against [and] get robbed on their way. Because of the violence they are afraid to go to work, fear [of] being robbed or shot at, discriminated against because they are not South African. So, they get told in their faces you are foreigners or what do you know?”* (educator 6). This was also perceived as having an adverse effect on community service practitioners to attain competence to provide safe maternal care. Tee, Ozcetin and Westhead (2016) conducted a study to establish the nature and scope of workplace violence amongst nursing students in the United Kingdom and found that nearly half of nursing students had experienced bullying/harassment while on clinical placement and it includes the periods of commuting to and from work.



Theme 3: Ineffective supervision, role modelling and communication between educators and professional nurses were negatively perceived as it adversely impacted on the professional development of community service practitioners

Holding the fundamental question on the forefront which involves the views and perceptions of educators about the midwifery training programme and how it impacted on the competence of community service practitioners, the following categories evolved –

Category 3.1: Ineffectual clinical supervision by lecturers who focused more on assessments, negatively affected the alignment of theory to practice

Clinical supervision is described as an education relationship between an experienced nurse and nursing students (A Dictionary of Nursing, 2008), and is the responsibility of both educators and professional nurses. O'Connor (2005) refers to clinical supervision as the cornerstone of clinical practice; Bruce, Klopper and Mellish (2011) believe that it is through the process of clinical practice that nursing students are provided with the opportunity to translate theoretical knowledge into practice. Educators were aware of how significant clinical supervision would be in assisting students to attain professional competence and to provide well-organized learning activities during clinical placement. Participants noted that due to a drastic increase in student numbers, the limited clinical supervision provided was affecting the attainment of competence negatively. Individualized one-on-one sessions with students was important for clinical facilitators, as it allowed students to verbalize their learning experiences and feelings in practice thus leading to professional development. *"Hmm, we[re] talk[ing] here about 30 – 40 students per one clinical educator, you are unable to reach every student individually, that makes it very difficult, and so you cannot have a one-one relationship with that student"* (educator 3). According to Mabuda et al. (2008), participants in their study indicated that lecturers do not accompany students to practice in order to enforce what had been taught in the classroom, leaving students with no option other than to agree with what professional nurses were telling them.

Lecturers also acknowledged that it is important to follow- up on students in the clinical setting, to assist them in aligning theory taught to them in the classroom with their practice in the clinical setting. However, they too found it challenging due to the large student numbers and their other teaching responsibilities. *"Which [what] might be lacking is the follow-up on that; the numbers in the classes is so big to really have a strong follow-up, especially the best way on alignment, I*

mean theory and practica” [practice] (educator 9). This *results* in students having to fend for them. It has been suggested that a lack of supervision may lead nursing students to learn incorrect procedures, become incompetent as they lack guidance and lose interest in the nursing profession as they feel frustrated in their work due to incompetence (Kaphagawani & Useh, 2013). Similarly, Brammer (2008) has conclusively shown that an insufficient support system in the clinical setting demoralize students from observing for learning opportunities. The outcome result is deprivation in the development of practical and theoretical knowledge (Mabuda, Potgieter & Alberts, 2008).

Clinical facilitators, however, on the other hand have an ambivalent assessment of midwifery lecturers and their presence during clinical assessments. Participants felt that the presence of the lecturers was not felt in the clinical area, where it was most needed. *“The only time they are seen is when there is a practical exam, continuous assessment. And I think that’s too late. I don’t know what they come to assess from a little page. Because they don’t have any interaction with that student while being groomed and moulded, and it’s important”* (educator 3). The following excerpt describes the view of a lecturer pertaining to this issue: *“I’m not in the services to see, I mean I’m there to do an assessment”* (educator 8). Consistent with this finding, authors Lofmark et al. (2005) in their study concluded that the use of lecturers as clinical supervisors often results in a significant lack of facilitation due to the lack of time that lecturers have because of their other role commitments. And more often they are only involved when there are student-related performance issues.

Category 3.2: Limited mentoring, supervision and the illustration of poor professional conduct by professional nurses in the clinical setting - adversely affected teaching, learning and the attainment of competence to provide safe maternal care

Dimensions of ascribed student learning, relate to students working under the direct supervision of an expert midwife during clinical placement in the clinical setting. This is important for the facilitation and establishment of a professional identity, as students observe the professional midwife in the practice setting and also to ensure patient safety while students practice their skills. Educators, however, felt that it was expected of students to take more responsibilities than should be expected of student midwives, due to a lack of expert guidance in the clinical area. *“And sometimes there isn’t a sister; the students have to work alone on their own. They need to function on their own because there is nobody to help them or to show them what to do”* (educator 7).

Furthermore, educators were of the opinion that the poor exhibition of professional conduct by professional nurses in the clinical setting might have a detrimental effect on the professional development of community service practitioners, to provide safe maternal care. Their concerns are confirmed by Armstrong (2010), who contends that student midwives tend to adopt the practices of their mentors, thus compounding potentially harmful practices and endangering the safety of maternal patients. As articulated by this participant: *“Working with midwives who just don’t care, doesn’t care about the patient they are only there because they earn money that’s it. Your patients are screaming their heads off and they just, you know, force you sometimes to do things. You know the student wants to get up to go see what the patients need, you know then they say no you sit, let her scream her head off. We are all sitting and having our lunch now, it is not their lunch time but they are all sitting and eating their lunch and it traumatises the students”* (educator 6).

According to Schoeter (2008), the environment in which one works as well as the type of organizational system in which one learns can affect the development of competence. Henderson, Alexander, Hayward, Stapleton, Cooke, Dalton and Creedy (2006) concur, stating that the single most important resource in the development of competent nurses is the clinical learning environment.

Category 3.3: Ineffective communication between educators and professional nurses negatively affected teaching and learning as well as the achievement of competence for community service practitioners

Smedley and More (2010) proposed that ideally the clinical learning environment is a community of practice, where learning processes are underpinned by a culture in which social interaction is vital. Further to this perception - Newton, Billet and Ockerby (2009) stated that a conducive and supportive learning environment depends upon the availability of support systems such as clinical supervision, a conducive and supportive learning environment and a good relationship between faculties, professional nurses in the clinical area and nursing students. Educators articulated the need to frequently communicate with professional nurses in the clinical area, in order for them to transfer appropriate skills to students as well as to keep up to date with the latest developments in the clinical area. This was perceived as important for the teaching and learning of community service practitioners to provide safe care to maternal patients; it is exemplified in the following excerpt: *“They expect us to send out competent students that know the drill. But if we don’t know what they have to practice, how can we teach that to the student”* (educator 11).

All participants acknowledged that there was a lack of communication between education institutions and professional nurses, whether they identified it as a problem or not. This had

significant implications for the quality of classroom teaching, as explained by this participant: *“In a class you will have students from five different facilities in your class and they fall within different regions. They will have like different protocols and that becomes problematic”* (educator 11). This was perceived as negatively influencing learning of the community service practitioners, impacting on their ability to provide safe maternal care.

In addition to this perception, educators mentioned the following: *“And the only way of staying up to date is when making contact. We use to make contact with the maternal and child health services at the directory and she will [would] give us like the latest protocols”* (educator 11). However, their efforts were jeopardized by barriers that exist between education institutions and the clinical placement facilities: *“But it is also problematic in the sense that we had to physically contact them, they don’t send it to us automatically”* (educator 11). The only way lecturers knew that new protocols were implemented, was when students spoke about it during facilitation sessions. *“So once we got into the situation that we are in class, we are discussing something and something new pops up. If something new pops up that [the] we would go hey, there’s something new happening”* (educator 11).

Theme 4 : Educator and student limitations include the lack of educator’s clinical experience, professional nurse’s lack of interest to teach, student’s readiness and motivation for teaching methodology and their feeling of being overwhelmed was negatively perceived because it affected the attainment of competence, which they experienced as being overwhelmed

This theme has the following categories: clinical expertise of lecturing staff and student’s readiness for the teaching methodology utilised. Categories are illustrated by excerpts from

participants' narratives and supported by literature to enhance understanding of discussions being presented.

Category 4.1: The lack of clinical experience of lecturing staff was negatively viewed as affecting the community service practitioners' achievement of competence

Kelly (2006) asserts that in order to assist students to integrate theoretical knowledge into the practice setting, nursing educators ought to be clinically and pedagogically prepared. Congruent to above mentioned statement, educators reported that the clinical experience of lecturers was an essential since, according to this participant: *“How can they educate on these things with authority if they have never actually done it”* (educator 5). Findings of a study done by Ip and Chan (2005) revealed that a lack of knowledge in educators and ward sisters about the implementation or integration of healthcare approaches in the subjects that are taught during clinical sessions, lead to ineffective guidance of nursing students.

Another participant noted that: *“You are expected to teach a subject of which you don't have the clinical background”* (educator 6). Relating theory to practice was difficult since the clinical experience was lacking. In addition, being able to reflect on your own past experiences would help the student to better apply theory. *“They intend to be listening better and they tend to remember better, if the lecturers have the experience and then they can just add that special bit to the lecture. The students tend to remember it better”* (educator 5). There is a large volume of published studies which describe the ability to enliven the discussions of theoretical concepts by illustrating them with real stories and situations that reflect current clinical experience can change what students may interpret as ideology into lasting impressions (Little, 2007). In addition, SANC recommends that educators should have at least five years of clinical experience in the specialty

area which they teach, to support the claim of educators that they are able to assist with the integration of theory with practice. A study conducted by Pillay and Matshali (2008) to establish the experiences of registered and student nurses, regarding the clinical supervision in medical and surgical wards revealed that some institutions lacked trained staff to carry out supervision and ended up using supervisors without experience.

Another lecturer said that she never had any working clinical experience as a midwife: *“I have never worked in the midwifery field and now I am in education as a midwifery lecturer, as it is not my background clinically”* (educator 8). Many studies have also investigated the effects of clinical experience on students’ learning and the problems that students encounter at clinical placement sites (Elcigil & Sari, 2007).

Theoretical lectures presented to students seem to be purely textbook-based with no real application to the clinical placement area because of a lack of lecturer clinical experience. *“You are educating purely textbook and then the institution doesn’t operate like that. So, you have a mixture of pathology in midwifery and the student is really... I have students crying in the labour ward and saying I can’t be here, I must go home”* (educator 1).

Category 4.2: The disinterest of professional nurses to teach students was impeding learning and the attainment of competence

Furthermore, some educators felt that professional nurses were not passionate about teaching; educators felt that this was a demoralising factor, which adversely affecting the community service practitioners’ learning to become competent and provide safe maternal care. *“But whether there is [are] enough midwives who want to teach, that is another story. You can have all the*

learning opportunities in the world [but] if you don't have somebody in your facility [or] at least two or three people who is [are] willing to teach the student, then it is of no use. I just feel that if the midwife or the registered nurse doesn't have an interest in learning [teaching] the student, then it can be staff shortages [or] it can be ample staff, it can be whatever she is not going to, [then] she is not" (educator 7).

Category 4.3: The students were unprepared for the outcomes based teaching methodology used in one programme

The educators felt strongly that the case-study teaching methodology utilised was inappropriate for all the students, as it resulted in students not obtaining the necessary opportunities to generate sufficient knowledge to apply it in their practice; as summed up by this participant: *"I don't think it is for every student group work is not for every student. You get those that will thrive, and you get those who will ride on the coat tail of others And you will get those who will fall completely apart, [because] they do not work well in a group or they have such high standards that if the rest of the group doesn't attain that standard that they fear failure in terms of their knowledge generation and their thinking"* (educator 6). Consistent with the findings of this study, Hall and Hord (2011) reported that both the professional and public arenas are voicing their concerns about improving teaching methods in areas of higher education, to assist in student-success as they create new knowledge. Vondracek (2009) postulates that using multiple teaching methods will assist students to engage during lectures, as it is able to address the various learning styles.

Many of the issues related to the methodology of knowledge transfer were exacerbated by students not understanding what was expected of them. *"I don't think it is working in that case. In my personal experience with students with case studies, we give them a case study they go dig*

up the strangest conditions that you have never heard of before and it is just too broad” (educator 6).

Category 4.4: Students’ lack of interest affected their learning and the achievement of competence to provide safe maternal care

The students own interest and expectations about education and training were mentioned as an important assumption for obtaining optimal benefits during the practice placement exposure, as one of them said: *“You do get a few in a group who is [are] not interested, who don’t want to and then they tend to influence the rest of the groups. Then you also get this student that is chatting all the time, even if you tell them that they must keep quiet [because] you know that you are busy and then they keep on chatting and not paying attention. They are not really pulling their weight [and] putting it all into this... putting it all into the course”* (educator 2). According to Elcigil and Sari (2007), students perform better both academically and clinically if they have social support from peers and significant others.

Theme 5: The quality and effectiveness of assessments were capricious, which affected learning and the students’ competence to provide safe maternal care

Category 5.1: The theoretical component focused a lot on what the student already knew, which limited the time to teach the management of midwifery-specific practice which adversely impacted on the students’ competence.

Educators felt that there was a great deal of theory to be covered and were overloading students with too much information. *“They [student] are overloaded”* (educator 11).

In addition, lecturers were of the opinion that considerable effort was devoted to teaching content already dealt with in previous years instead of focusing on midwifery-unique content. " ...say for example fertilisation, implantation because I think to a certain extent is revision. Really, I mean my daughter in grade 10 is doing that" (educator 9).

Participants were of the opinion that in order for community service practitioners to gain a better understanding of care-decisions made in practice, time should rather be devoted to the following: "...we should focus on major conditions like pre-eclampsia, hypertension" (educator 9). They also expressed the need to focus on essential things that - "We tend to neglect a little bit from the education part, the babies" (educator 11).

Category 5.2: *The necessity to incessantly re-teach clinical skills is overwhelming for the educators causing more pressure due to the limited time available, which impacts on the practice of midwifery-specific skills*

In addition, an essential issue that negatively impacted on the community service practitioners' learning was the students' professional background and former practice experiences. It influenced their actual level of competence as well as their degree of confidence. Clinical facilitators emphasized that re-teaching skills that students were already found competent in the previous year levels, was generating pressure and anxiety for them in the already limited period allocated to midwifery education. One specific clinical skill that arose during the interviews was: "For example, passing a catheter that is not a midwifery competency. That is a competency that comes before that and then you find they cannot do it but they [have] passed that competency" (educator 1). Another participant spoke of the frustration of having to: "...re-cap, you have to give them

sort of all those pre-concepts over again. Not only is the timeframe short but you have to start at the beginning again” (educator 5).

Category 5.3: Providing a scope for learning in preparation for assessment limited the students’ competence

Lecturers were concerned about strategies implemented by management to improve the midwifery module pass-rate: *“It is a huge concern because at this stage, the focus is lying on numbers of output, not on quality of output. It is something that was brought in by management to increase the successful amounts of candidates on the original programme” (educator 8).*

One of these strategies is the provision of an outline of important theoretical content for written assessments. This was perceived disparagingly as affecting community service practitioners’ competence to provide safe maternal care because it influenced the ability of the community service practitioner to apply theoretical knowledge to the practical setting, as explained by this participant: *“With test and with the exams we are forced to give students the demarcation on what they are going to write about. And this demarcation is given with every test and every exam, and it is a third extra information on what the students write about” (educator 8).*

It also resulted in rote learning without comprehension: *“They learn a lot of the work like parrots, basically learn the work off by heart. So, when you then ask them to apply that knowledge instead of just word by word giving back they completely fall out of the bus, they [are] not able to apply it to a scenario” (educator 9).* An example of this practice is illustrated by the following excerpt: *“They did intensive training with that stuff. They wrote off that stuff and basically, ja [yes], they wrote off all that stuff and they’ve forgot it. And when it is supposed to be produced again,*

haemoglobin you know in midwifery. If you want that haemoglobin, if you want the unit and everything and even more, they fall flat” (educator 3)

Participants were of the opinion that practices like these resulted in students passing the module who should have repeated the module. *“Unfortunately there are those who are forced through the system that shouldn’t be qualified because they are not safe practitioners” (educator 10). “It is because they did not reach [the] competency [level] while they were students” (educator 1).*

Category 5.4: The low pass criteria for the midwifery module affects safe practice

In the following excerpt, a lecturer highlights the importance for a higher pass criterion as the current criteria makes it too easy for students to pass and thus impacts on the ability of the community service practitioner to provide safe maternal care. *“If that year mark is going to make them fail, then it is not counted. Because of the way that our exam entry works with 35%, right, then they has (need) to have a 50% exam mark. If they fail either paper 1 or paper 2 but they still obtain 50%, they pass irrespective of whether they fail either of those papers. Tell me, is that a competent midwife? Would you like a person like that to look after a patient?” (educator 10).*

Category 5.5: Reluctance to fail students prevents learning and competence

The assessment of the practical ability of student nurses begins in the first year of training; as these students move through the years, the complexity of these assessments increases. In the first year the focus of these assessments are on crucial nursing care but by year three the importance shifts to evidence based decision making and the ability to manage the care of groups of patients (NMC, 2008). Educators and members of the university faculty have an academic and

professional responsibility to teach, supervise and evaluate students' performance, to ensure that the graduates of their programmes are competent to practice (Redmond & Bright, 2007).

In the excerpts below clinical facilitators described how they found it difficult to fail students and would instead rather afford students numerous chances to repeat the same assessment until a pass mark is achieved.

So some of the educators feel they cannot fail the students, the student have to pass so that they can go to the next level. Then the educators in that level take that student and let the student do, it over and over and over, that procedure till they find a pass mark” (educator 1). Another participant mentioned that the problem might be due to the outdated assessment tools utilised. *“The tools that we use for assessments, the tools are outdated and we need to refresh (and) that you know change some of the things in the tools”* (educator 10).

The situation was exacerbated by assessment tools which did not reflect the reality of practice-based learning, and were difficult to complete. *“I really find it hard to mark somebody during an assessment. I feel they're not bad and they're not good either, they're in the middle. So what grade like a 1, 2 [or] 3 would you give them?”* (educator 6).

Another participant commented that because a large group of students failed the examination, the faculty intervened by allowing students more than three chances to take the examination in order for students to be promoted to the next level. This was negatively seen as having an influence on the community service practitioners' ability to deliver safe maternal care. *“The students they fail the primary, they fail the re-eval [re- evaluation], they fail the special and, because there was, the faculty offered them another exam. So there were four opportunities for them to pass and still some of them did not pass“* (educator 4).

Level 2: Learning - this level relates to changes in learners' attitudes or the perception of learners about education practice. It also relates to the change in learners' knowledge and skills. In addition it relates to the students' acquisition of midwifery concepts, principles, cognitive and psychomotor skills

Theme 6: Learning and the attainment of competence were negatively affected by ignoring students' supernumerary status, motivation, slow accreditation process, the short duration and rapid rotation of the placement programme, the inclusion of midwifery in the nurse training programme and the low pass mark

Category 6.1: Ignorance of students' supernumerary status impacted on the achievement of programme objectives which negatively affected learning



The Nursing and Midwifery Council (2010) states that programme providers must ensure that students undertake the placement as a learning experience and are not considered part of the workforce. Supernumerary means that students will not, as part of their programme preparation, be contracted by any other person or anybody to provide nursing care (Nursing and Midwifery Council, 2010). This ensures that students undertake the placement as a learning experience and are not considered to be a part of the workforce (Arkell & Bayliss-Pratt, 2007).

Clinical facilitators, however, were of the opinion that being part of the workforce would benefit the students more. *“I think it is a good thing if they are seen as part of the workforce, I think then you are more included. You are taught how to be responsible, taught how to apply critical*

thinking, taught how to be more comfortable, and you just feel more inclusive, more included in the team” (educator 5).

Allan (2011) suggests that higher education institutes are uncertain of the value of supernumerary status as a strategy to support learning and that trained staff may perceive it as a barrier to learning. In a study done by McGowan (2006), students reported feeling like a pair of hands; they recognize that they are not developing a depth of knowledge and continue to remain task orientated. However, consistent with the findings that there are others who argue that supernumerary status can be a hindrance to learning, students merely observe staff that is unsure of the reason why the student is in their environment (Alan, 2011).

Category 6.2: Students’ lack of interest in clinical learning impacted negatively on teaching and learning



Valizadeh, Fathi and Zamanzadeh, (2007) postulate that students who believe the training is interesting, important and worthy become involved meta-cognitively and apply more cognitive strategies and are thus more advanced in education. Concurring with the authors, one of the barriers identified which might influence the attainment of competence was a lack of interest by students during their practice placement period, as noted by this participant: *“If I have seen a student standing with her hands behind her back and she doesn’t show any interest, I’m not going to show any interest in her. I’m not going to call her. I’m not going to say come here, look I want to show you this. It’s the student that must say, ‘Show me what you are doing, I want to do this and I want to do that’” (educator 8).*

Lewis (2010) identified student motivation as one of the education barriers which negatively impacted on learning and the achievement of competence.

Moreover, frustrations with gaining numbers to qualify were also listed as causing the perceived disinterest that students portrayed about improving their clinical competence. Students have to obtain fifteen deliveries in the period allocated in the clinical placement area to qualify. The qualifying total of fifteen deliveries is a SANC recommendation. *“Students need to show more interest. The student need(s) to say (that) I’ve done 15, ok [ay], so now I’m competent but let me be skilled. So carry on as long as you’re working there, carry on and do 30, do 40”* (educator 11).



Category 6.3: The short duration and rapid rotation of the placement programme impacted negatively on the attainment of competence

There was consensus amid the educator group that the duration and expectation of the SANC was adversely impacting on the learning of the community service practitioners to achieve competence, to provide safe maternal care. The interviews revealed how the structure and duration of clinical placement influenced the students’ attainment of midwifery competence. *“The duration of the midwifery programme is six months and within those six months SANC requires 1000 hours clinical placement”* (educator 10). Educators recommended that the training programme should be extended with at least another six months. Malik and Aylott (2005) reported that students frequently complained about not spending enough time in the clinical area, which made them feel uncomfortable. Mannix et al (2006) state that valuable time is wasted as a result of the frequency and duration of clinical placement rotations. The students needed to re-familiarise and reorientate themselves to the new clinical environments every time.

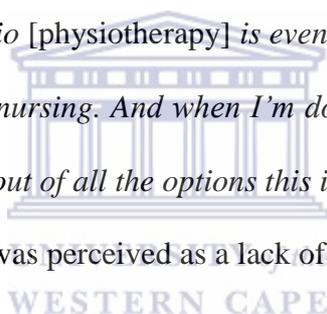
Category 6.4: The slow accreditation process of clinical placement sites influenced clinical placement space, limiting clinical exposure and adversely affecting attainment of competence

As universities have increased the number of undergraduate nurses, there is growing competition for restricted placements in the clinical setting (Andre & Barnes, 2010). The availability of clinical placement sites is constrained by a combination of organisational, regulatory and education requirements, as well as the capacity of the health service to supervise student nurses (Barnet, Walker, Jacob, Missen, Cross & Shahwan, 2011). Accreditation refers to a process of review and approval by which an institution programme or specific service is granted, a time limited recognition of having met certain established standards (SANC Act 33, 2005). In South Africa the SANC is the accrediting authority for nursing and midwifery. Educators expressed the need for expediting and simplifying the process. *“Making the whole process a little simpler, not by accrediting sites not suitable for students but by making it faster and easier. Get rid of that red tape and taking so long”* (educator 6). The availability of more sites would assist with balancing theoretical preparation and clinical placement by making it possible for educators to bridge the theory-practice gap. *“So that they can take that theory that they got in class and the skill that they have practiced in the skills lab (and) to link it with the clinical practice”* (educator 8).

Category 6.5: The inclusion of midwifery in the nurse training programme left students with no choice, which negatively impacted on the attainment of competence

Educators were of the opinion that community service practitioners’ displayed no interest to work in a maternal care setting despite of the inclusion of midwifery into the nurse training programme.

Educators felt that the students selected for registration into the comprehensive nurse training programme, was not committed to become midwives but only enrolled into the midwifery programme because it forms part of the nurse training programme. *“When you talk to them, they will admit and tell you they are only doing midwifery as part of the course but [that] they will never work in this set-up again”* (educator 11). Furthermore, educators believed that students were only there to receive the student bursary that was available for nursing students: *“And when you ask the students they will say bursary, it was the only course that offered me a bursary”* (educator 11). The following example echoed the concerns expressed by educators about the recruitment and selection process of future midwives. *“They don’t really have the passion or the desire to be a nurse; it’s just (that) there wasn’t any other option. It is the only thing which they will struggle to get into and physio [physiotherapy] is even more stringent. It is a stepping stone for something completely out of nursing. And when I’m done with my degree, I am going to do architecture or engineering. So, out of all the options this is the easiest one that would give me a bursary”* (educator 8). This gap was perceived as a lack of institutional support.



Category 6.6: The low midwifery pass mark adversely affected learning and the attainment of knowledge and competence

Educators expressed concern about the pass mark for the midwifery module, which might adversely affect the behaviour of the community service practitioner in the practice area. *“We can higher it there because how can a student go in as a professional nurse, to go in and when she passed with 37 %”* (educator 1).

Level 3 – Behaviour - this level relates to the transfer of knowledge of learning to the workplace.

Theme 7: Community service practitioners were perceived as poorly prepared midwifery practitioners who could not be trusted to work as independent midwives, since they lacked basic midwifery skills and displayed no interest to work in a maternal care setting

It is expected of community service practitioners, as newly qualified midwives, to step into the workforce equipped to provide safe maternal care for a complex maternal patient population. The research question sought to identify the views and perceptions of midwifery educators about the competence of community service practitioners to provide safe maternal care to patients in maternal care settings.



Category 7.1: Community service practitioners were perceived as poorly prepared midwifery practitioners due to the training programme

Educators felt that the education programme was unsuccessful in preparing the community service practitioner, to safely practice as a competent independent midwife: *“She is definitely not safe”* (educator 1). As reported by another participant: *“Really, they are ill-prepared; I think it is the integration of these four courses in four years, you know”* (educator 3). This participant expressed her gratefulness with the orientation programme available for the community service practitioner, after successful completion of her education programme: *“But thank heavens they’ve got a comm [community service year] serve year built into this, so that they can become competent”* (educator 3).

Category 7.2: Community service practitioners were perceived as being unreliable to work in a maternal care setting, due to the midwifery education programme

Educators imagine a competent midwife to be capable of functioning independently and able to provide safe quality care to patients in a maternal care setting. However, community service practitioners were found to be lacking: *“She don’t [doesn’t] know most of the procedures, how to do it and she is very dependent on the permanent staff, the permanent professional nurses. They have to take her by the hand and lead her all over and show her everything from the start”* (educator 1). Another participant mentioned that community service practitioners were still seen as students in the practice setting and could not be trusted to function as independent midwives. *“They are not in a senior position; they are still in a student capacity which is slightly a concern”* (educator 2).



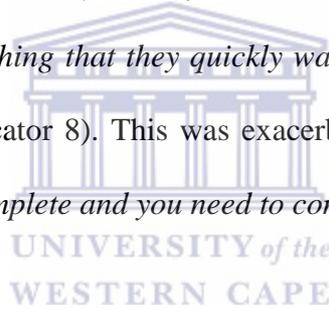
Category 7.3: Community service practitioners were perceived as lacking basic clinical skills

Educators appraised the competency of community service practitioners on aspects related to their scope of practice as a midwife - that deals with assessing, diagnosing, demonstrating and prescribing to a patient in an emergency situation. *“They know they’re allowed to give 10 units of oxytocin when there is no doctor available but they don’t know how to apply it; that you are physically allowed to draw it up in a syringe and give it to the patient or if it does happen and there is a postpartum haemorrhage or when the patient comes in with it, to give it”* (educator 9).

Another example provided by an educator: *“They cannot even do a proper episiotomy; they don’t know how to be an advocacy to the patient, for example they cannot do it from themselves. They*

also always need someone next to them to speak to the patient, they cannot speak to the patient. They don't know how to take consent from a patient (or) to do certain procedures” (educator 1).

Educators acknowledged that the midwifery curriculum may adversely influence the community service practitioner's ability to engage in reflective practice, regarding their knowledge and skills impacting on patient care provided. *“I think we need to move the curriculum away from just doing the task without the student understanding why I am doing this task and how this aligns eventually with my competence at the end when I graduate”* (educator 7). Furthermore the practical workbook intended to assist students with bridging the theory-practice gap has become just another burden for students to complete as soon as possible. *“The workbook it is a draft towards trying to align. However, I am not always sure if it is done with its importance because I can see with the students it is just something that they quickly want to finish, that the workbook if you hand it in, it is complete”* (educator 8). This was exacerbated by the fact that no *“marks are allocated towards it, it is just complete and you need to complete it to progress”* (educator 8).



Category 7.4 Educators were of the opinion that community service practitioners displayed no interest to work in a maternal care setting because of the inclusion of midwifery into the nurse training programme

Educators felt that because the midwifery module is incorporated into the R425 nurse training programme, students with no interest to ever work in a maternal care setting were left with no choice but to undergo midwifery training, which impacts on their ability to obtain competence. *“When you ask them, are they going to stay in midwifery, they tell you no, they are just doing it because it is part of their programme. So, they don't reach competency, they are just doing it to pass”* (educator 3).

4.2.3 Section 1C: Results of professional nurses' interviews

The results in section 1C respond to the following research objectives in line with the Kirkpatrick framework:

- To establish the [*nurse educators (lecturers and clinical supervisor)] and professional nurses views on the community service practitioners' competence to provide safe maternal care. [Addressed in section 1B]
- To determine possible gaps in the education of midwives that could preclude the provision of safe maternal care.

Table 4.3: Themes and categories from professional nurses' interviews

Themes	Categories
Kirkpatrick framework – Level 2	
<p>Theme 1: Learning was negatively affected by the structure of the midwifery clinical component, which adversely impacted on the attainment of competence to provide safe maternal care</p>	<p>1.1: The short duration of the clinical learning programme and limited clinical exposure was ineffective for learning and the development of competence to provide safe maternal care</p> <p>1.2: The rapid rotation of students through the different maternal care settings adversely affected learning, since students struggled to apply their theoretical knowledge to practice</p> <p>1.3: The need to acquire competencies related to multiple disciplines, e.g. midwifery and administration impacted on the time allocated for practicing midwifery specific skills which negatively affected learning and the attainment of competence to provide safe maternal care</p>

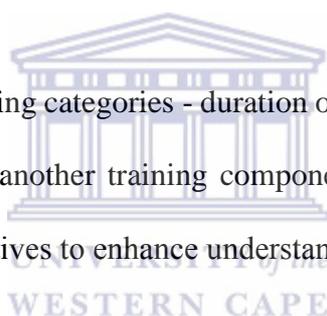
<p>Theme 2: Theoretical preparation for clinical placement was adversely affected by the asynchrony between theory and practice, and ineffective assessment procedures which negatively influenced learning</p>	<p>2.1: The time lapse between students obtaining theoretical preparation and being exposed to related clinical learning created a theory-practice gap</p> <p>2.2: The efficacy of assessment was questioned as it assessed theoretical knowledge more than clinical competence, which negatively affected learning</p>
<p>Theme 3: Clinical learning was adversely affected by the lack of communication, high workload of professional nurses and the difference in how clinical competencies were demonstrated</p>	<p>3.1: A lack of communication between educators and professional nurses negatively affected teaching and learning, as well as the achievement of competence</p> <p>3.2: Professional nurse workload and large student numbers impacted negatively on clinical supervision, which adversely affected the clinical experience and learning for the community service practitioners</p> <p>3.3: Demonstration of competencies by educators and professional nurses was confusing, as it differed and negatively affected learning</p>
<p>Kirkpatrick framework – Level 3</p>	
<p>Theme 4: Community service practitioners were theoretically well-prepared, however, they lacked the ability to apply their knowledge to patient care as they lacked clinical skills, self-confidence, portrayed defensive practice and needed more time to become competent safe midwifery practitioners</p>	<p>4.1 Community service practitioners were perceived as theoretically well-prepared for midwifery practice</p> <p>4.2: Professional nurses indicated that community service practitioners lacked clinical judgment in patient care, which adversely influenced their ability to provide safe maternal care</p> <p>4.3: Professional nurses identified that community service practitioners displayed a negative attitude when they lacked knowledge and skills, which was</p>

	<p>regarded by the professional nurse as defensive practice to protect themselves</p> <p>4.4: Professional nurses identified that the short duration of the programme as a gap in the development of the community service practitioners' competence</p>
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4.2.1 Discussion of themes and categories of professional nurses

Theme 1: Learning was negatively affected by the structure of the midwifery clinical component, which adversely impacted on the attainment of competence to provide safe maternal care

This theme consists of the following categories - duration of the programme, rapid rotation of the programme, sharing space with another training component. Each category is illustrated with excerpts from participants' narratives to enhance understanding of the discussions presented.



The aims of clinical teaching and learning are grounded on the minimum requirements and the guidelines related to clinical learning provided by the SANC (SANC, 1992). This states that the overall objective of clinical practice is to provide student nurses with meaningful learning opportunities in every area of placement according to the level of training, so as to ensure that on completion of the programme the student nurse is able to nurse efficiently.

Level 2: Learning - this level relates to changes in learners' attitudes or the perception of learners about education practices. It also relates to the change in learners' knowledge and skills.

Category 1.1: *The short duration of the clinical learning programme and limited clinical exposure was ineffective for learning and the development of competence to provide safe maternal care.*

The majority of professional nurses reiterated the view that the short practice placement period hindered the attainment of competence for community service practitioners, as it did not offer sufficient time for students to familiarize themselves with clinical environments. Also, professional nurses were of the opinion that community service practitioners needed more time to acquire knowledge and skills necessary to become competent midwives capable of providing safe maternal care, as summed up by this participant: *“My current feelings are that the undergraduate training programme does not optimally prepare the practitioner for the work environment or for the work post-qualifications on passing the 4 year programme”* (professional nurse 13).



Category 1.2: *The rapid rotation of students through the different maternal care settings adversely affected learning, since students struggled to apply their theoretical knowledge to practice*

Apart from the short duration of the placement programme, professional nurses expressed their concern about the rapid rotation of students between the different midwifery areas, this meant that students were not always exposed to best practice which impacted on the attainment of competence for community service practitioners. *“I feel that you cannot generate competencies as a third year midwifery student if you are placed for 2 – 3 days at a given time, in a specific clinical area”* (professional nurse 13). Professional nurses stated that the duration of clinical

placements have a negative influence on the attainment of competence for community service practitioners, to provide safe maternal care.

When asked about skills necessary to be perceived as a competent midwife, safe to practice maternal care: *“It is basic competencies like I explained earlier on, it is the catheterization and IV [intravenous] therapy, vaginal examinations, abdominals are not so bad, the deliveries are also not so bad ,the vaginal examinations is a problem, and then it will be things like neonatal resuscitation , shoulder dystocia, breech deliveries - you know those emergency type of things, also cutting episiotomies, suturing, those type of things”* (professional nurse 16).

All participants noted that students acquire these skills during clinical placement. They regarded sufficient time to practice these skills as important to ensure patient safety.



Category 1.3: The need to acquire competencies related to multiple disciplines, e.g. midwifery and administration impacted on time allocated for practicing midwifery-specific skills, which negatively affected learning and attainment of competence to provide safe maternal care

Simultaneously, with the midwifery component students were also doing another learning component, namely nurse administration. Participants were of the opinion that sharing space with another training component affected learning and the way community service practitioners were perceived in the practice setting, as it impacted on time spent in the maternal care setting, as explained by this participant: *“And also when they come and do their administrative off-duties because they also do that here in this antenatal ward. And ja, one thing about that administrative project - I don't know if they are placed to do it [in] fourth year or final year but all the students are doing it while they are busy with their antenatal hours”* (professional nurse 18). Another

participant mentioned: “*Because I know they do other modules beside midwifery*” (professional nurse 4).

It is the responsibility of education institutions in partnership with the Department of Health, to prepare nurses and midwives to cope with the complex natures of clinical practice (Burns & Patterson, 2005). An important measure for effective nurse education is clinical competence. Clinical competence refers to the ability of the graduate to perform nursing duties and to effectively integrate cognitive, emotional and psychomotor skills during nursing care (EdCan, 2008).

Theme 2: Theoretical preparation for clinical placement was adversely affected by the asynchrony between theory, practice and ineffective assessment procedures, which negatively influenced learning



This theme and ensuing categories narrates the difficulties professional nurses experienced whilst attempting to teach and build the skills of midwifery student’s during clinical placements, due to the lack of theoretical preparation prior to clinical placement.

Category 2.1: Relevant theoretical preparation of students prior to clinical placement was lacking, which adversely affected the teaching and learning of the community service practitioner

The link between classroom preparation and the clinical practice area were instrumental in developing skills required for the practice of midwifery. Evidence from literature suggests that there is a gap in the integration of theory with practice, which has been a concern for nursing

education for a long time and which have had an impact on learning for nursing students (Kelly, 2007). Professional nurses communicated that they were willing to supervise nursing students during their clinical placements, acknowledging the diverse experience they could provide them (Halcomb, 2010). However, difficulties were identified when students' theoretical preparation did not complement their clinical placement area, as these students lacked understanding. Comments below illustrate the participants' perceptions that prior to attending practice placement, it would be beneficial to them if they were informed about their role in the placement area: "*So what I have discovered [is] that students are placed at clinical facilities prior to receiving the theoretical information, with the result that you must first go over the theoretical part with them before you can do the practical part with them*" (professional nurse 10).

Whilst supervising student midwives, professional nurses had observed that regardless of having completed theoretical components related to the topic, students were ill-prepared as they lacked foundational knowledge related to patient care specific to the area of placement. Professional nurses articulated that they expected students to explain the theoretical part to them while involved in the practical demonstrations but found that a part was missing - the 'why' part, since it made sense but that the students could not do it.

Category 2.2: The efficacy of assessment procedures was questioned as it did not portray clinical competence and negatively affected learning

The data made it evident that assessment of performance could be difficult due to a vast number of factors that need to be considered or that could influence the process. There appears to be tension between academic qualification and competence to practice. Professional nurses had mixed feelings about the efficacy of assessment procedures, indicating the disparity between

professional development and proficiency. *“Because when the students have completed their assessments they will get very high mark, and then I will think, but you cannot even do this properly”* (professional nurse 2). Luhanga (2008) argues that pass rates in the practical assessments of nursing students appear to be higher than expected and that one possible reason is not the candidate’s abilities but rather the assessor’s reluctance to fail them. Similarly authors, Garside and Nhemachena (2013), indicated that determining the level of nurse competence at which a student should be deemed competent is problematic. Watson, Stimpson, Topping and Porock. (2002) questions the perception of competence by asking if someone is 90% competent, as judged by a series of tasks or observations; are they competent to practice or do they have to receive 100%? Mason-Whitehead (2008) suggests that competence should not be seen only as the aptitude for the health care practitioner to perform effectively once, competence requires that practitioners have the ability to repeat their performance on each attempt by a satisfactory standard.



Theme 3: Clinical learning was adversely affected by the lack of communication between educators and professional nurses, the high workload of professional nurses and the difference in how clinical competencies were demonstrated

This theme has the following categories, a lack of communication, high workload, and the difference in how clinical competencies were demonstrated. Categories are illustrated by excerpts from participant’s narratives and supported by literature to enhance understanding of discussion being presented.

Category 3.1: A lack of communication between educators and professional nurses negatively affected teaching and learning, as well as achievement of competence

Learning in practice requires a good partnership with academic institutions and health care facilities, to ensure dialogue about what contributes to learning in practice

In addition to the perception of being overburdened by inappropriate student numbers in the clinical setting, professional nurses communicated about disparities in the way clinical placements were allocated for student placement at any one time. The university organised clinical placement as well as student off-duties for their students, whereas off-duties for other students were arranged by professional nurses. Participants reported feeling confused about such processes and expressed a desire for uniformity in the allocation of placements for students.

“Students from [name] institution come here with their off-duties already worked out, while we work out the off-duties of students from [name] institution (so) that way we can make sure that students are placed during days we know there are more learning opportunities available. It also causes problems when there are so many students on duty at one time” (professional nurse 18).

Another participant explained: *“ And most of the times, the only time we know about the students is when they stand in front of you, no communication from the institution, then we have to call the institution and ask them about the students”* (professional nurse 17).

Participants communicated that they would like to have more influence over the clinical placements and the allocation of student off-duties, as requested by this participant: *“University not to send students with off-duties”* (professional nurse 18).

Since professional nurses were not involved in drawing-up the teaching and learning objectives for student midwives, clinical supervision from the education institutions were limited. The interest and motivation for identifying suitable learning opportunities for student midwives were

affected. Professional nurses therefore suggested that they would find it helpful to have frequent discussions with midwifery educators, to review aspects of students training and development. *“We don’t know, communication in our set-up is very lacking. We don’t really know at the end of the period if they have achieved their goals. We don’t know if they have achieved those objectives when they leave”* (professional nurse 17).

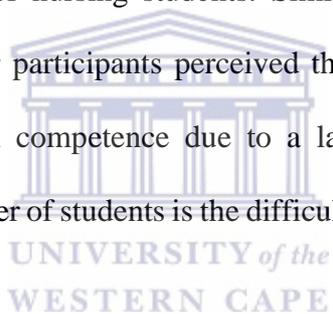
Heidari and Norouzadeh (2015) in their study conducted to determine nursing student’s perspectives on clinical education indicated that a lack of awareness of nursing students’ needs in the clinical environment has been identified as a factor that leads to poor student progress.

Category 3.2: Professional nurse workload and large student numbers impacted negatively on clinical supervision, which adversely affected the clinical experience and learning for the community service practitioner

Professional nurses indicated that the placement of large student numbers at a facility negatively affected teaching and learning, since the professional nurses are not able to give students the necessary support they require. *“You know sometimes it is so overwhelming, we will have you, we have (name) and we will have the medical students. Now I must not say it but I give preference to the medical students”* (professional nurse 17). *“Especially if you have a busy day then the students can forget about training, everything is then just rushed; you don’t have the time to teach them”* (professional nurse 15). Another participant said: *“When you have the workload of a thousand deliveries per month, then these people come and go and you always need to create beds in the labour ward. So, in the feeding of this assembly line you don’t have time to optimally spend on creating learning opportunities for students in your ward”*(professional nurse 6). Kemper (2007) identified that the presence of students in the ward is seen as an added burden by ward nurses.

Furthermore on this perception, another participant shared her opinion about the large student numbers in clinical placement settings and that this proved to be overly taxing for them: *“Really with six students and two sisters, I cannot see how much that students can actually learn, because if I’m working in the labour ward and I’m working with six students, and I have to repeat, I have to say six times the same thing, so it tires you, so by the time you get to the sixth student you know, it’s six times the same information* (professional nurse 13). The same professional nurses were expected to provide care for pregnant women, post- partum patients and their newborn babies, making it challenging for professional nurses to execute their teaching roles.

Waldock (2010) asserts that time and workload is considered key factors that contribute to the reduced learning opportunities of nursing students. Similar results are reported by Magobe, Beukes and Muller (2010), their participants perceived the shortage of staff as a contributing factor to students’ poor clinical competence due to a lack of clinical supervision. Another implication of an increased number of students is the difficulty in finding clinical placement space (Ganely & Sheets, 2009).



Professional nurses acknowledged that they played a key role in not only developing these skills but also to model professional conduct; the absence of good professional role models were perceived as deterring learning: *“You have a community service practitioner, that she is a community service practitioner this year and next year she is most probably a shift leader. And if she has not been properly groomed into doing those core competencies in an optimal fashion, she is then going to be a role model to a new community service practitioner. And it could be like the blind leading the blind”* (professional nurse 15).

One professional nurse described how she worked in partnership with community service practitioners. *“And I make very sure on day two that it is very clear that my door is always open*

for them, if there is something they don't understand [or] something they need to do and it is not anywhere they can come back to me. Then they can come to me and they can explain why they must do that and why it is necessary for them to do that. If there is anything extra, I'll put it in extra for them" (professional nurse 12).

Professional nurses discussed their responsibility in guaranteeing that community service practitioners absorbed the importance of core midwifery skills. *"Yes I do demonstrations of procedures, the abdominal assessment, your pelvic assessments, your how you see your clients, how you work with your partogram and the HIV testing, the bloods drawn. What you do with your patient"* (professional nurse 6). Longworth (2013) stated that support roles are undertaken by more experienced, and often senior registered nurses to assist learning guides.



Category 3.3: Demonstration of competencies by educators and professional nurses were confusing as it differed and this negatively affected learning

Professional nurses were no longer adhering to midwifery practice that was taught during training. Professional nurses were aware of the inconsistencies in the demonstration of competencies between them and the educators supervising students at clinical settings; how confusing this might have been for the community service practitioner. *"Because they [students] will tell us but that's not how the clinical facilitators taught us or that is not how we understand it. So it is a little bit confusing for the students"* (professional nurse 13). This raised concern as professional nurses were aware that the different care methods were having an impact on the nature and content of learning for community service practitioners. If standards were declining, competency by the midwife would be minimal, interrupting the vicarious reinforcement that learning happens by imitating others (Quinn & Suzanne, 2007).

Level 3: Behaviour - this level relates to the transfer of knowledge of learning to the workplace

Theme 4: Community service practitioners were theoretically well prepared; however, they lacked the ability to apply their knowledge to patient care as their clinical skills, self-confidence, portrayed defensive practices, no interest to work in a maternal care setting as well as needing more time to become competent safe midwifery practitioners

Professional nurses were asked what possible gaps in the education of community service practitioners precluded ensuring the delivery of safe maternal care.

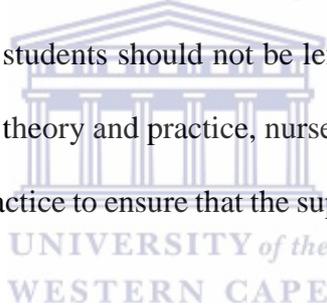
Midwifery nursing students when approaching graduation are expected to have adequate midwifery competence to fulfil their duties safely and effectively. An adequate supply of midwives are necessary to provide high-quality, safe patient care (Aiken, 2014). However, Berkoff et al (2008) reported that nurse leaders have not been satisfied with the new graduate nurses' competence. Only about one in every four leaders was fully satisfied with the performance of the new graduate nurses; more than a quarter were somewhat dissatisfied or worse. The graduate nurses met the expectations of nurse leaders in only two competencies, namely the utilization of information technologies and rapport with patient and families.

Category 4.1: Community service practitioners were perceived as theoretically well prepared for midwifery practice

Professional nurses were of the opinion that community service practitioners were theoretically well prepared: *"I find that they know their theory"* (professional nurse 5). From the data it emerged that the perception during training is that more attention is given to theoretical preparation than to the clinical component, indicating that it could be a reason why students do

not take the clinical component seriously and thus fail to attain the required standards: “*At [name] institution they just focus on theory, it’s just theory, theory, theory*” (professional nurse 2).

Participants felt that although community service practitioners have achieved adequate theoretical knowledge, they lacked the ability to demonstrate the application of their theoretical knowledge to patient care. “*Because they can tell you things, but they cannot do it*” (professional nurse 5). Another participant put it this way: “*I find that with many students they know the theory but they find it difficult to apply that theory [when] they don’t know how to link the two*” (professional nurse 3). Masoodi, Afzali, Etemadifar, and Maghadasi (2009) identified in their study that educators indicated a lack of suitable environment and a lack of confidence in scientific discussions when necessary, as the two most significant problems for this situation. Gillespie and Mcfetridge (2006) indicated that students should not be left alone to draw the links themselves; in order to draw the link between theory and practice, nurse educators need to keep abreast of the latest developments in clinical practice to ensure that the support provided to students is grounded in theory and clinical practice.



Category 4.2: Professional nurses indicated that community service practitioners lacked clinical judgment in patient care, which adversely influenced their ability to provide safe maternal care

There was a strong view that community service practitioners do not realize the seriousness of reporting abnormal deviations in the condition of pregnant patients: “*At one stage they will come and report and at another stage not, they don’t always come and report blood pressure because they don’t always knows the normal values*” (professional nurse 15). Another participant noted that because of a knowledge deficit: “*They will come and they will say no they don’t know,*

especially if the patient have tested the urine and now there is protein in the urine” (professional nurse 5). Another example quoted *“They will come and tell you that there was a decel [deceleration], that they can identify but the rest we must come and have a look at. And we must evaluate. And that is very, very important in this antenatal ward”* (professional nurse 15). Consistent with this finding the Joint Commission International Centre for Patient Safety (2007) asserts that over 70% of sentinel events reported resulted in a patient’s death and 10% resulted in loss of function.

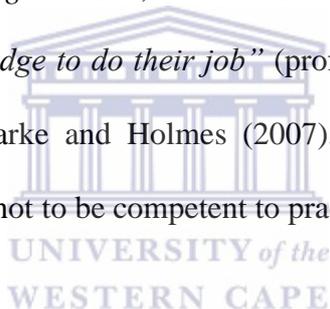
In one site professional nurses gave the example of community service practitioners from one education institution undertaking placement at the same clinical setting. *“With the [name] students I find that they also seem to me less confident, as if they are scared to do things”* (professional nurse 10).

Professional nurses expressed concern about the lack of basic skills demonstrated by community service practitioners. *“So they cannot see their patient complete because now I have to do the catheter, so the protein is high and I say put up the drip so that we can give the patient the magnesium sulphate and they cannot do it”* (professional nurse 2).

Another professional nurse made it clear that women’s needs during pregnancy can be very complex and that the midwife needs to rise to this challenge. *“Now the patient complains about a vaginal discharge, I then have to insert a speculum and look at that discharge and treat that discharge as well. I can’t just treat the patient halfway and not do the rest. Because actually that’s what is happening, they only focus on that one area. What about the rest? So how can you become competent if you are just focusing on one thing”* (professional nurse 4).

Category 4.3: Professional nurses identified that community service practitioners displayed a negative attitude when they lacked knowledge and skills, which was regarded as defensive practice

A professional nurse went on to refer to an atmosphere of defensive practice due to a lack of knowledge: *“They negatively feed into what we are currently wanting to do in providing optimal quality care because when you are not competent, you also not going to be confident. And when you [are] not confident then you are going to end up feeling threatened about what you need to do and when you feel threatened then you get into a defensive mode”* (professional nurse 17). Another participant commented: *“And when you look at the media, what are the media talking about? Healthcare workers having attitudes; the attitudes is (are) rooted in the insecurities they feel about not having the knowledge to do their job”* (professional nurse 18). Abovementioned findings are consistent with Clarke and Holmes (2007), who asserted that newly qualified professional nurses are assumed not to be competent to practice independently.



Category 4.4: Professional nurses felt that community service practitioners portrayed no interest to work in a maternal care setting, which impacted adversely on their development

There was a strong and shared perception amongst professional nurses that students do not enjoy their midwifery training and do not regard it as a lifelong vocation. Schunk, Pintrich and Meece (2007) suggest that motivated students have the benefit of higher levels of success. It is believed that they are only doing the midwifery component because it is a part of their nurse training programme and therefore pay very little attention to the practical component; on placement will show no passion in the midwifery clinical setting. According to Scullion and Guest (2007), having clear goals will serve as a motivating factor. As voiced by this participant: *“When the*

students finish their training, they don't want to work in midwifery because [it is] very seldom [that] I get a student that would tell me they want to be a midwife" (professional nurse 3).

Stomberg and Nilsson (2010) conducted a study amongst nursing students at the University of Betham, to establish variation in nursing student motivation to complete their programme of study. They found that the desire to become a registered nurse and having a positive attitude towards the studies, were the main factors influencing high motivation to complete the study programme. Portraying confidence in front of doctors was also perceived as progression towards independent practice: *"We had a lady with severe hypertension that we prepared for the administration of magnesium sulphate. So, the patient needed a catheter and the sister said she don't [didn't] know how to insert the catheter. She did not know how and so the doctor gets [got] upset"* (professional nurse 6).

Although the expectation is that newly graduated community service practitioners should be competent and practice autonomously (Clark & Homes, 2007), most of the professional nurses expressed concerns that the community service practitioner cannot be left in charge of a unit or ward and needed constant supervision. Nevertheless, van der Putten (2008) states that the newly qualified graduate find the increasing level of responsibility and accountability for managing clinical care particularly overwhelming. Professional nurses constantly referred to community service practitioners as students. Professional nurses indicated that high risk areas should not be manned by community service practitioners. *"Not in this ward because we must still guide them. Maybe in a general ward but not in a high risk antenatal ward! And guidance means everything here in the antenatal ward, and after months of guidance only then I think they will get [become] competent"* (professional nurse 17).

4.2.4: Section 2 Discussion of the findings across participant groups

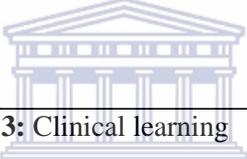
The following section is a discussion of the findings across all participant groups according to Kirkpatrick's model, which was used to structure the findings. In presenting the findings the themes were carefully cross-referenced against each other to identify possible horizontal themes, which would serve as concluding statements. The purpose of this section is to capture the experiences of community service practitioners, lecturers, clinical facilitators and professional nurses about their perceptions on the midwifery education module, as well as the competence of community service practitioners to provide maternal care. A summary of the themes and categories of all participant groups is depicted in table below.



Table 4.4: Summary of themes related to experiences of community service practitioners, midwifery educators and professional nurses as well as the horizontal themes and the concluding statements

Community service practitioners	Educators	Professional nurses	Horizontal themes	Concluding statements
<p>Theme 1: Duration and structure of the midwifery education programme negatively affected learning and the attainment of competence for community service practitioners</p>	<p>Theme 1: The timing, duration, nature, as well as the inclusion of midwifery into the nurse education programme negatively affected learning</p>	<p>Theme 1: Learning was negatively affected by the structure of the midwifery clinical component, which adversely impacted on the attainment of competence to provide safe maternal care</p>	<p>Theme 1: Learning was negatively affected by the timing, duration, nature, structure, as well as the inclusion of midwifery into the nurse training programme</p>	<p>Statement 1. The design and delivery of the midwifery education programme negatively affected learning and community service practitioners attainment of competence</p>
<p>Theme 3: Clinical learning was adversely affected by the lack of synergy between theory and practice, clinical learning requirements, assessments by the professional nurses,</p>	<p>Theme 2: Learning in the clinical setting was adversely affected by clinical requirements, limited clinical learning opportunities, assigned student duties, lack of synergy between theory and practice and the unsupportive environment in which</p>	<p>Theme 2: Theoretical preparation for clinical placement was adversely affected by the asynchrony between theory and practice, as well as ineffective assessment procedures which negatively influenced learning</p>	<p>Theme 2: Clinical learning was negatively affected by the clinical learning requirements, assigned duties which were not aligned to theoretical preparation and level of training, insufficient learning opportunities, ineffective assessment procedures, ineffectual supervision, differing</p>	<p>Statement 2: The programme lacked synchrony between-and and the quality of teaching theory and clinical skills which was further negatively impacted by an unsupportive learning environment including insufficient learning</p>

<p>ineffectual clinical supervision and differing techniques for demonstrating competencies</p> <p>Theme 2 :Preparation for clinical placement was adversely affected by the lack of relevance and synchrony between theory and practice, the focus on learning for assessment , the timing of written assessments and exposure to ideal situations during skills laboratory sessions negatively influenced learning</p>	<p>students were placed for clinical practice</p> <p>Theme 5 : The quality and effectiveness of assessments affected learning and the student’s competence to provide safe maternal care</p>	 <p>UNIVERSITY of the WESTERN CAPE</p>	<p>demonstration of skills, unsupportive learning environments, variable quality of teaching assessments, the focus of learning for assessments, the exposure during skills laboratory sessions and the timing of written assessments</p>	<p>opportunities to meet the clinical requirements, ineffective clinical supervision and assessments</p>
<p>Theme 4: Learning in the clinical setting was adversely affected by personal limitations of professional nurses and ineffective communication between</p>	<p>Theme 3: Ineffective supervision, role modelling, and communication between educators and professional nurses was negatively perceived as adversely impacted on the professional development of community service practitioners</p>		<p>Theme 3: Learning was negatively affected by ineffective supervision, ineffective role modelling, communication, slow clinical site accreditation process, lack of student supernumerary status, short placement</p>	<p>Statement 3: Ineffective role modelling and communication by professionals. Students’ lack of motivation and a lack of supernumerary student status, ineffective clinical supervision</p>

<p>educators and professional nurses</p>	<p>Theme 6: Learning and the attainment of competence were negatively affected by ignoring students' supernumerary status, student motivation, slow accreditation process, the short duration and rapid rotation of the placement programme, the inclusion of midwifery in the nurse training programme and the low pass mark</p>		<p>duration, lack of student motivation and the low pass criteria</p>	
	<p>Theme 4: Educator and student limitations including lack of educators' clinical experience, Professional nurses' lack of interest to teach, student readiness and motivation for teaching methodology and their feeling of being overwhelmed was perceived negatively, as it affected the attainment of competence</p>	<p>Theme 3: Clinical learning was adversely affected by the lack of communication, high workload of professional nurses and the difference in how clinical competencies were demonstrated</p>	<p>Theme 4: Learning was negatively affected by the lack of educator clinical experience, professional nurses' high workload and their lack of interest to teach , lack of standardization of clinical teaching ,ineffective communication between educators and professional nurses, the students' readiness and motivation for the teaching methodology</p>	<p>Statement 4: The lack of experience of educators, willingness and personal limitations of professional nurses, receptiveness of teaching method, motivation of students and challenges with the standardization of clinical teaching negatively impacted on the attainment of competence</p>

	<p>Theme 1: Community service practitioners were perceived as poorly prepared midwifery practitioners who could not be trusted to work as independent midwives since they lacked basic midwifery skills and displayed no interest to work in a maternal care setting</p>	<p>Theme 1: Community service practitioners were theoretically well-prepared, however they lacked the ability to apply their knowledge to patient care as they lacked clinical skills, self-confidence, portrayed defensive practice and needed more time to become competent, safe midwifery practitioners</p>	<p>Theme 5: Community service practitioners were not well-prepared and not ready to work independently since they could not apply their theoretical knowledge to practice.</p>	<p>Statement 5: Community service practitioners were not well-prepared practitioners because they lacked basic midwifery skills, and required more time to become independent safe midwifery practitioners</p>
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4.2.4.1: Discussion of participant experiences relating to the midwifery education programme

Table 4.4 reflects that all three participant groups expressed mostly similar experiences about the midwifery education programme. Whilst most of the themes that emanated were similar, participant experiences deviated. Participants focused mostly on those areas that needed further improvement.

4.2.4.1.1 Concluding Statement 1

The design and delivery of the midwifery education programme negatively affected learning and community service practitioners' attainment of competence

An evident thread throughout all the interviews was the desire for a longer duration of the midwifery education programme. This was often discussed in relation to the attainment of midwifery skills and knowledge. All participants questioned the benefits derived from the existing six months training period, as the current period was seen as being inadequate to effectively prepare midwifery students to fulfil their professional development and assume their responsibilities as independent midwifery practitioners.

This raised the issue about the inclusion and timing of the midwifery component into the nurse training programme. Educators believed that students should be given the opportunity to explore other possibilities by allowing the midwifery component as an elective.

Furthermore, professional nurses indicated that due to the fact that the midwifery education component was offered simultaneously with another related training component students were

overloaded. Educators on the other hand mentioned that by presenting the midwifery component too early in the nurse training programme disadvantaged the students because they were perceived as emotionally and academically underprepared for the education programme.

The time allocated for the theoretical component was also too short and by allowing students to drag another theoretical learning component from the second year, increased the pressure and workload of the students.

Furthermore, the educator group requested that as with other professions, nurses and midwives need a well-structured and well-resourced recruitment and induction strategy prior to commencement of their studies. This would enable the recruitment of candidates who are passionate about nursing and midwifery.

The study findings support previous work which has described the link between theoretical knowledge, technical skills and competence (Gilespie, Wallis & Chaboyer, 2006). Similarly, Biggs (1999) claimed that effective learning requires a knowledge base, a motivational context, learning activities and interaction. These corresponds to the underpinning assumptions of the researcher, as suggested by the National Health Workforce Task force report (2010), discussed in detail in chapter one.

4.2.4.1.2 Concluding Statement 2

The programme lacked synchrony between- and the quality of teaching theory and clinical skills, which was further negatively impacted by an unsupportive learning environment including as well as insufficient learning opportunities to meet the clinical requirements; ineffective clinical supervision and assessments

All participants confirmed that many of the teaching and learning difficulties were exacerbated by the asynchrony between theory and practice. This asynchrony between theory and practice seemed to stem from insufficient placement space at clinical facilities, due to an increase in student enrolment numbers at education institutions. Furthermore, educators, professional nurses and community service practitioners all commented on the importance of aligning theoretical preparation to clinical practice placement, which would assist students to optimally benefit from the placement experience. This was described by participants as a point where education and learning met.

Without exception, community service practitioners indicated that written assessments assisted with the integration of theory with practice.

However, concerns were expressed with the narrowed focus for learning just for assessment purposes and the timing of written assessments, which inhibited comprehensive learning and student performance during assessments.

In addition, the concern was expressed by professional nurses about clinical assessments performed by academic staff which does not reflect the clinical competence of students but rather students' theoretical knowledge.

This created the expectation that the student would translate the theoretical knowledge into action and perform as a skilled midwife in the clinical setting, whilst their role was that of a student.

This confirms the statement by The Nursing Council of New Zealand (2011), that competency assessments are influenced by the knowledge, skills and attitudes as well as environmental and situational factors.

In addition, community service practitioners indicated that the dissimilarity between academic controlled clinical learning settings and the real clinical setting created tension and a feeling of unpreparedness for practice placement. One way of improving this experience would be for educators to repeat the competency demonstration on real patients in the real clinical environments. This would provide opportunities for students to learn and gain experience from a variety of situations.

The number of students placed at a facility impacted on the clinical experience of participants. Another hurdle identified by both participant groups was the continuous competing for experiences with students from other education institutions, who all wanted to attain the same competency.



Participants perceived this competition as an adverse aspect of the attainment of the required learning needs.

Other constraints cited by participants included the inability to meet SANC's learning needs, the environment, particularly the lack of teaching and learning space at clinical facilities, under-resourced skills laboratories and the limited midwifery specific competencies included in the midwifery workbook of students.

4.2.4.1.3 Concluding Statement 3

Ineffective role modelling and communication by professionals, students' lack of motivation and a lack of supernumerary student status, ineffective clinical supervision

The data made it evident that the learning needs of midwifery students were not always clearly understood by professional nurses in clinical facilities.

Educators commented that students were allocated to perform menial routine duties instead of being allocated to midwifery-specific skills.

This could stem from the perceived lack of communication between academics and professional nurses at clinical facilities. This indicates that better communication is required between professional nurses and academics.

The most problematic aspects of clinical student supervision strongly emerged via question strands concerned with the perceived lack of clinical competence of community service practitioners. Clinical facilitators spoke about having to juggle large student numbers, as well as having difficulty in navigating through the complexities of their clinical and educative roles. Their responsibilities regarding students practice learning, was complicated by issues such as daily pressures, travel and communication with the wider team.

Lecturers, on the other hand, said they felt busy and rushed due to their multiple roles and consequently worried about the quality of clinical supervision they facilitated.

Professional nurses cited their high workload, facilities overcrowded with students, staff shortages and the lack of communication between them and academics as barriers complicating student clinical supervision.

Community service practitioners on the other hand spoke of incidents where they had to work unsupervised. This affected students' clinical supervision experience and had a negative impact on student learning. Conversely, community service practitioners agreed that clinical assessments done by professional nurses were generally opportunistic. They claimed that competencies were signed off as being competent without it being assessed by professional nurses. This is worrying as patients could be exposed to unsafe practices (Fitzgerald, Gibson, & Gunn, 2010).

This indicates that competency assessments can be difficult due to a number of factors that can impact on the method.

4.2.4.1.4 Concluding Statement 4

The lack of experience of educators, willingness and personal limitations of professional nurses, receptiveness of teaching method, motivation of students and challenges with the standardization of clinical teaching negatively impacted on the attainment of competence

Participants felt that the inadequate clinical experience of the lecturing staff was a significant factor, which influenced the teaching and learning experience of both the student and the educator.

In-depth interviews revealed that in one case, management's expectation for an educator was to lecture on the midwifery education programme without having any midwifery clinical experience.

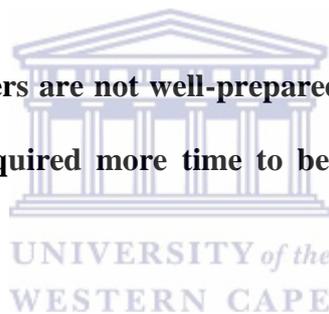
Having expert instructors and supportive communication are important factors in creating a clinical learning environment (Jahanpour, Azodi, Azodi, & Khansir, 2016). The data made it clear that the level of capability of professional nurses with regard to supervision of midwifery students and the point to which they were comfortable with the students performing the role, had an impact on the students. If a professional nurse was perceived to be capable in her/his role, midwifery

students gained from her/his knowledge and skills. On the other hand, if the professional nurse was of the opinion that the students may cause difficulties, the opposite was the case.

The students' lack of interest in pursuing a career in midwifery emerged from the data; via the volume of commentary it was evident in respect of the perceived lack of midwifery competence amongst midwifery graduates. This could stem from the fact that the midwifery component had been integrated into the nurse training programme, making the midwifery programme compulsory for all nursing students even for those with no interest in maternal healthcare.

4.2.4.1.5. Concluding Statement 5

Community service practitioners are not well-prepared practitioners because they lacked basic midwifery skills and required more time to become independent, safe midwifery practitioners



The above issues have implications regarding the quality of learning and assessments. In this study there was no debate amongst participants on what to expect from community service practitioners as midwives. All shared the perception that they considered these graduate nurses as novices who required support and assistance.

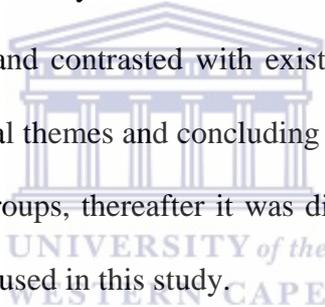
Educators felt that due to the mentioned oversights in the midwifery education programme, community service practitioners were perceived as poorly prepared midwifery practitioners. They were of the opinion that community service practitioners needed further supervision and guidance.

Professional nurses on the other hand, indicated that community service practitioners were theoretically well-prepared but lacked midwifery-specific skills and therefore they could not be

trusted to work independently. The findings of this study is similar to a study conducted in Ethiopia assessing the competence of newly qualified midwives and nurses. (Tegbar, Firew, Young-Mi, Mintwab, Dejene, Gibson, Teshome, Broerse, & Stekelenburg, 2014).

4.3 SUMMARY

This chapter focused on the presentation and discussion of results that emanated from focus group discussions held with community service practitioners, in-depth interviews held with midwifery lecturers and clinical facilitators from the two education institutions and with professional nurses from the primary, secondary and tertiary maternal healthcare settings in the Western Cape area. The findings were compared to and contrasted with existing literature sources, as a means of supporting the findings. Horizontal themes and concluding statements were developed across the themes of the three participant groups, thereafter it was discussed according to the Kirkpatrick theoretical framework which was used in this study.



CHAPTER 5

DEVELOPMENT AND DESCRIPTION OF A FRAMEWORK TO ALIGN MIDWIFERY THEORY AND PRACTICE

5.1 INTRODUCTION

In chapter four the results of the focus group discussions conducted with community service practitioners and in-depth interviews with midwifery educators and professional nurses were discussed and corroborated against existing literature on the topic. The purpose of this study was to explore community service practitioner's, midwifery educators, and professional nurses' perceptions of the midwifery education programme and the influence it has on the competence of the community service practitioners in maternal care settings. The findings in phase one of the study is used in phase 2, where the main concepts will be identified from the data collected in phase one. Creating conceptual meaning from the identified concepts will provide a foundation for the development of a framework to align midwifery theory and practice and in so doing improve midwifery education in the Western Cape. The ultimate purpose is to improve the competence of community service practitioners to deliver safe maternal care towards positive patient outcomes. The emphasis of this chapter will therefore be a discussion of the process of the development; and a description of aforementioned framework.

To facilitate this process, as described in chapter 3, section 3.5, this phase follows a series of steps outlined by Walker and Avant (2011), Chinn and Kramer (2015) and Dickoff, James and Wiedenbach (1968).

Chinn and Kramer (2015) clarify the development of conceptual nursing frameworks by several theorists during 1952 – 1989. They highlight the debate about whether the works and theory – like constructions of theorists should be called theories, conceptual models, theoretic frameworks or conceptual frameworks. They conclude that irrespective of the nomenclature used, those developed for nursing practice were taught in nursing education, applied in practice and used to conduct research. For this reason the researcher of this study chose to refer to the outcome of this chapter as the development of a framework.

The chapter therefore focuses on achieving the following objective of the study which was:

- To develop a framework to align theory and practice for improved midwifery education in the Western Cape based on the findings of the study

The following steps as outlined chapter 3 guide the presentation of framework development:

- Step 1: Concept synthesis - Identification of concepts from data generated in phase one
- Step 2: Statement synthesis - Development of relational statements
- Step 3: Theory synthesis - Framework development

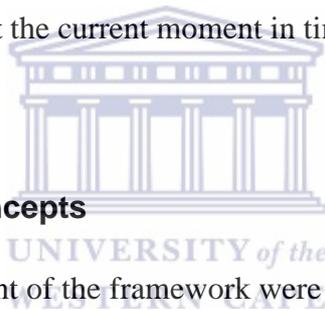
Following step 3, an overview and purpose of the framework is presented, followed by the context of the framework, the assumptions of the framework, its structure and the guidelines to operationalise the framework; and lastly a description of the process for evaluating the framework is presented.

5.2 STEP 1: CONCEPT SYNTHESIS

The process of concept identification includes the identification of main and related concepts necessary for the development of the framework. Walker and Avant (2011) purports, that concepts are mental constructions and are an individual's attempts to order their environmental stimuli.

Concepts allow for classifying of experiences in a meaningful way both for the individual and for others (Walker & Avant, 2011). The process of concept synthesis can therefore be defined as an activity where concepts, their characteristics and relations to other concepts are clarified (Nuopponen, 2010). It allows for decisions about which phenomena matches the concept and which do not (Walker and Avant, 2011).

According to Chinn and Kramer (2015) identifying, classifying and defining concepts for the framework will enable the creation of conceptual meaning by increasing awareness of the range of possible uses and meanings of words. However, Walker and Avant (2011) cautions that the analysis or synthesis of concepts should never be viewed as a finished product but rather as capturing critical elements of it at the current moment in time.



5.2.1 Identifying main concepts

Main concepts for the development of the framework were identified from results of the analysis of data that emerged from focus group discussions with community service practitioners and in-depth interviews conducted with midwifery educators and professional nurses in phase one of the study.

The process of identification of concepts began by critically looking at, and deriving meaning out of the four concluding statements which were generated from the themes that cut across all the participant groups in phase one of the study.

Table 5.1 below indicates the process of classifying and identifying concepts and main concepts extrapolated from horizontal themes and concluding statement.

A total of twenty one concepts were identified. These concepts were further synthesized by means of examining the similarities and differences which resulted in the final deductive formulation of the following six main concepts:

1. Positive curriculum design
2. Positive teaching and learning experience
3. Positive role-modelling
4. Supernumerary student status
5. Skilled human resources and a positive work environment
6. Competent midwives

These main concepts were aligned to the four levels of the Kirkpatrick model which relate to reaction, learning, behavior and results and used to develop the framework to align theory and practice to improve midwifery education.



Table 5.1: Process of identifying and classifying concepts and main concepts

Kirkpatrick's model	Horizontal themes	Concluding statements based on horizontal themes	Concepts	Main concepts
Level 1 Reaction	Theme 1: Learning was negatively affected by the timing, duration, structure, and the inclusion of midwifery into the nurse training programme	Statement 1: The design and delivery of the midwifery education programme negatively affected learning and community service practitioners attainment of competence	<ol style="list-style-type: none"> 1. Timing of programme 2. Duration of the programme 3. Structure of programme 	<ol style="list-style-type: none"> 1. Effective curriculum design
Level 1 Reaction	Theme 2. Clinical learning was negatively affected by the clinical learning requirements, assigned duties which were not aligned to theoretical preparation and level of training, insufficient learning opportunities, ineffective assessments procedures, ineffectual supervision, differing demonstration skills, unsupportive learning environments, variable quality of teaching assessments, the focus of	Statement 2: Lack of synchrony between, and the quality of, teaching theory and clinical skills which was further negatively impacted by an unsupportive learning environment including insufficient learning opportunities to meet the clinical requirements; ineffective clinical supervision and assessments	<ol style="list-style-type: none"> 4. Asynchrony between instructional strategies and practice 5. Insufficient learning opportunities 6. Unsupported learning environment 7. Exposure to clinical opportunities 8. Assigned student duties 9. Assessments 	<ol style="list-style-type: none"> 2. Positive teaching and learning experience

	learning for assessments, the exposure during skills laboratory sessions, and the timing of written assessments		10. Ineffective clinical supervision	
Level 2 Learning	Theme 3: Learning was negatively affected by ineffective supervision, ineffective role-modelling, communication, slow clinical site accreditation process, lack of student supernumerary status, short placement duration, lack of student motivation students, and the low pass criteria	Statement 3. Role-modelling and communication by professionals was ineffective for students who did not have supernumerary student status and who lacked motivation 	11. Role-modelling 12. Communication 13. Student motivation 14. Student supernumerary status	3. Positive role-modelling 4. Supernumerary student status
Level 2 Learning	Theme 4. Learning was negatively affected by the lack of educator clinical experience, professional nurse's high workload and their lack of interest to teach, lack of standardization of clinical teaching, ineffectual communication	Statement 4. The lack of experience of educators, willingness and personal attributes of professional nurses, receptiveness of teaching method and challenges with the standardization of clinical teaching	15. Educator clinical experience 16. Professional nurse's high workload 17. Standardization of clinic teaching	5. Skilled human resources and a positive work environment

	between educators and professional nurses, the students readiness and motivation for the teaching methodology	negatively impacted on the attainment of competence		
Level 3 Behaviour	Community service practitioners were perceived as poorly prepared midwifery practitioners who could not be trusted to work independently, since they were not able to apply their theoretical knowledge to their practice	Community service practitioners are poorly prepared practitioners lacking basic midwifery skills, and need more time to become safe, knowledgeable, independent midwifery practitioners	18. Skilled 19. Independent 20. Safe 21. Knowledgeable	6. Competent midwives

5.2.2 Concept classification

The survey list of Dickoff, James and Wiedenbach (1968) was used to classify the concepts in the framework against the six vantage points and survey questions which include:

Agency - Who or what performs the activity?

- i) Patiency or recipiency - Who or what is the recipient of the activity?
- ii) Procedure - What is the guiding procedure, technique or protocol of the activity
- iii) Dynamics - What is the energy source for the activity?
- iv) Framework - In what context is the activity performed?
- v) Terminus or goal - What is the end point of the activity?

Figure 5.1 below depicts the reasoning map for the clarification of identified concepts.

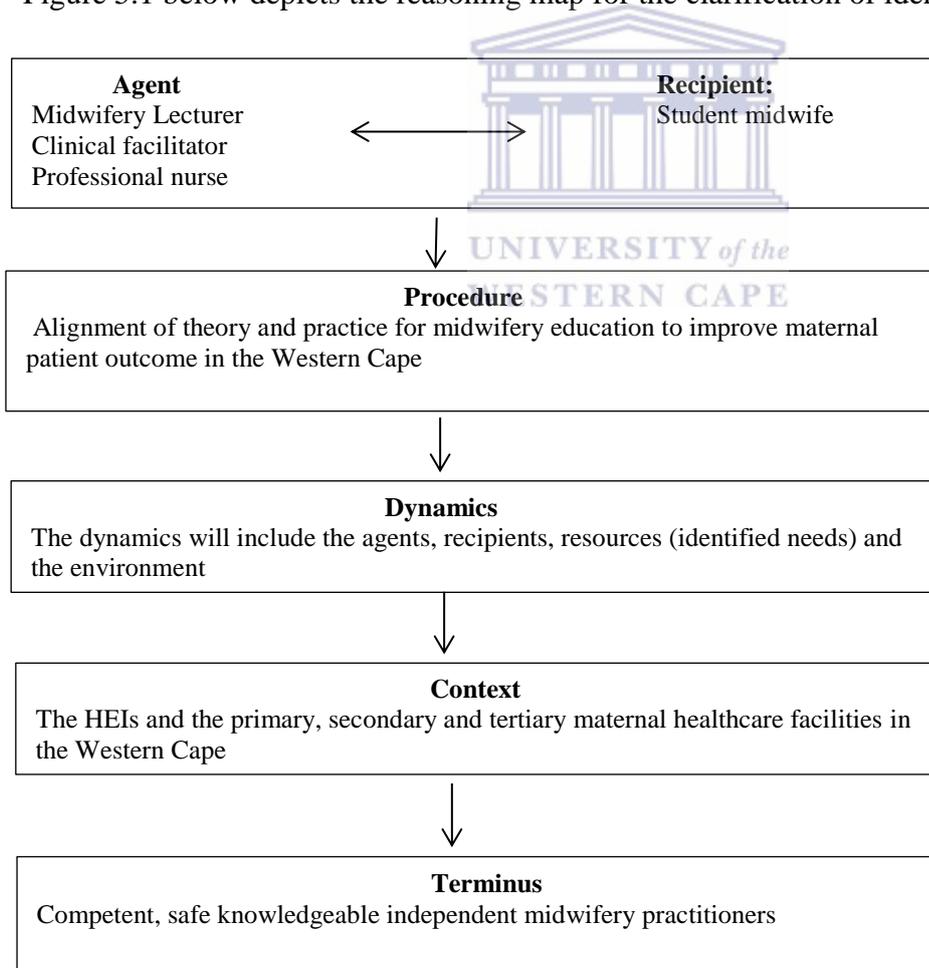


Figure 5.1: Researcher's reasoning map adapted from Dickoff et al. (1968)

Table 5.2: Concept classification

Main concepts identified with related concepts	Arrows depicting logical arrangement from concept identification to concept classification	Concept classification
<p>Effective curriculum design</p> <ul style="list-style-type: none"> - Timing of programme - Duration of programme - Structure of programme <p>Positive teaching and learning experience</p> <ul style="list-style-type: none"> - Asynchrony between instructional strategies and practice - Insufficient learning opportunities - Unsupportive learning environment - Exposure to clinical opportunities - Assigned student duties - Assessments - Ineffective clinical supervision <p>Positive role-modelling and Supernumerary student status</p> <ul style="list-style-type: none"> - Role-modelling - Communication - Student motivation - Student supernumerary status <p>Skilled human resources and a positive work environment</p> <ul style="list-style-type: none"> - Educator clinical experience - Professional nurse’s high workload - Standardization of clinical teaching <p>Competent midwife</p> <ul style="list-style-type: none"> - Skilled - Independent - Safe - Knowledgeable 		<p>Agent: Lecturers, Clinical facilitators and Professional nurses</p> <p>Recipient: Student midwives</p> <p>Procedure: Alignment of theory and practice to improve midwifery education with the ultimate intent to improve maternal care outcomes</p> <p>Dynamics: Challenges regarding effective curriculum design constructive alignment, educator, professional nurse and student’s personal attributes and managerial challenges</p> <p>Context: Educational institutions - primary , secondary and tertiary midwifery health care facilities in the Western Cape</p> <p>Terminus: Competent, safe, knowledgeable, independent midwifery practitioners</p>

5.2.2.1 Discussion of the implementation of the survey list

The following is a discussion of how the concepts and the core concepts relate to the survey list:

i) Agent

The first question in the survey list is “who or what performs the activity?” The agents are the educators, clinical facilitators and the professional nurse who are responsible for the education of midwives. The educators in consultation with stakeholders design theoretical and clinical learning outcomes for midwifery; they select relevant midwifery topics, and plan learning activities including clinical placements for the education programme. The curriculum is implemented using various teaching, learning and assessments strategies. Educators, clinical facilitators and professional nurses all play a significant role in facilitating the transfer of theory to practice while modeling positive professional behaviour that will help transform students learning experience into meaningful learning enabling them to become competent midwives.

The concepts linked to the agent include:

- Effective curriculum design
- Positive teaching and learning experience
- Positive role-modelling
- Supernumerary student status
- Skilled human resources

ii) Recipient

The second survey question is “who or what is the recipient of the activity?” “The recipient in this study is the student midwife who is facilitated to develop the necessary knowledge, skills and

attitudes for midwifery practice under the supervision of skilled lecturers, clinical facilitators and professional nurses.

Concepts linked to the recipient include:

- Effective curriculum design
- Positive teaching and learning experience
- Positive role-modelling
- Supernumerary student status
- Skilled human resources

iii) Procedure

A third question in the survey is “what is the guiding procedure, technique or protocol of the activity?” The procedure is the development of a framework to align theory and practice for midwifery education with the ultimate intent to improve maternal patient outcomes in the Western Cape. The concepts linked to the procedure include:

- Effective curriculum design
- Positive teaching and learning experience
- Positive role-modelling
- Supernumerary student status
- Skilled human resources

iv) Dynamics

The fourth question in the survey is “What is the energy source for the activity?” In this study, the dynamics refers to the interaction between the agents, recipients, resources and the environment.

It therefore represents both the education institutions and clinical practice includes the agents, the recipients, environments and resources. The concepts linked to the dynamic include:

- Effective curriculum design
- Positive teaching and learning experience
- Positive role-modelling
- Supernumerary student status
- Skilled human resources

v) Context

A fifth question in the survey is “in what context is the activity performed?” The context in this framework refers to higher education where these Bachelor Nursing Science (BNSc) programme is offered and where the study was conducted. The second context is the maternal care settings where students are placed for clinical exposure.

The university/college is where the theoretical component is delivered and where simulated learning occurs in skills laboratories. The clinical practice settings provided students the opportunity to apply the knowledge skills and attitudes in a real life setting under the supervision of professional nurses and clinical facilitators.

Concepts linked to the context include:

- Effective curriculum design
- Positive teaching and learning experience
- Positive role-modelling
- Supernumerary student status
- Skilled human resources

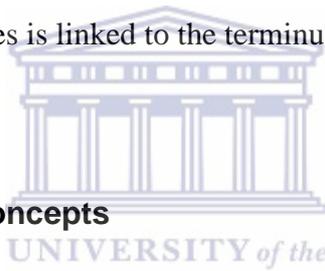
vi) Terminus

The last question of the survey is “what is the end point of the activity?” This is the competent safe, knowledgeable independent midwifery practitioners who will deliver safe maternal care. The concept linked to the terminus is:

- Competent midwives

It is evident from the classification that five of the six concepts are linked to the agent, recipient, procedure, dynamics and context. This indicates how broad and encompassing the teaching and learning environment / context is, in which engagement between, amongst other, students, lecturers, clinical facilitators and the curriculum occurs.

The concept – competent midwives is linked to the terminus which is the purpose of the study.



5.2.3 Defining the main concepts

In answering the fourth research question “What are the concepts forming the framework to align theory and practice to improve midwifery education”, positive concepts emerged from the concluding statements.

Definitions are one source that offers information about conceptual meaning, by clarifying shared usages and ideas associated with a concept. Therefore, in view of this discussion main concepts will be defined by way of dictionary definitions after which a subject definition will be given. These two definitions will then be summarized as it relates to this study.

i) Effective curriculum design

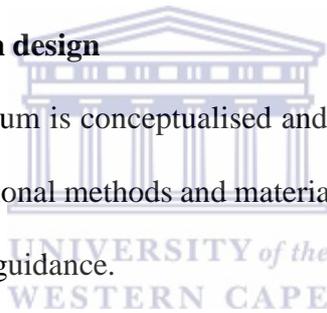
The first main concept is effective curriculum design which has three related concepts: timing of the programme, duration of the programme, and the structure of programme.

Dictionary definitions of Effective curriculum design

Effective curriculum design refers to the identification of elements of the curriculum, it states what their relationships are to each other, and indicates the principles of organization, and the requirements for the administrative conditions under which it operates (“Effective Curriculum”, 2016).

Subject definition of curriculum design

It refers to the way the curriculum is conceptualised and arranged e.g. its major components - subject matter or content, instructional methods and materials, learner experiences or activities, to effectively provide direction and guidance.



Summary

Effective curriculum design refers to the student’s total learning experience which depends on the arrangement of the curriculum in a way that its major components including the timing, duration, nature and the structure provide direction and guidance in the programme.

ii) Positive teaching and learning experience

The second concept namely positive teaching and learning experience has seven related concepts which are asynchrony between instructional strategies and practice; insufficient learning

opportunities; unsupportive learning environment; exposure to clinical practice; assigned student duties; assessments and ineffective clinical supervision.

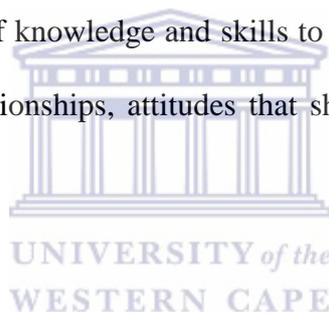
Dictionary definition of positive teaching and learning experience

Teaching is undertaking certain tasks or activities, the intention of which is to induce learning.

While learning occur as a result of a classroom or related activity structured by a teacher for the purpose of helping students to achieve their study objectives (“Teaching and learning”, 2016).

Subject definition of positive teaching and learning experience

Positive teaching and learning experience refers to a total satisfaction with all methods to impart knowledge, and the acquisition of knowledge and skills to meet students and educators teaching and learning needs, beliefs, relationships, attitudes that shapes and influences every aspect of teaching and learning.



Summary

Positive teaching and learning experience refers to the total satisfaction of both educators and students with the teaching and learning methodology and the learning that takes place as a result of structured teaching and learning activities including clinical practice exposure, assigned student duties, assessments and clinical supervision which shapes and influences teaching and learning.

iii) (a) Positive role-modelling and (b) Supernumerary student status

The third concept namely, positive role-modeling has related concepts, namely, role model, and communication.

a) Dictionary definition of positive role model

Positive role model is defined as someone who other individuals inspire to be like, either in the present or in the future (“Positive role model”, 2016).

Subject definition of positive role model

Skillful role models could enable students to discover knowledge embedded in clinical practice where they work, and observation of a role model enables them through a process of reflection to internalize the role models’ behavior which can be copied in future.

Role models who portray a positive attitude and are approachable therefore play a vital role in supporting students in clinical learning (“Positive role model”, 2016).

Summary

Positive role model refers to educators, (lecturers and clinical facilitators) and professional nurses who have the required knowledge, skills and attitude who students look up to. Students aspire to be like them in their professional roles in the present and future when they enter the midwifery profession.

b) Dictionary definition of supernumerary student status

Supernumerary student status refers to exceeding the usual stated or prescribed number, or to someone not enumerated among the regular components of a group and especially of a military Organization (“Supernumerary”, 2016).

Subject definition of supernumerary student status

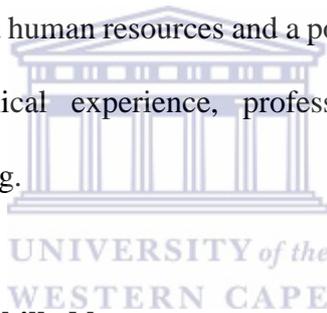
During clinical placement students are seen as additional to the required workforce and staffing figures (Royal College of Nursing, 2007).

Summary

The purpose of student's clinical placement should be focused on meeting the clinical learning outcomes set in the programme. Students should be viewed as over and above the permanent staff allocated to the ward and not part of the workforce.

iv) (a) Skilled human resources and (b) Positive work environment

The fourth concept namely skilled human resources and a positive work environment have related concepts namely educator clinical experience, professional nurse's high workload and standardization of clinical teaching.



a) Dictionary definition of skilled human resources

The Business dictionary defines skilled human resources as the resource that resides in the knowledge, skills and motivation of people; it improves with age and experience. It is regarded as the scarcest and most crucial productive resource.

Subject definition of skilled human resources

Skilled human resources is defined as skilled services that can be performed safely and effectively only by or under the direct supervision of a licensed practical nurse or a registered nurse ("Skilled human resources", 2016).

Summary

Skilled human resources are people who have the necessary knowledge, skills and attitudes to provide quality patient care and whose primary goal is to enhance health.

b) Dictionary definition of a positive work environment

A positive work environment involves the physical geographical location as well as the immediate surroundings of the workplace, such as a construction site or office building. It involves other factors relating to the place of employment such as the quality of air, noise level, and additional perks such as free child care, unlimited coffee, or adequate parking (“Work environment”, 2016).

Subject definition of a positive work environment

Positive work environments are settings that support excellence and decent work. In particular they strive to ensure the health, safety and personal well-being of staff, support quality patient care and improve the motivation, productivity, and the performance of individuals and organizations (ICN, PC, 2008).

Summary

A positive work environment is one in which positive relationships exist and which has the necessary infrastructure and resources to ensure that its purpose is met.

iv) Competent midwife

The fifth concept competent midwife has related concepts namely, safe, skilled, knowledgeable and independent.

Dictionary definition of competent midwife

A midwife is a licensed person who is registered with the South African Nursing Council based on completion of a recognised education and training programme to nurture, assist and treat the client, who can be a woman, a neonate or a family, in the process promoting a healthy pregnancy, labour and post -partum period. In working with the clients according to prescribed professional codes, they acknowledge them. (SANC, 2015)

Subject definition of competent midwife

A midwife is an individual who having been admitted to a midwifery education programme has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service (SANC, 2015).

Summary

A competent midwife is an individual who has successfully completed a midwifery education programme and is registered with a professional body - specialises in pregnancy, childbirth, postpartum and women's sexual reproductive health.

5.3 STEP 2: STATEMENT SYNTHESIS

Walker and Avant (2005) purports that relational statements are statements that indicate which concepts are linked or relate to each other. Relational statements are based on the concept synthesis. Some concepts may only have one relationship while others might be interrelated in many ways (Walker & Avant, 2011). The following relational statements have emerged:

- An **effective curriculum design** serves as the foundation for all components of midwifery education. The design of the curriculum is a collaborative process involving higher education institutions and health care facilities. Planning includes amongst other plans for **skilled human resources** in both contexts, who will successfully drive the education agenda to create a **positive work environment**. An effective curriculum design also represents all teaching and learning activities with relevant timing and duration within the programme. It is important that all theoretical and practical teaching and learning activities are closely linked and aligned. Integrative learning in clinical programmes enhances the alignment of theory and practice. The duration of learning must be commensurate with the credits allocated to the learning package. It is important to remain cognisant of the fact that students learn at a different pace. Therefore maximum rather than minimum duration should be considered. This will ensure that students have a **positive teaching and learning experience**.
- A **positive teaching and learning experience** for both students and educators is fostered through the availability of **skilled human resources, role models** who display a positive attitude towards students within a **positive work environment**. The learning experience will not be viewed as positive if the learning environment does not offer sufficient and relevant learning opportunities which can be supervised by skilled clinical facilitators. In addition students will have a positive experience if they are able to meet their learning

outcomes which can be facilitated through assuming a **supernumerary student status** which will enable the development of **competent midwives**.

- A **competent midwife** is a professional person who is skilled and independent - specialising in pregnancy, childbirth, postpartum, and women's sexual and reproductive health. Developing competence is possible through assuming a **supernumerary status** during clinical learning **within a positive work environment**, which offers the needed space to meet the clinical outcomes with the support of **skilled human resources** who **role model** positive skills and attitudes. This will ensure a **positive teaching and learning experience** which is based on an **effective curriculum**.

5.4 STEP 3: THEORY SYNTHESIS

The process of framework development included the use of concepts which were identified and defined. Relational statements which link the concepts were then developed. Theory synthesis is often presented in an expository form, however graphic representation and conceptual frameworks also depict the relationships within and among statements which represent the theory (Walker & Avant, 2011). An objective of this study was to develop a framework to align theory and practice for improved midwifery education in the Western Cape.

5.4.1 Overview and purpose of the framework

The overview of the framework is based on figure 5.2 which serves as a reference for the alignment of theory and practice in midwifery education. From the viewpoint of all participants the duration of midwifery education programme appears to impact the attainment of competence for midwifery

students. In addition, standardization of clinical teaching was considered important for ensuring that student midwives are familiar with learning expectations.

The framework depicts, through links between concepts, how an effective curriculum design support the alignment of theory and practice can ensure the development of competent midwives.

The attainment of midwifery competence is therefore viewed as an end product in this framework.

The midwifery educators and professional nurses are seen as pivotal role players in facilitating student midwives attainment of competence.



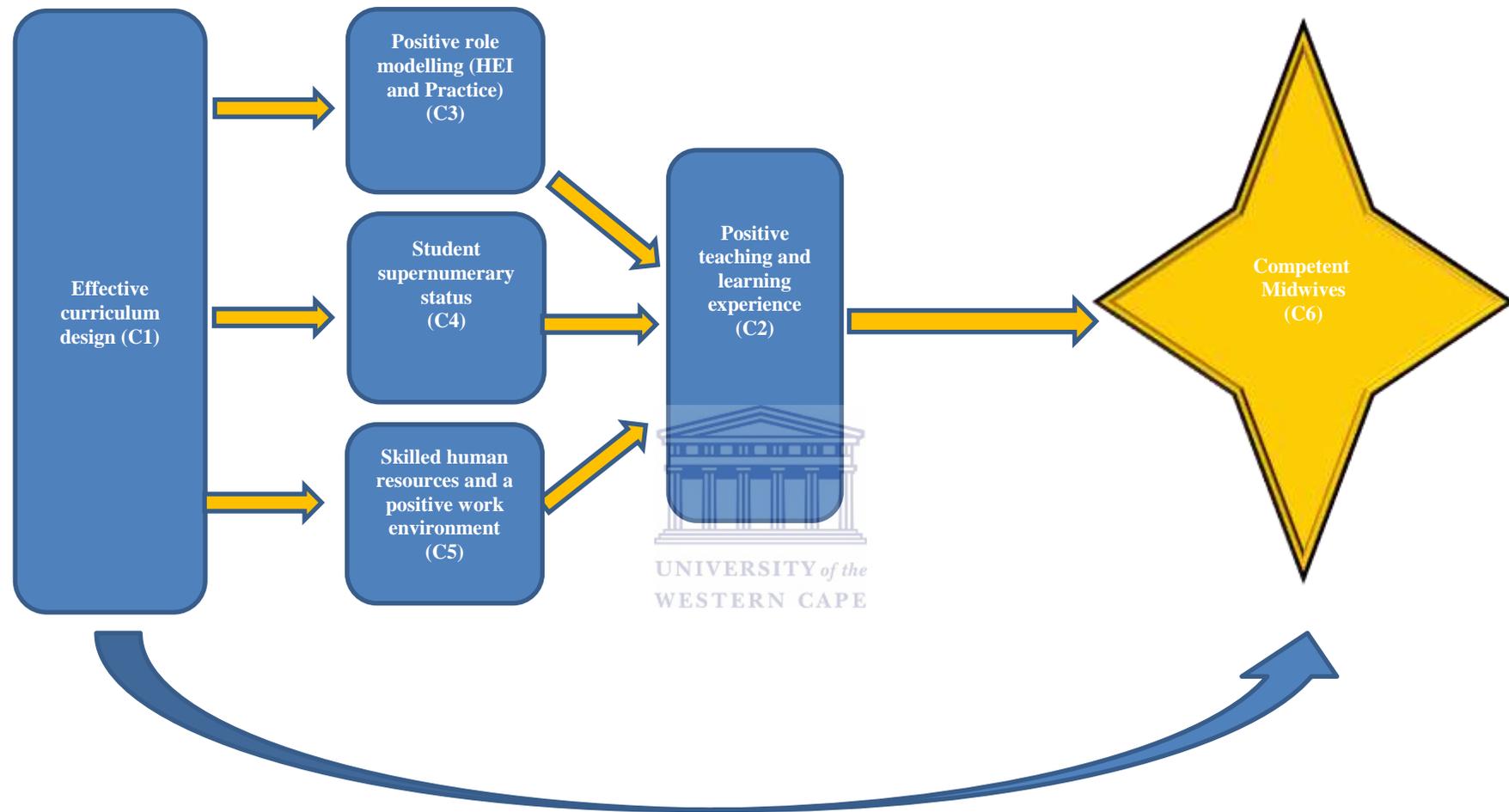


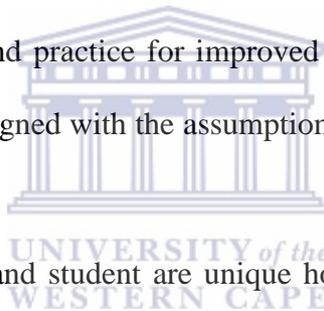
Figure 5.2 Framework to align theory with practice to improve midwifery education

5.4.2 Context of the framework

The context of this framework is the college and the higher education sector in the Western Cape where midwifery programmes are offered and where the study was conducted. The maternal care settings are those which have been accredited by the South African Nursing Council for the training of student midwives. The clinical facilities include primary, secondary and tertiary health facilities. The context is meaningful, since the fieldwork for the development of the framework was conducted there. The context is described in detail in chapter one.

5.4.3 Assumptions of the framework

The framework to align theory and practice for improved midwifery education is based on the following assumptions, and are aligned with the assumptions as suggested by the National Health Workforce task Force (2010):



- The midwifery educator and student are unique holistic beings who interact within the social environment, in this way the assumption is made that the midwifery educator and student cannot be separated from the environment. The environment provides the context within which the student works. The context is the educational institutional settings and the clinical practice settings.
- Midwifery education is grounded in the nursing profession's core values, ethics, knowledge and practice; it is informed by the desired learning objectives, stipulating the content and resources (both theoretical and practical). Midwifery education is responsive and accountable to the needs of the patient, student, and staff, and that the midwifery educational programme allows for the integration of theory and practice.

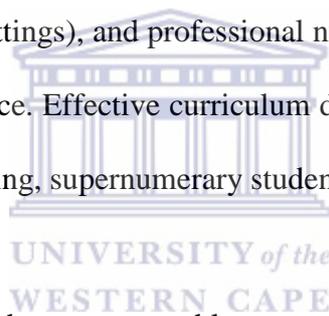
- That midwifery education is a dynamic real-life environment in which theoretical knowledge is assimilated with practice.
- The education of midwives is shaped by a common set of core competencies defined by the SANC and embedded in a well- designed and approved curriculum.
- That learning is a way of interacting with the world, and that meaning is not imposed or transmitted by direct instruction, but is created by the students learning activities. The educator is responsible for creating the environment conducive for learning while the student take responsibility in the construction of their own knowledge and skills through interactive discourse.
- A student’s motivation to learn is an important factor in success and is closely linked to self-determination to perform to the highest standard.
- It is clear to educators and students, what the objectives are, where all can see where they are supposed to be going, and where these objectives are embedded in assessment tasks.
- Personal beliefs and mental frameworks of lecturers impact on the method educators structure their learning environments and facilitation of the learning process.
- That good communication between stakeholders, educators and students elicits activities that mould, and deepen understanding.

5.4.4 Structure of the framework

The framework is visually represented in figure 5.2. To make it possible to follow the thinking and development of this framework to align theory with practice to improve midwifery education, the process and structure of the framework is described in this section. Six concepts are represented in the framework each numbered according to their presentation in table 5.1. The letter “C” refers

to “concept”, for example, “effective curriculum design” depicted as C1 is concept 1 in table 5.1. The process and structure of the framework depicts the concepts as interconnected with each other by used of arrows.

Effective curriculum design (C1) is the first main concept and is depicted as a vertical rectangular blue structure in the framework on the left and is defined as the total learning experience provided by a school. It includes the content of courses (the syllabus), the teaching, learning and assessment methods employed (strategies), and other aspects, like norms and values, which relate to the way the school is organized. Active student participation facilitated by midwifery educators (who have a role both in the HEI and clinical practice setting) and by clinical facilitators (in clinical practice settings), and professional nurses is considered to be the optimum way of aligning theory and practice. Effective curriculum design is linked with yellow arrows to the concepts positive role-modelling, supernumerary student status and skilled human resources.



Positive role-modelling (C3) is the top square blue structure, in the middle of the framework. Clinical exposure should be undertaken under the supervision of suitably experienced professional nurses, midwifery educators and clinical facilitators. Skillful role models could enable students to discover knowledge embedded in clinical practice where they can work with and observe a role model that enables them through a process of reflection, to internalize the role models’ behaviour and build on previous knowledge and experiences. Role models who portray a positive attitude and are approachable therefore play a vital role in supporting students in clinical learning. For the framework to be effective these role models should ensure that students gain appropriate experience aligned with theoretical instruction during their period of clinical placement. Educators

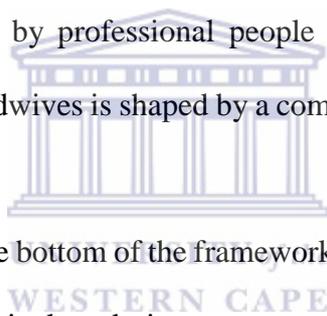
should retain responsibility for the students throughout their clinical placement period, assisting students to apply theoretical knowledge to the clinical practice setting, and liaising with professional nurses about the student's progress.

Student supernumerary status (C4) is depicted as the middle square blue structure, located towards the middle of the framework. Student's supernumerary status is said to mean that students undertaking clinical practice as part of their study programme are regarded as additional to the workforce requirements and staffing figures in the clinical area. They should be allocated responsibilities linked to their clinical learning outcomes and within their scope of practice. Supernumerary student status would mean that the unit is not dependent on the student's presence for managing the unit's activities.



Skilled human resources and a positive work environment (C5) is the bottom square blue structure towards the middle of the framework. Skilled human resources are the resources residing in the knowledge and skills of people whose actions and primary goal is to enhance health. A combination of skilled staff will ensure that the daily activities within a unit are adequately attended to and that students learning needs are met. A positive work environment is create from harmoniously relationships between staff who exude confidence and competence. For the framework to be effective it requires nursing and midwifery workforce to remain competent in their practice. Therefore educators, clinical facilitators and professional nurses must engage in life- long learning and continue to build on their professional education.

Positive teaching and learning experience (C2) is depicted by the rectangular blue structure to the right of the framework. Positive teaching and learning experience refers to the total satisfaction of both educators and students with the instruction methodology utilised to impart knowledge and skills. This includes the learning that took place as a result of teaching and learning activities including clinical practice exposure, appropriately assigned student duties, appropriate assessments and effective clinical supervision which shapes and influences teaching and learning. The competent midwife (C6) is the end product of the midwifery education programme, and is depicted as a four point yellow star situated to the right of the framework. The points signify the qualities the midwife possess, namely, knowledge, skills and a safe and independent practitioner. The star is shown in the colour yellow which indicates the growth of the person. The competent midwife is educated and trained by professional people who are skilled, knowledgeable and independent. The education of midwives is shaped by a common set of core competencies defined by the SANC.



The semi-circular blue arrow at the bottom of the framework, although not a main concept, depicts the progression from effective curriculum design to competent midwives which is underpinned by the alignment of theory and practice.

5.4.5 Guidelines to the operationalize the framework

Broad guidelines to operationalize the framework are discussed in this section.

5.4.5.1 Guidelines to operationalize the effective curriculum design

Proper planning and design of the midwifery education programme is the first very significant step towards producing competent independent midwives.

Nurse educators' and faculty needs to consider the following when designing the curriculum for the midwifery education programme:

- Effective curriculum design should allow sufficient time for the education, training, supervision, monitoring, support, and the assessment of students to meet all teaching and learning objectives.
- The design must show an appropriate balance of theoretical and practical teaching and learning activities which must be coherently planned to ensure the alignment of theory and practice.
- The time commitment for teaching and learning should be flexible, fitting, and in the best interest of midwifery educators, professional nurses and students involved.
- Research have shown that the inclusion of midwifery into the nurse training programme imposed undue hardship upon some students, who for instance have no desire to work in a maternal care setting thereby compromising the rendering of maternal patient care. Therefore the design of the nurse education programme should offer the student options or electives which articulation with other modules within the programme.
- The student selection and admission process into the midwifery education programme is primarily determined by individual education institutions and the faculty of nursing; however standardised entry requirements will encourage credibility and consistency, ensuring that prospective students have a similar knowledge base. Student selection and

admission includes maintaining a positive student/educator ratio, since exceeding this ratio may have adverse effects on the education of midwives.

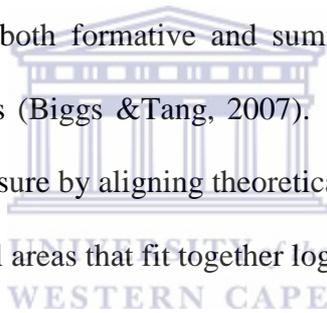
5.4.5.2 Guidelines to operationalize positive teaching and learning experience

Teaching and learning activities are documented and shared with educators (lecturers and clinical facilitators), professional nurses and students. In this way students know what to expect and can plan their learning according to their learning needs.

When midwifery educators plan teaching and learning activities the following needs to be considered:

- Student's clinical experiences are selected and aligned with theoretical teaching. Suitable teaching and learning environments are selected to ensure that students have the best learning experience. There are a few learning environments that can be useful to help with the alignment of theory with practice, such as: (i) dedicated teaching in interactive classrooms, (ii) teaching sessions in a well-equipped skills laboratory, and (iii) teaching in the clinical area at the bedside of the patient. Important to note is that teaching and learning in the clinical area is influenced by the number of students and the availability of learning opportunities.
- Clinical supervision by educators (both lecturers and clinical facilitators) must be meaningful and planned to facilitate and reinforce learning, develop student's confidence and competence in practice.

- Regular and effective communication about student learning and the midwifery programme must take place between educational institutions (lecturers, clinical facilitators) and clinical staff (professional nurses).
- Student's practical books/ portfolio of evidence should be used as a tool to communicate practical learning objectives, motivate students, monitor students' performance, give feedback, and then signed off to indicate that the student is deemed competence.
- Assessments play an important role in the process of certifying midwives as being competent. It is therefore important that educators develop appropriate assessment rubrics, which provides both educators and students with a clear theoretical and practical framework for meeting the assessment criteria. Practical knowledge necessitates appropriate assessments, both formative and summative, that correlates with relevant concepts and philosophies (Biggs & Tang, 2007). Furthermore, tie together theoretical teaching and clinical exposure by aligning theoretical teaching with clinical placement by placing students in clinical areas that fit together logically.



5.4.5.3 Guideline to operationalize positive role-modelling and student supernumerary status

Educators (lecturers and clinical facilitators) play a significant role in the education of midwives ensuring that students obtain the necessary knowledge and skills needed to function as an independent competent midwife.

- Policy on student status should be developed by the relevant government departments and implemented to ensure that student supernumerary status is honored. This will create better learning space for students.

- This will mean that the staff compliment in the clinical facilities must be strengthened as the workforce of student will no longer be available. Student learning should therefore be well structured to ensure that the clinical placement is meaningful.

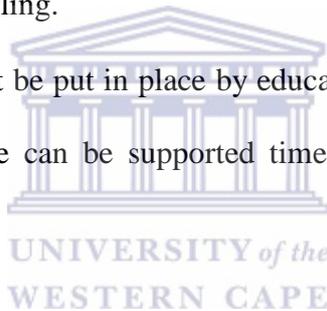
5.4.5.4 Guidelines to operationalize skilled human resources and a positive work environment

- All categories of staff (lecturers, clinical facilitators and professional nurses) must engage in learning activates that keep them abreast of developments in nursing education and practice.
- The need for a collaborative process in the education and training of student midwives cannot be over emphasized as education needs practice and vice versa. Within this study it became evident that there was very little involvement of clinical practice in planning the teaching and learning objectives and activities for midwifery education.
- Collaboration with clinical practice staff with regards to the education and training of student midwives to ensure that the midwifery education programme remains relevant for clinical practice.
- A positive work environment can be developed when colleagues have positive attitudes. This is supported when staff is confident and competent and are able to fulfil the job expectations.
- Effective communication must become standard practice as clear communication assists with developing understanding between people.

- Regular meetings are required to discuss and provide feedback on student performance, learning needs and challenges.

5.4.5.5 Guideline: Competent midwife

- The education of midwives is shaped by a common set of core competencies defined by the SANC.
- Student midwives must be assessed against this set of learning outcomes before they are deemed competent.
- Mechanisms must be put in place educators to monitor student progress and to identify those who might be struggling.
- Support programmes must be put in place by educators and faculty to ensure the student who are at risk of failure can be supported timeously e.g. remedial skills laboratory sessions.



5.5 EVALUATION OF THE FRAMEWORK

The following critical areas of evaluation related to the framework were obtained from Chinn and Kramer (2015):

5.5.1 Clarity

This is to ascertain that the definitions of the concepts in the framework are clear and its intended meaning is understood. The depiction of the framework must be understood by those evaluating the framework, the research supervisor and a colleague confirmed the clarity of the model.

5.5.2 Simplicity

The framework should be simple and straight forward to understand. In keeping with simplicity, the framework has minimal number of concepts and is not crowded. Arrows are used to depict relationships between concepts. Overlying concepts also illustrate relationships between concepts which are easy to understand.

5.5.3 Generality

The framework concepts are related to education in general and midwifery education in particular. This means that the framework can be used within other education disciplines and in other different contexts.



5.5.4 Accessibility

The researcher plans to present the framework to the nursing departments where the research was conducted which will enable improvement in midwifery education. Publication of the framework will effect widespread improvement in midwifery education and practice.

5.5.5 Importance

Given that new nursing programmes are currently being developed according to the SANC new qualifications, development of this framework is timely for informing the development of these programmes. In addition, existing programmes can be improved based on the framework.

5.6 SUMMARY

The focus of this chapter was on the development of the framework to align midwifery theory and practice to improve midwifery education in the Western Cape. A visual representation of the framework was also presented. The following chapter will focus on the summary, conclusion, limitations and recommendations.



CHAPTER 6

SUMMARY, CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

The framework to improve midwifery education was presented in chapter five. In addition, an overview of the framework; the context for which it is developed; the assumptions; and the structure of the framework were described. Lastly, the concepts within the framework were described; guidelines to operationalize the framework were presented which was followed by the framework evaluation.

In chapter six the conclusions will focus on whether the study objectives were met. This chapter will also discuss the study limitations and provide recommendations based on the findings off the study.

6.2 SUMMARY AND CONCLUSION

The purpose of this study was to obtain information about the experiences of midwifery educators, (lecturers, clinical facilitators) professional nurses, and community service practitioners regarding the education of midwives and the perceived competence of the community service practitioners to deliver safe maternal care. This information was used to develop the framework to align theory and practice that would enhance the education of midwives, and thereby improve maternal care outcomes in the Western Cape. The objectives of this study were:

- To establish the experiences of the community service practitioners regarding midwifery education and their perceived competence to provide safe maternal care.
- To explore the views and perceptions of nurse educators (lecturers and clinical facilitators) regarding the education of midwives to deliver safe maternal care.
- To establish the nurse educators (lecturers and clinical supervisor) and professional nurses views on the community service practitioners' competence to provide safe maternal care.
- To determine possible gaps in the education of midwives to provide safe maternal care.
- To develop a framework, based on the findings of the study, to align theory and practice for improved midwifery education in the Western Cape.

A qualitative exploratory, descriptive, theory generative research design was employed to achieve above-mentioned purpose and objectives. The study was conducted in two phases.

Phase one was the exploratory descriptive phase during which data was collected from the nurse educators, professional nurses and community service practitioners. The data was analysed inductively and a number of categories in each participant group culminated into vertical themes for each group. These vertical themes were then used to generate horizontal themes which cut across the participant groups.

Phase 2 was the theory generative phase which followed the steps outlined by Walker and Avant (2014), Chin and Kramer (2015) and Dickoff, James and Wiedenbach (1968) for the development of the framework to align theory and practice in midwifery education. Phase 2 was presented in 3 steps which included concept synthesis, statement synthesis and theory (framework) synthesis.

The purpose of this research has been achieved since the researcher succeeded in developing a

framework to align theory with practice which if used will improve midwifery education. The framework is simple, clear, and understandable and important for use in higher education institutions in collaboration with clinical practice in the provision of midwifery education.

6.3 LIMITATIONS

The following limitations to this study are reported:

- The study was limited to the Western Cape Metropole nursing education institutions, and primary, secondary, and tertiary maternal care settings only. Therefore the results of this study cannot be generalised to all other nursing education institutions and maternal care settings in other provinces.
- Similarly, the study was conducted only in the public maternal health care sector and therefore its findings may not be transferable to private maternal health care settings. Despite these limitations, the study results will be available as a point of reference for use by both private and public sectors.
- The main purpose of this research was limited to the development of a framework aligning theory with practice so as to improve midwifery education. This study therefore focused on midwifery education and the impact it has on the competence of the community service practitioners as a midwife and not nurses in general.

6.4 RECOMMENDATIONS

The following recommendations are made for the application of the framework to align theory with practice to improve midwifery education:

6.4.1 Recommendations for midwifery education and practice

- The framework to align theory with practice to improve midwifery education should be used by midwifery educators at higher education institutions to assist them with reviewing existing programmes to ensure the alignment of theoretical teaching and learning activities with clinical teaching and learning activities. This will prepare student midwives to become competent independent midwifery practitioners.
- The framework should also be used in design and development of new midwifery programmes to prevent the repetition of the current challenges with specific reference to the timing of midwifery (when it is offered) in the programme, its duration (amount of time spent on midwifery education) and structure (alignment of theory and clinical learning), amongst other design aspects. This recommendation is timely as none of the higher education institutions in the Western Cape have as yet implemented the new programmes.
- Midwifery education must be viewed as a collaborative process between nurse educators (lecturers and clinical facilitators) and professional nurses. This will improve ownership of the process and ensure shared responsibility and commitment to the educational endeavour.
- Dedicated professional nurses should be identified to be trained as preceptors by the higher education institution. They will be responsible for assisting students with the integration of theory and practice. This will address, in part, the challenge of limited staff and high workload which leads to ineffective supervision of student midwives.
- It is important for midwifery nurse educators to spend time in the clinical area to keep up to date with current trends and to develop the necessary skills for the facilitation and alignment of theoretical learning with practice.

Professional nurses and nurse educators consciously role model positive behaviour and communication which are learnt by student midwives.

6.4.2 Recommendations for research

- The framework to align theory with practice to improve midwifery education should be implemented at HEI's offering midwifery training and its effectiveness can be the focus of future research.
- The research may be repeated in other education contexts and the model can be adapted for contextual use.

6.5 SUMMARY

This final chapter has provided an overview of the research process and provided the researcher with the opportunity to account for the purpose of the research and the achievement of the research objectives. The limitations of the study were described and recommendations for nursing education and practice and research were made based on the findings of the study. The researcher believes that the framework to align theory and practice to improve midwifery education is ready for implementation by lecturers at HEI's offering midwifery training.

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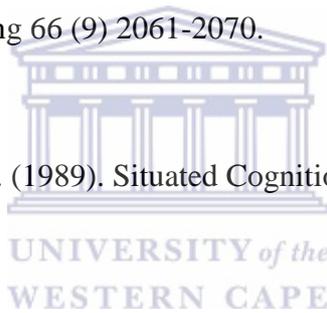
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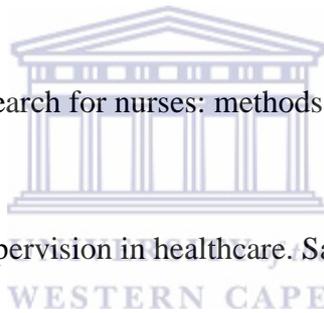
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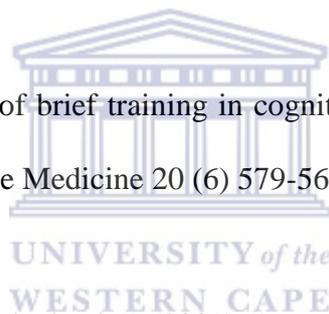
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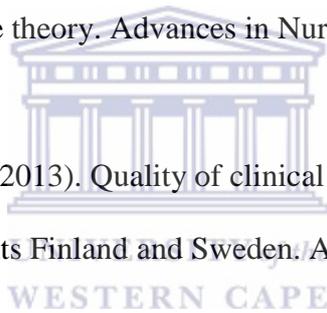
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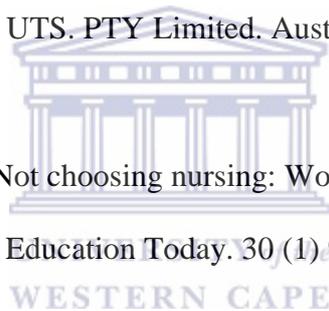
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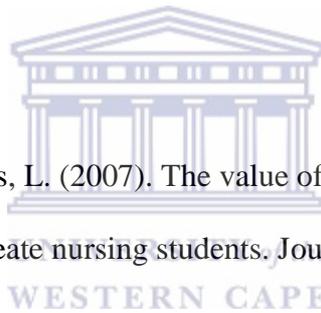
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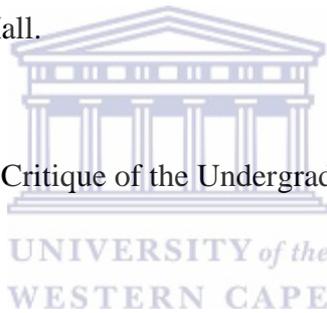
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Appendix 1: Ethics clearance letter



OFFICE OF THE DEAN DEPARTMENT OF RESEARCH DEVELOPMENT

30 October 2013

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:
Mrs W Phiri (School of Nursing)

Research Project: A framework to align theory and practice for improved midwifery education in the Western Cape.

Registration no: 13/9/35

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

UNIVERSITY of the
WESTERN CAPE

The Committee must be informed of any serious adverse event and/or termination of the study.

A handwritten signature in black ink, appearing to read 'Josias'.

*Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape.*

Appendix 2: Interview guide for midwifery educators

Questions	Probes
1. What are your views and perceptions regarding the education of midwives to deliver safe maternal care?	Explain Elaborate Give examples
2. What are your views regarding the community service practitioner's competence to provide safe maternal care?	Provide more detail
3. What are the possible gaps in the education of midwives that would ensure the provision of safe maternal care?	



Appendix 3: Interview guide for professional nurse

Questions	Probes
1. What are your views regarding the community service practitioner's competence to provide safe maternal care?	Explain Elaborate Give examples
2. What are the possible gaps in the education of midwives that would ensure the provision of safe maternal care?	Provide more detail



Appendix 4: Interview guide for community service practitioners

Questions	Probes
1. What are your views and perceptions regarding the education of midwives to deliver safe maternal care?	Explain Elaborate Give examples
2. What are the possible gaps in the education of midwives that would ensure the provision of safe maternal care?	Provide more detail





UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592274, Fax: 27 21-9592271

E-mail: wphiri@uwc.ac.za

Project Title: Develop a framework to align theory and practice to improve midwifery education in the Western Cape

What is this study about?

I am Wendy Augusta Phiri, a registered PhD student in Nursing Science at the School of Nursing at the University of the Western Cape. I hereby invite you to participate in this research project because you can contribute to improving midwifery education in the undergraduate nurse education programme offered at both the nursing college and university in the Western Cape the intent to improve maternal patient outcomes. The purpose of the study is to develop a framework to align theory and practice for improved midwifery education.

What will I be asked to do if I agree to participate?

You are asked to participate in in-depth or focus group interviews, and to talk about your experiences regarding the midwifery training programme, and how the training programme contributed to the competence of the community service practitioner's ability to provide safe maternal care.

Interviews will last no longer than 60 minutes. Written informed consent will be required.

Would my participation in this study be kept confidential?

We will do everything within our power to keep your personal information confidential. All data gathered from the survey will be stored under lock and key for five years after the results of the project have been published after which it will be destroyed. Only my supervisor, and myself (the researcher) will have access to the data. The publication of the results of the project, will not mention any names of participants.

What are the risks of this research?

The researcher is not aware of risks associated with participating in this research project.

What are the benefits of this research?

The results may assist the researcher to develop a framework to align theory and practice to improve midwifery education with the intent to improve maternal patient outcomes. Information acquired during this research project will be shared with all participants prior to public dissemination. Results of the study will be published in an accredited journal.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may withdraw from participating at any time. If you decide not to participate in this study, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Wendy Augusta Phiri at the University of the Western Cape.

If you have any questions about the research study itself, please contact:

Researcher: Wendy Augusta Phiri Lecturer

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: 021 959 2271

Cell: 0848210107

Email address: wphiri@uwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Research Supervisor Prof F Daniels

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021) 959 2271; Email fdaniels@uwc.ac.za

Dean of the Faculty of Community and Health Sciences

Prof Jose Frantz

021 9592631

Email: jfrantz@uwc.ac.za

University of the Western Cape

Private Bag X17

Bellville 7535



This research has been approved by the Senate Research Committee and Ethics Committee of the University of the Western Cape.

Appendix 6: Consent form



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959, Fax: 27 21-959

Email wphiri@uwc.ac.za

Project Title: Develop a framework to align theory and practice to improve midwifery education in the Western Cape

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name.....

Participant's signature.....

Witness.....

Date.....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Mrs. WA Phiri

University of the Western Cape

Private Bag X17, Belville 7535

Telephone: (021)959- 324

E-mail wphiri@uwc.ac.za

Appendix 7: Focus group confidentiality binding form



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

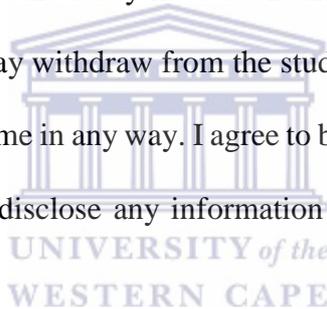
Tel: +27 21-959 2274, Fax: 27 21-959 2271

E-mail: wphiri@uwc.ac.za

FOCUS GROUP CONFIDENTIALITY BINDING FORM

Project Title: A framework to align theory and practice for improved midwifery education in the Western Cape

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I agree to be audio-taped during my participation in the study. I also agree not to disclose any information that was discussed during the group discussion.



Participant's name.....

Participant's signature.....

Witness's name.....

Witness's signature.....

Date.....

Appendix 8: Letter of request to conduct research at Health Institution



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592274, Fax: 27 21-9592271

E-mail: wphiri@uwc.ac.za

The Nursing Services Manager

PERMISSION TO CONDUCT A RESEARCH STUDY IN YOUR FACILITY

I hereby request to conduct a research study in your hospital. The study is entitled: A framework to align theory and practice for improved midwifery education in the Western Cape.

This study is part of the requirements for acquiring a PhD Degree in Nursing Science. The study will be done under the supervision and guidance of Professor F Daniels of the School of Nursing, University of The Western Cape.

The research aim is to develop a framework to align theory and practice for improved midwifery education. Data will be collected using in-depth interviews – with Professional Nurses and focus group interviews for Community Service Practitioners at a time and place convenient for them. Focus groups will be held in a private room as arranged, and it will take about 60 minutes to conduct an interview.

The researcher will adhere to the rights of participants to privacy and confidentiality. The identity of all respondents will be protected; a code number will be used during focus groups and field notes instead of their real name. The name of the institution will not appear on the research report. All records will be kept for 5 years after publication of the results after which it will be destroyed. Only the supervisor, researcher, independent coder and statistician will have access to the data. The participants will not be coerced into participation and should they wish to withdraw at any time during the study, their wish will be respected.

The researcher will ensure adherence to the highest standards of research planning, implementation and reporting.

If you have any questions about the research study itself, please contact:

Wendy Phiri

School of Nursing

Community of Health Sciences

University of the Western Cape

Modderdam Road

Private Bag X17

Bellville

7353

Office: 0219593244

Email: wphiri@uwc.ac.za

Should you have any questions with regard to this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department : Prof Karien Jooste

Email: kjooste@uwc.ac.za

Dean of the Faculty of Community and Health Sciences

Prof Jose Frantz

021 9592631

Email: jfrantz@uwc.ac.za

University of the Western Cape

Private Bag X17

Bellville 7535

This research has been approved by the Senate Research Committee and Ethics Committee of the University of the Western Cape.

Appendix 9: Permission letter from Tygerberg Hospital



Tygerberg Hospital

REFERENCE: Research Projects
ENQUIRIES: Dr G Marinus
TELEPHONE: 021 938-4141

ETHICS NO: 13/9/35

A framework to align theory and practice for improved midwifery education in the Western Cape.

Mrs W A Phiri

PERMISSION TO CONDUCT YOUR RESEARCH AT TYGERBERG HOSPITAL

In accordance with the Provincial Research Policy and Tygerberg Hospital Notice No 40/2009, permission is hereby granted for you to conduct the above-mentioned research here at Tygerberg Hospital.



A handwritten signature in black ink, appearing to read "D Erasmus".

DR D ERASMUS
CHIEF EXECUTIVE OFFICER

Date: 9 September 2014

Administration Building, Francie van Zijl Avenue, Paarl, 7500
tel: +27 21 938-6267 fax: +27 21 938-6890

Private Bag X3, Tygerberg, 7505
www.cape.gov.za

Appendix 10: Permission letter from Groote Schuur Hospital (UCT)



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee



Room 252-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone (021) 406 6492 • Facsimile (021) 406 6411
Email: Sumaya.arietdien@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

18 September 2014

HREC/REF: 561/2014

Prof F Daniels
Department of Nursing
UWC Community Health Sciences

Dear Prof Daniels

Project Title: DEVELOP A FRAMEWORK TO ALIGN THEORY AND PRACTICE TO IMPROVE MIDWIFERY EDUCATION IN THE WESTERN CAPE (PhD-candidate-W Phiri)

Thank you for your response letter, addressing the Issues raised by the Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above mentioned study.

Approval is granted for one year until the 30 September 2015.

Please submit a progress form, using the standardised Annual Report Form, if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

We acknowledge that the following student- Wendy Phiri is also involved in this study.

Please add the UCT FHS HREC contact details to the informed consent document. Please submit the updated Informed consent document to the HREC.

Please note that the on-going ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC REF in all your correspondence.

Yours sincerely

pp Tuboged

PROFESSOR K BLOCKMAN
CHAIRPERSON, HSF HUMAN ETHICS

Federal Wide Assurance Number: FWA00001637.

Institutional Review Board (IRB) number: IRB00001938

Hrec/ref:561/2014

Appendix 11: Letter of request to conduct research at Education Institutions



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592274, Fax: 27 21-9592271

E-mail: wphiri@uwc.ac.za

The Head of Department - Nursing

PERMISSION TO CONDUCT A RESEARCH STUDY IN YOUR INSTITUTION

I hereby request to conduct a research study in your hospital. The study is entitled: A framework to align theory and practice for improved midwifery education in the Western Cape.

This study is part of the requirements for acquiring a PhD Degree in Nursing Science. The study will be done under the supervision and guidance of Professor F Daniels of the School of Nursing, University of The Western Cape.

The research aim is to develop a framework to align theory and practice for improved midwifery education. Data will be collected using in-depth interviews with midwifery Educators and Clinical facilitators at a time and place convenient for them.

The researcher will adhere to the rights of participants to privacy and confidentiality. The identity of all respondents will be protected. The name of the institution will not appear on the research report. All records will be kept for 5 years after publication of the results after which it will be destroyed. Only the supervisor, researcher, independent coder and statistician will have access to the data. The participants will not be coerced into participation and should they wish to withdraw at any time during the study, their wish will be respected. The researcher will ensure adherence to the highest standards of research planning, implementation and reporting.

If you have any questions about the research study itself, please contact:

Wendy Phiri

School of Nursing Community of Health Sciences

University of the Western Cape

Modderdam Road

Private Bag X17

Bellville

7353

Office: 0219593244

Email: wphiri@uwc.ac.za

Should you have any questions with regard to this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department

Prof Karien Jooste

Email: - kjooste@uwc.ac.za

Dean of the Faculty of Community and Health Sciences

Prof Jose Frantz

021 9592631

Email: jfrantz@uwc.ac.za

University of the Western Cape

Private Bag X17

Bellville 7535



This research has been approved by the Senate Research Committee and Ethics Committee of the University of the Western Cape.

Appendix 12: Permission letter from the Western Cape College of Nursing



Western Cape
Government

Health

STRATEGY & HEALTH SUPPORT

Health.Research@westerncape.gov.za
tel: +27 21 483 6857; fax: +27 21 483 9895
5th Floor, Norton Rose House, 8 Riebeeck Street, Cape Town, 8001
www.westerncape.gov.za

REFERENCE: RP 180A/2013
ENQUIRIES: Ms Charlene Roderick

School of Nursing
Private Bag X17
Bellville
7535

For attention: **Wendy Phiri**

Re: Develop a framework to align theory and practice to improve midwifery education in the Western Cape

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact the following people to assist you with any further enquiries in accessing the following sites:

Karl Bremer Hospital
Mowbray Maternity Hospital

L Naude
S Fawcus

Contact No. 021 918 1222
Contact No. 021 659 5578

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

Yours sincerely

Dr J Evans
ACTING DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 05/02/14

Appendix 13: Permission letter from the University of the Western Cape

FACULTY OF COMMUNITY
AND HEALTH SCIENCES
SCHOOL OF NURSING

Private Bag X17, Bellville, 7535
South Africa
Tel: +27 (0) 21 959 3074
Fax: +27 (0) 21 959 2879
Website: www.uwc.ac.za
E-mail: rsarel58@uwc.ac.za

15 November 2013

RE: Permission to collect data.

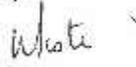
Mrs W Phiri

Your proposal title: Develop a framework to align theory and practice to improve midwifery education in the Western Cape.

This is to confirm that permission is granted to conduct your study at the University of Western Cape (School of Nursing).

Management wishes you all the success with your study.

Sincerely


**Head of School
K.JOOSTE**



**UNIVERSITY of the
WESTERN CAPE**

A place of quality, a place to grow, from hope to action through knowledge

Appendix 14: Letter of request to conduct research Department of Health



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592274, Fax: 27 21-9592679

E-mail: wphiri@uwc.ac.za

Prof C Househam
Head of Health
Department of Health
4 Dorp Street
Cape Town
8001

Dear Prof Househam



REQUEST FOR PERMISSION TO CONDUCT RESEARCH INVESTIGATION WESTERN CAPE

I hereby request to conduct a research study in the public health facilities in the Cape Metropole area. The study is entitled: Develop a framework to align theory and practice to improve midwifery education in the Western Cape. This study is part of the requirements for acquiring a PhD Degree in Nursing. The study will be done under the supervision and guidance of Professor F Daniels of the School of Nursing, University of The Western Cape.

Data will be collected using- in-depth and focus group interviews. These will be held at public facilities (primary, secondary and tertiary levels of midwifery care), as well as the nursing college in the Cape Metropole area. Community service practitioners, Professional Nurses, Midwifery Educators and Midwifery Clinical facilitators will be invited to partake in the study. Interviews

will be held in a private room as arranged, and it will take around 45 minutes for individual interviews and 60 minutes for focus groups to conduct an interview.

The researcher will adhere to the rights of participants to privacy and confidentiality.

The identity of all respondents will be protected; pseudonyms (fictitious names) will be used instead during interviews instead of their real names. The questionnaires will be allocated code numbers. The name of the public facility will not appear on the research report. All records will be kept for 5 years after publication of the results after which it will be destroyed. Only the supervisor, researcher, independent coder and statistician will have access to the data. The participants will not be coerced into participation and should they wish to withdraw at any time during the study, their wish will be respected. The researcher will ensure adherence to the highest standards of research planning, implementation and reporting.

I am also attaching the proposal, information sheet to participants as well as the informed consent sheets for your information.

If you have any questions about the research study itself, please contact:

Researcher: Wendy Augusta Phiri
Lecturer
University of the Western Cape
Private Bag X17, Bellville 7535
Telephone: 021 483 3133
Cell: 0848210107
Email address: wphiri@uwc.ac.za



Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Research Supervisor, School of Nursing: Prof F. Daniels
University of the Western Cape
Private Bag X17, Bellville 7535
Telephone: (021) 959 2271; Email: fdaniels@uwc.ac.za

This research has been approved by the Senate Research Committee and Ethics Committee of the University of the Western Cape.

Appendix 15: Permission letters from the Department of Health



STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
Tel: +27 21 483 6857; fax: +27 21 483 9895
5th floor, Norton Rose House, 6 Riebeeck Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: RP 180A/2013
ENQUIRIES: Ms Charlene Roderick

**School of Nursing
Private Bag X17
Bellville
7535**

For attention: **Wendy Phiri**

Re: Develop a framework to align theory and practice to improve midwifery education in the Western Cape

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact the following people to assist you with any further enquiries in accessing the following sites:

Macassar MOU	Sr Alexander	Contact No. 021 857 2251
Elsies River	Ms R Kasker	Contact No. 021 931 0213
Bishop Lavis	Sr Allie	Contact No. 021 934 4050
Kraaifontein	Ms L Steyn	Contact No. 021 987 0080

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

Yours sincerely

A handwritten signature in black ink, appearing to read 'DR NT Naledi'.

**DR NT Naledi
DIRECTOR: HEALTH IMPACT ASSESSMENT**

DATE:

CC DR A HAWKRIDGE
CC L BITALO

DIRECTOR: KHAYELITSHA / EASTERN
DIRECTOR: NORTHERN / TYGERBERG



**Western Cape
Government**

Health

STRATEGY & HEALTH SUPPORT

Health.Research@westerncape.gov.za
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REFERENCE: RP 180A/2013
ENQUIRIES: Ms Charlene Roderick

**School of Nursing
Private Bag X17
Bellville
7535**

For attention: **Wendy Phiri**

Re: Develop a framework to align theory and practice to improve midwifery education in the Western Cape

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:

Karl Bremer Hospital	L Naude	Contact No. 021 918 1222
Mowbray Maternity Hospital	S Fawcus	Contact No. 021 659 5578

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

Yours sincerely

Dr J Evans

ACTING DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 05/02/14

Appendix 16: Example of focus group interview transcript: Community service practitioners

I: *So, I would like to know, what are your views, your perceptions, pertaining to the current under graduate midwifery training, how do you feel about it? Anyone?*

P 2: I would say the training is stressful

Participant 2: sorry, I would say it's stressful, the time period the duration is much, much too short, for all of that information. The prac(practical) with the theory, it's really it's, it's not enough. Uhm, I'm still not feeling comfortable, if I have to go work now in a maternity ward in a midwifery ward, WARD I still, I'm still unsure of what I'm supposed to do there, honestly.

I: *Even after you've been through the, through the training?*

Participant 2: I've been through the training but I, also its maybe with more experience comes that confidence, but like now, I really, I also, I still feel like, I really. I'm not comfortable in a, in a maternity ward yes.

I: *Ok. So you said the duration of the prac.(practical) of the*

Participant2: Is much too short.

I: *How long was, how long was your prac?*

Participant 2: Uhm the, theory section was just 6 months I think we had 3, 3 weeks uhm abnormal and 3 weeks normal

Participant 3: 3 weeks normal and the 3 weeks abnormal, just the theory that was too short for me, and then plus, minus how many months in the wards just to gain this experience.

I: *So in total how long was your midwifery training?*

Participant 3: 6 months.

I: *Was it 6 months in total?*

Participant 4: Not 6 months I think it's more... plus minus six months.

Participant 2: Everything yes.

I: *So you said that the theory was only 3 weeks abnormal, and 3 weeks normal and 3 weeks abnormal, so that was the time spent in class?*

Participant 3: In class, yes.

I: *And the rest, the remaining of that 6 months, were you placed at the hospitals?*

Participant 3: Yes. because we spent most of our practical, at the uhm MOU's we only had 7 days to work uhm abnormal, which is high risk, so for us I felt that uhm they didn't prepare us enough for the high risk, its more the low risk, that we got more exposure to, but all in all when it comes to the theory, I feel they did good, it was enough, and we did get enough time to get through it and be able to know what we must expect when we come to the hospital setting, but it's just that here now, when we got to the high risk, it wasn't enough time for us to actually see and experience the things we've learnt.

I: *So you say you were only placed for 7 days in total?*

Participant 3: Yes, for high risk.

I: *Only 7 day's placement in high risk and you feel that it was way too little to prepare you to be a competent midwife?*

Participant 1: No, 7 days was just not enough.

I: *And how long was your placement in the low risk area?*

Participant 2: We got enough, because ever since we started class uhm with [name], was it once or twice now, to the MOU's in a week?

Participant 2: We went 3 times in a week.

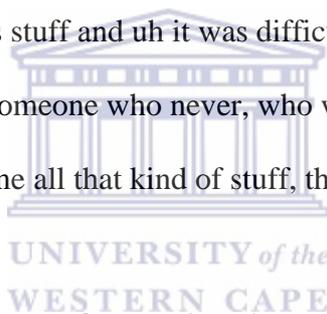
I: *So you were placed for 3 days?*

Participant: 4: Yes, for for, at the MOU, so that was for me enough.

I: *It was sufficient?*

Participant 4: It was sufficient yes.

Participant number 3: Ok for me... the practical side was fine, it was actually good, but now I didn't get exposure to the high risk side, and like, I only went for, in theatre I only went once, it was for breach, and I was never exposed like, I never saw episiotomy done as a student, it was never done. I never saw that, and the preparation of patient I never, I can't remember myself preparing the patient for, for caesa (caesarean section), that I, I didn't see it, I think I was placed in [name] hospital, but we only went there thrice and the sisters, the sisters, didn't show us that, that stuff, we were never showed that stuff, and we never saw a patient prepared for caesa (caesarean section) we just, we were just called, by one of the students to say that now the patient is going for caesa (caesarean section), it was prepared we only went, in the, in the theatre, we did not see all the preparations stuff and uh it was difficult for me when I started here in labour ward, because I was like, someone who never, who was never in the labour ward. They started me, they started teaching me all that kind of stuff, the maternity record book, and stuff like that.



Participant 4: And then, when we came for practice, the maternity guidelines where changed, there was new maternity guidelines used, cause they introduced now the maternity case record, and when we were studying we were using the gravidogram only, so now we had to get use to the books side of things and the new guidelines.

I: Ok, so that made it difficult for you?

Participant 2: YES

Participant 3: For me, I, I think I got, I got enough exposure, but it's, it's just that you can't learn everything. For me it's like, you, you, they, they can't teach you everything, like all at once so you must, you must get orientation at the hospital, like the hospitals are different, maybe you did your practical's, then maybe [Hospital name] or, when you get here, the records are different,

and all of that, so I think the training which I got at least it taught me the basics which I needed to know and also together with the theory.

Participant 2: I was still explaining, what? Ok, and what I was uhm, some of the what, the stuff that we were taught in the class was a little bit different, like the policies and the procedures, let's say for example the PMTCT(Prevention Mother To Child Transmission) that we were shown in the class, it was different it was a different one from the hospital so we couldn't link that, for example when you are writing the exam, it was a little bit confusing for me to remember which one is it, I had to write that one that I was taught in the class, not the one I was practicing with in the, in the hospital.

I: OK, so you say that the policy was different, it was an older version?

Participant 4: Yes an older version, in the class, and a latest one was the one in the hospital.

I: So that made it difficult for you?

Participant 4: Yes.

I: Participant number 3 had her hand up.

Participant 3: That's also what I wanted to add, because I remember the time the new PMTCP (Prevention Mother To Child Transmission) was introduced, we, I remember we had an assignment and we had to take both and see what the differences were, so it was really for us confusing getting something else in class and when we get to practical, and if you come and do this things that we got in class officially, it's not the latest, it's now also can cause some medical legal hazards, or I mean create problems for the patients.

I: Ok. So you are saying that uhm, what you've been taught in class was actually different from what you, what you, what you were supposed to practice in the practical setting, pertaining to policies.

Participant 1: At low risk. At low risk I feel it was enough, but then when it came to high risk, now, we only were placed for seven days, and we had to rotate within that seven days, but I was one of the stubborn students, I did not rotate like the others did, because I needed to gain a lot of experience pertaining labour, in the labour ward, so antenatal and post-natal, I felt I had enough exposure in the low risk, so it's not so different when it comes to high risk patients pertaining, uh when you do antenatal and post –natal care, so I felt I had to be placed more in the labour ward where I can experience all these breach presentations, if these going to be caesarean sections or vacuum extractions, and cutting episiotomy's, which we did not learn in, at the MOU's, so I felt we needed to be placed more in the labour ward.

I: So at the placement areas you were placed at do you feel that you were given enough learning opportunities?

Participant 4: No, I wouldn't say that.

I: Can you just give me more detail, why you say so.

Participant 4: Because I just said that I have never seen an episiotomy done, but they did explain why they not doing episiotomies in the MOU's. At the high risk, they think it's punitive against the patient, and I see here now that I worked in labour ward. The MOU's refer the patients, they say, they, they declare the patient delayed second stages, but only to find out if, only to find out that if an episiotomy was performed on this patient they couldn't have referred the patient, the baby would just pop up, pop out. It was not actually a delay second stage, the outlet was not enough for the baby to pop out.

I: So by performing the episiotomy the baby could have been delivered at the MOU?

Participant 4: Yes. Because at the MOU's because of the maternal guidelines that were introduced, uhm we should avoid cutting episiotomy's, so they still at, in that mind.

Participant 2: the pelvic assessment that one, the sisters don't do at the MOU. Because I see now here, now that I am working in the labour ward, it's still not done.

I: So you still don't do it?

Participant 3: No, we still don't do it. So it's irrelevant.

I: So should you have had the authority to design this program, you would have removed pelvic assessments from the objectives?

Participant 1: No, I feel that it is important but the staff must be trained on how to do it.

I: and pelvic assessments is part of the objectives that you must know?

Participant 2: Yes.

I: OK so you never received that training.

Participant 4: No

Participant 3 : and also if I can recall, its like three or five pelvic assessments that your supposed to have with the objectives that your supposed to have but I mean, I think my personal opinion definitely pelvic assessments that you, you have to have training on honestly, because like I mean episiotomy and like epi, it could not be like preventative learning but still then you at least know what you are doing there do you understand? So they should definitely put more, expose you more to pelvic assessments at the MOU's at the anti-natal they should I mean stuff it really makes, I don't know how I can say it.

Participant 1: It makes it, it makes uhm, it's very important, for example if you don't do the pelvic assessments, the people will come here or they will refer people in labour saying that its prolong labour or whatever, delay second stage, when we get here and we do the pelvic assessment then we realise the patient is uhm CPD (cephalic pelvic disproportion), and then all the time patient's been in labour getting pains and all that unconfutable when all along the patient could have just been taken straight for a caesarean section.

I: Ok so you feel that pelvic assessments are still important?

Participant 1: Still very much important!

I: Ok so and so what do you think, what should be the role of the educational institutions to ensure that procedures like that, that the objectives are met in the practice area.

Participant 2: I feel they do, to some extent, because the supervisors or the tutors that follow us up when they go to us at the placements they practice with us what we supposed to do, the objectives, they try their most that we practice all of this things that we must do, because if sometimes we don't get time with the professionals or the midwives then at least if they are there they can take on one patient with us then demonstrate it with us, and let us also practice so I feel they do

I: They do try to

Participant 4: to let us uhm meet our objectives.

Participant 3: 1 for me to uhm I I feel like I, I didn't get that pelvic assessment, I also have a problem with that uhm, but my tutor I don't remember something. No like we did it on you know mos those uhm, like we don't do it practical like with, with the patient, so I feel like if it was done like she makes it feel like the real thing then I would have been...

I: do I understand you correct, you think that the simulated patient thing spoiled the whole procedure for you?

Participant 4: I feel so. The dummies that we use. I mean with the patient itself she'll tell you if you hurting me, or you not hurting me or, but you'll really get the feel of the cervix or you'll really get the, you can open up your fingers, but with the, with the can I say the dummy, you can't, real... I really I can't, although they tell you the anat... the marks on the pelvis or where your supposed to feel it's not, the experience is not the same, its honestly not the same, so if you're really do it like practical, practical with the patient that will benefit you more, I think, so

maybe if they could get someone in class, I mean it's a midwifery class isn't it, so if they could maybe get a, I know, I know you go out the faculties and you do it there but with you mentor or with your teacher self in class, because she's the one that's teaching you and she's the one that's telling you this is what you're supposed to feel for, but now you get to the facilities then there's a sister there that's telling you 'no but you're supposed to know this and your supposed to know that' now you're standing here and what am I doing.

I: And the demonstration was done on a dummy?

Participant 2: We had a pelvis there

I: And?

Participant 3: Just the pelvis yes, so I mean they could have moved that pelvis in any direction, do you understand, whereas with a patient if you had that patient there you would know you suppose to move yourself not the dummy in whatever direction, do you understand? But now you have that patient, and then you have to, so it was really I think in class they should give us maybe someone really, so that your teacher is with you there to come and teach you, and show you the proper way, although you have your mentor there, coming to the facilities and stuff, but your mentor's not there 7 till 4 with you in the mornings, your mentors not there whenever you 9 till 7 till 7 at night ja.

I: So when you need her the mentor's not there.

Participant 4: When you really need yes.

I: And what about the professional nurses?

Participant 3: They sometimes very unapproachable, sorry to say. Because I can see now in the wards they have their own work, they have doctors come straight down onto them, and they have their patients coming, you know, so where's that time for that student really, to give time to that

student and teach her the proper ways, because they also taking now shortcuts there, here in the wards.

Participant 1: Yes, for me it was different, I think because my sister, the sister that I was working with, I asked her to demonstrate to me that thing, that pelvic assessment thing, and she said to me, she doesn't know how to do it, but when I do the PV's (per vagina - vaginal examination) she'll sign for that thing the pelvic assessment thing.

I: Ok clarity for me now, so the sister just signs off something that wasn't really done by the student?

Participant 1: No I don't mean it that way, but...

Participant 3: They said it's the same, whenever you, but as a student you want your book to be signed so you do whatever so that you, they find you competent

I: Uhm, so that they find you competent, is it, was that done for competence or was it just a matter of signing off procedures?

Participant 2: They don't evaluate you, they only sign off procedures. But where I was working I did pelvic assessments, the sister I was working with, she m... ante-natal, so not even in labour, in labour I just practiced, I was already finished with my pelvic assessments, because ante-natal the sister let me do it, she explained to me and she checked with me if what I found is right, so I was, I was taught how to do a pelvic assessment by the sister, she's a very good midwife that one.

Participant 4: So, yes I was still explaining that my pelvic assessment was signed together with the virginal examination, but I didn't actually do it.

I: So uhm suggestions on how we can approve factors like that?

Participant 2: The clinical supervisors, should go to the wards with their students, and do that pelvic assessment with the students and make sure that, and sign, sign, it off there, the five pelvic assessments, because the midwives in that clinical facility don't do it

Participant 4: It depends on the specific clinical supervisor, because, everyone is different, and everyone's got a passion for, they can be uhm clinical supervisors for midwifery but then they don't like midwifery, or they were not exposed as much as they needed. So with me, my clinical supervisor she was in love with midwifery, so she actually made sure when she comes to see us that we did something very important, so she taught us the stuff we need to know, she'd take patients and she'd give us case studies in the hospital setting, and we'd manage patients with her, I felt that she really prepared us for the real world, because even as a student, the first day I came to high risk, on my first day me and my friend, uhm, we got there we introduced ourselves it was before 7, before hand, it was just after, it was just after hand over, the sister asked us to monitor patients, do observations, we got there, and the patient was in labour, we didn't run away, we knew what to do, and we delivered the baby, we screamed for sister but we were still busy, and the sister came she was very impressed, so we did deliver the baby, and eve, since, since, since that day I don't, I never got the impression that the sisters were like uhm unsure about what I know or what I don't know, because I did what I was taught and if I didn't, if I weren't sure I'd ask, and they were willing, so I did my high risk here at [name] hospital, so I was treated as a mid-wife, not as a student there, so I used the learning opportunities like when I, I cut my first episiotomy there, it was me and a doctor. Doctor asked me if I done it before, I said no, but I did, I was shown in the skills lab, so you watch me, I'm gonna do it, which I did, and with the suturing as well, I did what I was taught in class, and I did it well so I feel, it's up to a person as well, because sometime people would be like, you did on a sponge you did on a doll, they afraid or don't trust themselves, so if you trust yourself, and you know there someone supervising you

then you do the things, and you make sure when you get the opportunity you practice. The program was fine

Participant 4: uhm clinical supervisors they are not, they are one person, and they placed for maybe four or three different institutions, and then the students they must see, of which they can't see everyone like every week or every day of the placement, because when they get to an institution they need to teach the students and practice with them so maybe they see the others maybe twice or maybe the others once only, so I feel if there can be uhm more of them, and actually also at the institutions at least they spend some time with us, they would be able to spend some time with us, because if she's here, she's like, ok I must only be here for an hour, I need to go there, I need to go there for the day, and she leaves and we haven't learnt actually anything, or we only learnt a small portion of what we need to know.

I: The sisters in the ward also helped?

Participant 1: The sister does teach us, but then, or maybe let me just say... most of them maybe they studied long time ago, when they bit rusted and all that, so they like know the practical ok, they good but when they teach you, they can't, sometimes even the language barrier is a problem, the people they don't like speaking English, the sisters would be like oooo I have to speak English they don't know these words now, because they learnt you know [name] is a big name now all of a sudden, so they become resistant to teach you because now you gonna come with that language of class, you know you speak big words and all so, you know to them it's like oooo I've done this a long time, or I have to speak English now, and they, they, actually for, they would say that like oooo I must speak English I can't, and then now what must you do.

I: So you actually more reliant on the supervisor, and she, she only comes around to see you every two weeks.

Participant 3: Yes, and then in the institutions there's shortage of staff, and then if you there, the usual's, like, I know we must assist but then sometimes you like, ok the day has passed I never learnt what I was supposed to do, my objects, I never did one, I was placed for intake and output, I was placed for whatever, of which I needed to learn this.

I: Ok so, it's a shortage of staff, and you are being used to do other things.

Participant 4: Yes, yes, the work force, you part of the work force now.

Participant 1: that's what's happening more and more in, in the, in the, in the, the wards

I: Are your objectives taken into consideration when duties are assigned to you

Participant 3: Yes, because even most of the student getting placed on, over weekends in wards, and then most of the permanent staff getting placed during the week, because there is, but they don't have, they don't have supervision over the weekends, the sister is there yes but I mean over weekends, sorry to say but they very lax

I: so it's not the same like being placed over the week, during the week

Participant 4: During the week, yes, because during the week these' that doctors rounds, and during weekends, it's just medical emergencies, or so, real emergencies or so.

I: Does anybody have anything more to say

P: No

I: Then I want to say a big thank you to each of you.

Appendix 17: Example of interview transcript: Clinical facilitator

I: What are your views and perceptions regarding the training of the current under graduate midwife to deliver safe maternal care?

P: In the first place I think that the time is not enough to prepare that midwife ahmm, educated enough and skilled enough at the end of the programme. So when I say time, there is no time for practica (practice) to let the students practice the practica (practice). It's never enough, cause (because) there are so many other interference in the programme. So you don't actually have enough time to focus on the student. When you are in the facilities with the students to prepare them for the practica (practice), then you must also attend some meetings, you must prepare the administration work, you must come for teaching, helping with the teaching at the college. Then the summative assessments keep you so much busy that there really is not enough time to focus on the student. And the amount of students, you are unable to reach all the students individually.

I: How many students do you have?

P: We talk about 30 – 40 students per clinical educator. You have different facilities to look after other students or accompany other students in the community. And in the community you have you have 3 -4 facilities to look after. And in one facility is about 10 – 15 students, that is accept the huge amount of students you have in the hospital you also need to focus on. Also the students we deal with is not students who qualify for the programme.

I: Can you please provide more detail?

P: They are admitted into the programme because of seats that must be filled. They don't meet the criteria of the programme, they are chosen because there must be a certain amount of students when they do the selections. Then they find students so that they can show the department that they have find the number of students, so we will go on with that amount.

Because if students have met the criteria then that student would not have found it difficult

during the programme. Yes and that maths thing students that come into the programme without that maths, you see in the first and second level they have to calculate, you see the medication administration procedures.

I: Is this important for midwifery?

P: Yes it is important for midwifery, cause the patient must still receive meds, the patient still receive IV fluids which needs to be calculated cause the student can easily give the wrong dose to the patient, calculate the wrong dose actually. Yes that's the third one, so you get students that is in their third year of training who can't even speak proper English, so it is very difficult now to reach that student, to get that student competent to do something, cause (because) there is a lack of understanding between you and the student because of the language also. Yes and another thing, I think the time if you go back to the one year programme, or even if the programme could be more than the six months then it will give more time for the students. Because, for example the students come into midwifery, then they go into class for three weeks, after the class they go back for three weeks, then they have to go into the facilities. The placement is such maybe they did not do the theory that they are, or in that area of placement that they go. For example they are placed in high risk placement and they just did the normal of midwifery part of midwifery. And then the student don't have a clue of what is going on there, because they don't have the background of theory of that. So now you need to teach the student in that area that she don't have the background of theory of that. So then it is difficult then to reach that student, and for that student it is difficult to become competent, because she don't have a clue what is going on around her. Because she had the theory of the normal of the normal pregnancy and now she is in the abnormal situation. Because she don't know what is going on there she cannot work with the patient, because she don't have an understanding of the diagnosis of the patients, the types of patients, and what to do with the patients.

I: So would you say that this could impact on the quality of the programme output?

P: Definitely our CSP's are definitely not safe, cause when she steps in as a Registered nurse in the community, for example firstly she is scared, don't know what to expect, she don't know most of the procedures, how to do it and how to handle emergency situations. She is there to learn for the very first time as a student. Now she is forced to learn, because of her placement, there is no other placements for her but midwifery, and now she has to learn very fast. And now she is very dependent on the permanent staff. They have to take her by the hand to lead her all over the show. You have to teach her from the start, because you get those Comm serve sisters who cannot even do a episiotomy. They don't know how to be a advocacy to the patient for example, they cannot do it for themselves. They always need somebody next to them to speak to the patient. They don't even know how to take consent from the patient, to do certain procedures. I think it is because they did not reach competence while they were students.

I: Can you provide more detail?

P: They did not reach competency while they were students, now she is going in with that same uncertainty. The students were found competent in very few procedures, very few procedures. Because it is not all the procedures that you have to find them competent in, some of the procedures they just have to do while they are working in that area. Because it is not part of their practica (practice) book. And some of the procedures are [procedures that come from year one and year two. Then I find that these students forget how to do that. Like passing a catheter that is not a midwifery competency that is a competency that come before that. But when the students is in that year, there is a emergency situation or things, then you find out that the students don't know how to do it. But they passed that competency in that year, the previous year second or first year. We expect in the third year level that the student are able to do it, or even cannulation, IV cannulation they cannot do it, and that is not procedures of midwifery. So now you are in an

emergency situation you grab that student because you expect that that student will be able to do it, but you find that that student cannot do it, you cannot tell that student go catheterise that patient, go put up a drip for that patient, or things like that, cause that student don't know how.

I: Are you saying that the programme does not adequately prepare the student?

P: It seems like the students cannot integrate, the information they are given in the previous levels to the third year level. When they come into the third year level they focus only on that small amount of procedures, they think they can forget all other things they have learned in all the other previous years. So they think it is only now about the pregnant woman and the baby alone. On top of all the other previous they have received in all the previous levels. Students seems to separate their learning, I don't know if it is the student who separate it or the discipline, that separate it, but definitely a separation from previous levels to the third year midwifery level. So it is a big problem you cannot use the student in general side, because that student think she is only there for midwifery. So they cut off everything outside of midwifery.

I: Can you think of possible ways how we can improve the education of midwives?

P: My own opinion is that those students were not actually competent when they were found competent. So some of the educators feel that they cannot fail the students, the student have to pass, so that they can go to the next level, and that they have to pamper the student and things like that. That the student is not competent then they have to find a way to make that student competent.

I: Can you provide more detail?

P: Ja the students were found competent by the educators in the previous years, but the students failed that procedures then the educators of that students in that level take that student and let that student do the procedure over, and over , and over that procedure till they find a pass mark. Then the fail mark doesn't now count, so they take now that pass mark so that that student just

can go to the next level. The students are given more than three opportunities to do the same procedure over and over again till a pass mark is found.

I: So what would you like to see changed in the programme to improve the programme?

P: The pass mark we can higher it there, cause (because) how can the student be allowed to become a professional nurse and nurse the patient if she has passed with a 35%. How can you nurse a patient with a 35% pass mark, that's a danger in nursing? We need to up the pass mark at least to 50, cause 35 is very low. Also at the college we don't have enough models to teach the students on in the sim lab. We are supposed to demonstrate the procedures to the students in the college before the students go out, but because of our models there is a lack of that.

I: Anything more?

P: No that's all

I: Thank you so much



Appendix 18: Example of interview transcript: Lecturer

I: What are your views and perceptions regarding the education of the current undergraduate midwife?

P: Ahmm, regarding the education ahmm I would say, with our current curriculum that we have ahmm we strive to provide them with the most current competences that they are supposed to have when they go out and practice as midwives. But as the curriculum is currently as it is

currently they are doing it in their third year, so by the time that they get so to the community service, a year has lapsed. And now they did not concentrate on what goes on in midwifery. And then also the other thing is with the community service, they are not placed in midwifery for the whole placement. They will be like rotated through the whole departments

I: Ok are you talking about the comm serve year now?

P: Yes, the community service year, so what will happen is they might or might not end up in a midwifery department. By the time they get to a midwifery department it's like they have forgotten everything that they have learned. On the other hand and now I am reflecting on my education, we started midwifery in our fourth year, for six months in our fourth year, so when I was newly employed, luckily for me I started immediately in midwifery, but still for me it was problematic. In the sense I still had to, many times in the beginning I still had to go to my books. So just to sort of up-date myself, cause we did midwifery in the first semester, and psychiatry in the second semester. So ja as I've said, so I think that is the problem now also, students because of that year lapse, students they tend to shift midwifery to the back of their mind and forget about it. So now they go back into the practice and they are expected to just know everything. Which is difficult and I think there it comes down to the student themselves. If they are not prepared to go back and reflect on what they have learned, it becomes, it becomes erhh problematic. So what I am actually trying to say is, I think an important skill to instill in them I think is the life-long learning, they need to know that it is their responsibility to stay current, or as I've said in my case to go back to your books if you don't know about anything.

I: Can we talk about the current training, the education of the midwifery students.

P: Well as I've said currently we tend to focus on like previously we had the big five. So we try to stay on what is current with what is happening outside as far as the education, there is a lot of things that needs to be covered, erhm theoretically wise, but if you look at our six months in that

six months or not even full six months that we have, there is only so much that we can do. So we try to focus on the important things, now we have the five H's. so we have shifted our focus to the five H's

I: Could you give more detail please

P: The five H's is HIV, Hypertension, Healthcare worker, the competency of the healthcare worker, and the healthcare strengthening, that is the new, according to the Saving Mother's report. So when that comes out, that comes out every three years, we go to the latest presentation of that and we identify what is the new developments or what is the problem currently in the community.

I: So you based your curriculum on the current problem

P: Yes, so your normal is mos basically, it's based on your normal things, but I am talking abnormal when I am talking about that Saving Mothers, because we don't, a pregnancy is a pregnancy, how it progress. We have the normal and we have the abnormal. So the normal will stay as is, but to stay current we focus on what is abnormal. In terms of, I'm just thinking we are using the Saving Mothers but there is also Saving Babies, which we tend to neglect a little bit the education part, to bring that into alignment, the two of that the Saving Mothers and the Saving babies report. Erhmm, ja.

I: how do you align your practice and theoretical teaching?

P: ok, in terms of that gap, what we currently have in place, is we have our skills lab, the skills lab is the skills laboratory where students will practice their skills in simulation, before they are supposed to touch the real patients outside. So what we do is our skills lab programme, goes hand in hand with our theoretical programme. What we do is, let's take a simple example what we do this week the first antenatal visit, in the same week in the skills lab they will have the practical history taking and all of those goes hand in hand with the first antenatal visit, so the

students get a chance to practice there. Then they are supposed to go out into the field and practice on real patients, but the supervisor find that they are competent. On competent that they have practiced enough. Erhmm, in terms of placement itself, the theory practice gap that is a little bit problematic. Because we cannot place all the students in the same department. For example I'm just taking the first antenatal visit. Ideally you would have wanted all the students to walk into a antenatal clinic for their first placement so that they can take that theory that they got in class, the skill that they practiced in the skill lab to link it with the clinical practice now. But unfortunately due to the shortage of clinical facilities it is impossible. So we end up placing students in a labour ward. Now that student doesn't have any theoretical knowledge or practiced any skills with regard to labour, only covered the first antenatal visit. Now the sister in the labour ward is now expecting that student to perform.

I: Can we correct that?

P: that's a very difficult one, because as I've said ideally it would have been that way if I think in terms of correcting it. To be honest I really don't have a suggestion with regards to that. It would not make sense for us to try and adapt our theory, to how it goes in practice .Because you would end up teaching a student, say for instance a student is now placed in a labour ward first placement, now half of the class you are teaching the first antenatal visit, the other half of the class you are now teaching labour. And then that student who is placed in the labour ward rotates to antenatal. You are taking the student back, you have done labour with that student now you are taking that student back to antenatal. It does not make logical sense, erhmm I would really suggest that accreditation of the facilities and even for example we don't use BANC facilities. BANC is the basic antenatal care, so erhmm that clinics, basically it is in day hospitals, they run on certain days, they don't run every day. So it is just certain days during the week that they would have BANC clinic. And it is not specifically a midwife that does these clinics, cause

(because) see it's got a tick sheet, and she just ticks off on the tick sheet when she examines the patient. If she identifies anything abnormal the patient gets referred. So for us when we are busy with our midwifery students, that's not sufficient because the student don't get the opportunity to see how the patient should be treated at the first. Say for example a sister at the day hospital in the BANC clinic and it is hypertensive patient in pregnancy. That is mos our pre-eclamptic patients, they don't have of rechecking the patient giving the patient medication. They just refer the patient, so that's a lost opportunity for the student. Because once the student get to the exams it is expected of the student of how to manage that patient before referral. Erhm, so that is the major reason why the BANC clinic is not used. Even if think in terms of if we should consider using BANC if it runs once a week at the day hospital our student is supposed to do two-three days at the facilities, so what must the student do for the rest of that week.

I: This two-three days what are you referring too?

P: Clinical practice, students are not necessarily placed at clinical placement after receiving theoretical information, erhmm when they start off with their clinical placement they start off after a two week, or last week and the year before it was one week, one week of orientation. This year it is back to two weeks because we thought that week is not sufficient to prepare that student. The student don't have any theory, what happens during that orientation. The student gets orientated with regards to the most important things they will be exposed to when they go out to the facility so they do like history taking, the abdominal assessment, the partogram for those starting in the labour ward. So that when they go into the facilities at least they know something, so they will still be able to function there. But they won't have the theory yet, theory only start during the first week when they are placed, and then it starts from the very first antenatal visit.

I: So would you say by placing students in the clinical facility without having theory, can contribute to this perceived theory-practice gap?

P: Definitely, definitely, ermmm we have asked many times to go back to a block system, ermmm up until today we were still unsuccessful but I agree with you, because in my opinion if the student could come in for a month block we can give them that theory, and in that block we can also have our skills lab, so we will have simulation lab and simulation practicing of their skills and after that practice, which I think will be much better.

I: Can you provide more detail about the two-three days of clinical practice

P: We don't meet SANC's clinical requirements of the amount of hours, previously we did not, and it's been a few years now that we did not meet it. But once again lack of facilities, the facilities are flooded not only with our students, but also college students, paramedic students that have to rotate through the facility. so what happened is that due to the flooding of the facilities we had to cut down on the hours, so it was three days that amounts to 33 hours per week, then it was cut down to 24 hours two days. So, and then because of the SANC requirements we had to push up the hours again, because when it comes to student complete, the completion form ask for the amount of hours, and so ja, we got to, we managed to get to the group of last year up to, to, they will still be doing midwifery hours up to their fourth year, then they will end up with the required SANC hours which is 1000 hours. Which if I can say so myself, it is not stipulated anywhere, erhm. I've asked for the directive, oh let me say so, it says a 1000 hours, but it doesn't stipulate like say the student must do so many hours antenatal, labour ward postnatal, and neonatal. But every time we run into that problem that it is expected of us to give a break- down of those hours , but ermmm ja, we try to meet that requirements, which we did after quite a traumatic transitional period. The ermmm only there which is also a problem is that look at the student's programme they are completely overloaded now, cause they

will have now, the current students who will be doing now this year is having, they are working three days a week and the other day is a class day and the other day is a skills lab day. That is six days in a week, meaning they have one day off. Do you hear what I am saying so the load of the student is quite hectic. I suggest they stretch this programme over a year, they cannot make a 1000 hours in six months without overloading the students.

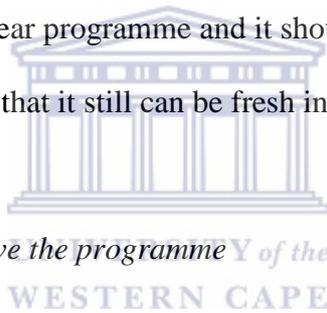
I: Clarification so the programme runs over six months and this include class time and clinical exposure.

P: Yes so that's why the suggestion spread it out over one year, and you would definitely meet all that requirements. Because the other issue here is that they are not only doing the midwifery, together with the midwifery they are doing unit management, during that same six month period. And for unit management they also have objectives to meet, which lots of the frustrations from the facilities side is that the students have to leave the wards, because they have to do a unit management assignment, which, is, it shouldn't have to be a problem because doing off-duties, or ordering stock, I don't know all the objectives out of my head. But that are things you can do in a midwifery ward, so they can still do that. And I have repeatedly told the facilities there is no need for the student to leave the ward to tend to their assignment, since they can do it within that ward. Then we also have students that come with second year modules, that they did not pass for example pharmacology, human biology ermmm, introduction to mental health that type of modules they bring with them to third year that is on top of midwifery and unit management. Then that becomes problematic, cause (because) now they need to go to classes for that modules. And it impacts on their clinical placements and theoretical class, and I don't know. And because they have to pass the second year module they will now not focus on their midwifery or their unit management, because they have to pass the second year modules. They will tend to stay out of work, and forfeit learning opportunities, they will stay out of class, missing out on the theory,

then they have to make that up on their own, they are free to consult us if they have a problem. But I mean just think about it, if you stay out of class, out of work how free will you feel to approach the lecturer. Because the first thing that we will ask was why were you not in class, or at the clinical facility. You will be definitely embarrassed.

I: So do you feel that the current midwifery programme prepare the community service practitioner sufficiently to become a safe practitioner?

P: I would say no, in terms of everything I have just told you, I would say no. Although I have told you initially we tend to focus on the current things, but if maybe they did midwifery in the first semester of the third year, by the time they get to their community service and then I would say no. In terms of what they are getting theoretically, I think the time is too little, I think, my suggestion is make midwifery a year programme and it should be the last year of their training, do you hear what I am saying. So that it still can be fresh in their minds. For me it will make much more sense.



I: Any more suggestions to improve the programme?

P: ermmm, no.

I: Once again thank you so much for your time.



Appendix 19: Example of interview transcript: Professional nurse

I: *What are your views and perceptions regarding the education of midwives?*

P: Are we now referring to the R425 students, so it is the undergraduate midwives

I: *Yes the undergraduate R425 nurse training programme, specifically the midwifery training programme.*

P: For me it varies between the educational institutions, ahmm, the UWC institution students I find that they know their theory, but they cannot apply that theory. They find it really difficult to put the link between the two, because they can tell you things but they cannot do it for you. Then when it comes to the WCCN institution students it sometimes flips cause you will sometimes find students that are very good at doing it, but then you find the other student who are not, ok, I think it is more of a personal thing then rather, then rather, because they study for the same period, but somehow some of them, not the UWC institution student. Generally you will find

that the WCCN institution students they are much better prepared than the UWC institution students.

I: Can you explain, give examples?

P: The UWC students I find, they also seem to be less confident, ne as if they are scared to do things, ne as it is different with the WCCN student's ne, they will jump in quickly, they tend to do more things they will come and ask more questions, that type of thing, they are confident. The UWC students they are just focused on theory, it seems to me you guys are just theory, theory, theory, and ne. I think with WCCN it is more focused on midwifery, ne. So when the students come in from the training institutions to the hospitals or facilities, here they seem to link the theory more easily to the practice. But at UWC I know they do other modules beside the midwifery module, ne, at WCCN they focus just on the midwifery, midwifery only, yes

I: OK, so what is your role in the education of these students?

P: I have to teach them practical, ne, so what I expect of them is that they must give me some theory, not necessary all the theory. Because when I have to explain something to them, for example the abdominal examination, I feel that they must first be able to tell me, how do we do it and why do we do it, ne, why do we do it. Because for me it is important that you give me a reason why you are doing something, cause then it makes sense. Why you are doing it, ne. so I expect them at least to be able to tell me, you know what the different our patients are, ne. even though they might not know their names, that's ok but they must still have an idea, they must still have an idea, ne. and then I will teach them the rest, that is our function here ne, basically just to teach them how to do those things that they have been taught to do, ne, how to do it.

I: So you are responsible for teaching them the practical side of their training, am I correct, so would you say that your role are similar to those of the Clinical facilitators?

P: Yes, but I am a bit concerned when it comes to the Clinical facilitators because many times the information we are giving is different to what the Clinical facilitators are giving, because when I tell them stuff they will say but that is not what, how we understand it. Yes, so it is a bit confusing for the students. Ahmm, I don't have much contact with the UWC facilitators. But I know previously with the Western Cape College of Nursing, we have a nice understanding, so we knew that the information she was giving is the same information we give, ne, but before we picked up this discrepancy with UWC, ne, that they are being told (laughing) something else, ne. But because there is not much contact, but hopefully this year, there is better contact with the Clinical facilitator who is coming now, so then I will be able to.... But the sisters will immediately come, but sister the students are doing this, which is not the same as we are normally doing, and this confuses the students. We then tell them that any procedure you are doing, ne, you must do it according to your book, ne. Because you will find that sometimes the sisters do things different, ne, but you will come to the same conclusion in the end, ne. They need to have done everything according to the book. You may start at the bottom and go to the top; they may start in the middle then go around but end at the bottom, but you both will end up at the same thing. Ahmm, you know that type of thing, ne, cause as I have explained with us as midwives I also say it this way, when we started working as midwives ne. we worked with senior midwives we sort of picked up different methods from different midwives, and it soon become part of you. And when you do something it is very different from what somebody else might be doing, but it actually is the same, hmm, you know. So we tell the students do according to your book, cause (because) just a simple example, I feel that a delivery for example, you first have to wash and then dress, when I talk to the students. But you find you first have to clean and then you throw your towels, ne, whereas another sister feels differently, throws the towels first and then clean. You know it is just that difference but we will get to the same thing, eventually;

you know that is what I am talking about. But I tell the student you must work according to the book, and not according to what the sister have done.

I: What are those competencies a CSP will need to make her a safe practitioner?

P: For me I have always felt, and it is not just particular to midwifery, but I have always felt that you must know what the normal is. Because if you know what the normal is you will be able to pick up if it is abnormal, ne. So it is important that as any practitioner you should know what the normal are. So if you are looking at, you see if you look at the labour ward ne, it is separate from the antenatal ward and also not quite. Because if a patient comes in in labour, she is still in the antenatal period, and unfortunately in midwifery, there's (laughing) a lot of information, and I think that's what makes it difficult, for students as well as the CSP's, because there's all this information, and I think they find it difficult to individualise their patients, and to pick out the problems then. So for me when the CSP's nurses are coming in I feel, I had to teach them everything again, ne, cause I have to make sure they know, ne. and until I can see that they are competent, ne, then I can feel satisfied then I can say fine I can leave you on your own, ne. so for me I still regard them as being students. I don't know how much they know ne, they need to show me how much they know. So it is very difficult for me to tell you now, they need that competency and they need that competency, cause I don't know which competency each person has, I will built on the ones they don't have, but the ones they already got, I can leave those. But I don't think the training is sufficient to make them competent.

I: So any suggestions on how we can improve the training?

P: I would prefer that the training be longer, cause (because) you can see the difference between the students doing the year than the ones doing the R452. They have more practical, they have more practical than the 425. I think the theory is the same, I suspect it is the same, but they do a lot more practical, cause (because) their course is longer. You know the ideal would be... cause

sometimes, with the areas as we are now, the facilities ne. we are very few staff, so we sit with the situation even here where in the labour ward we only have two sisters with six students. So the ideal would be if we could have a one on one. Whereby a sister, ne would work the whole day with a student, and everything the sister does obviously the student will do it with her that would actually be the ideal. Because really with six students and two sisters really it is not... I can't see how those students are going to learn. If I'm working in the labour ward, and I'm working with six students, and I have to repeat. Cause (because) what I normally tell the sister is that you can only work with one at a time, ne, cause you have to think of the patient's privacy as well. And even the cubicles we have it is not ideally to have so many students at the same time, ne, so normally you can only end up working with one person at a time. But we have to do that six times over, you know what I am trying to say, you become tired at ermmm, you start... you now you come to a time you feel like saying I don't feel like doing this anymore, you know cause I have to say six times the same thing. So it tires you by the time you get to the sixth student you are tired of giving this information (laughing) you know what I am trying to say, ne. Especially if you have got a busy day, the students can forget about learning, you just need to rush, you don't even have the time to teach them. Because it is just too busy, they can be there but you are just too busy, you don't have time for that individual you know, this is what I'm doing and this is why I'm doing it, you just don't have the time to do it, because there is another patient waiting, it makes it very difficult. And the students are too many for the Clinical facilitator as well. You know I don't actually know what they do with the students, there are times that they come and they take the students, and I assume they show them how to complete maybe the Partogram, you know those type of things. Then there are times that they take them also to show them maybe the abdominal examination, you know those types of things. But they only stay for a short period of time.

I: Ok so practical teaching is mostly your responsibility

P: Yes it is cause (because) the Clinical facilitators only stay for a short period of time. And it is difficult with the workload, but if time and workload allows it we do it, but if it is busy then I can't.

I: And do you have sufficient learning opportunities for all the students placed at your facility?

P: No, (laughing) no I don't think so I don't know there seem to be suddenly this whole (sighing) this whole, increase in students I don't know where it is coming from. But they don't seem to realise, that there are so many people qualifying but they are not really competent. And you will also find that when the student finish, they don't want to work in midwifery, because very, very seldom I will get a students that will tell me, they want to be a midwife, and I don't know, I've asked them why. They just say no, no, they don't really give me a answer why. So I don't know is it because of the responsibility of the mother and the baby, and there being no doctors, you know it could be that I don't know, I don't know. But I can't even recall when I last had a student who said I want to be a midwife. You see when they come in I tell the student how much you are going to learn depends on how much you want to learn. You have to be available to be taught, so if I have a student who is not interested, ne then they are not going to learn. Or if they say I will never be a midwife, then they not going to learn, they have already told themselves, ne. so they come in and then they just do the procedures, that's it. Further they don't show much interest.

I: So are you also involved with assessing student's clinical competencies?

P: No the Clinical facilitators they do the assessments. But you know the funny thing is. When we work in the.... You know I was always wondering about this, because when the students have completed their assessments they will get a very high mark, ne, and I would think but you can't even do this, because I would give them a task you know especially when it comes here to

the end you know, so especially the UWC students you know. They will say, they must come make up hours, make up hours you know, so they will already have finished in the hospital as well, cause (because) they are coming back, ne, and then some of them will already have their assessments, ne. So now I ask them and they will say yes sister we got 90%, so I will say yes lets go work, then we work and now I say you got 90%, and I ask that question you got 90% and then you can't even do that, so how did you get 90%, so I am also wondering about that assessment tool. Because I think if we were assessing we would never give that mark. You know the reason why I am asking about that assessment tool, with us if you do the abdominal assessment; it's not just that abdominal assessment. If a patient comes in ne, and that abdominal assessment is part of your examination it's your antenatal visit, its part thereof , ne. so I need to make sure this patient's blood pressure, her urinalyses, her HB, that she actually had one of the rapid tests, see if that is normal, so if that rapid test was not done I must send her back, she might have had her weight done or, those type of things, ne. then I also need to check before I even touch the patient, I have to check what is the gestation of the patient, measure the SF, do the abdominal, all those things. So if the student only does the abdominal. I feel that is not an examination of the patient. Because I must see the patient holistically, cause (because) if there is something wrong with that patient, I need to manage it, I cannot just leave it, her blood pressure can be high but I have done the abdominal and off she goes. I need to manage that blood pressure she is my patient I must see her complete.

I: Ok so those are the types of things you would like to see in the skill assessment of the student?

P: Yes, cause you cannot just do an abdominal it is ridiculous, it's not comprehensive. Yes cause now the patient complains of a vaginal discharge, ne. I then have to do a speculum to look at that discharge, and treat that discharge as well. I can't just work halfway and not do the rest. So that is what happening, ne is how can you become competent if you are just assessed on one thing,

you see, ne. It must be included cause it doesn't make sense. This is what we need to do, if a student takes a patient for a assessment, I phone the sisters, that patient must still be seen by you, cause then the sister will tell me none of the other things have been done, see. Cause when I have students coming here before they can do an abdominal examination, ne, I tell them they have to work for at least a week in the preparation room, the preparation room is where the urinalysis, blood pressures and HB's are done, they have to work a full week there, before going to an abdominal examinations. Because if they go into abdominals they might not know what is happening there to pick up a problem with this patient, they cannot just do an abdominal they must do all the other things as well, I expect them to know it all. So when we do an abdominal with them they must tell me all these things. And they cannot do this they only do an abdominal. The labour ward is not so a problem, but it is the antenatal clinic that we experience most of our problems. But the problem we also have, but maybe it is a misconception with regard to ourselves, but maybe we have been trained differently. But when the midwifery students come, they are third year students, now when we trained as second years, we could do almost everything, ne things like catheterisation, and we could do drips, ne, you know those... we could give injections.. These students they don't seem to be able to do these things. Now I don't know what happened then in their first two years but, ne but we expect them to know these things, ne. But now they come and say we don't know these things especially with these patients who come with the urinalysis things, then I will say they must do a in and out, then they don't know, they don't know. So they cannot see their patient complete, cause now I have to do the catheter. Now there is protein, and I say fine enough put up the drip so that we can give magnesium sulphate, ne,

I: So these are all the skills necessary to be a competent midwife?

P: Yes, some of them can't even do blood pressures, in their third year. Because we don't use a dynamap, now they tell me they use a dynamap in the hospital, ne it's all good and well, ne, but in midwifery we are not supposed to use a dynamap, you are supposed to do a normal baumanometer blood pressure. Because a dynamap is going to give you a lower blood pressure, ne, they cannot do a blood pressure. The same with the foetal heartrate, they must use the foetalscope, then they bring the doptone I say no, no no, just bring the foetalscope, we don't have time to look for the doptone, they don't know they can't hear anything (laughing).

I: So would you say they need longer practical exposure?

P: like I say, I think it should be a year course. I don't think the practical exposure is enough. For me it is enough, cause I have to teach them basic things also. Because specifically as a midwife we must be able to put up a drip, pass a catheter, ne, and those types of things. When I get a CSP who come to me I do not make her part of the shifts, so in other words she is extra. I feel I cannot allow her to work part of a shift, because it is going to place a burden on the other person she is working with. We only got two midwives per shift, so if she becomes the second midwife, it places a burden on the first midwife. Because she would not be competent to manage emergencies on her own, you understand what I am saying. She might be able to do the basic things deliver the baby, ahmm admit patients, those basic things but as soon as an emergency occurs, ne, she will not be competent enough to manage that emergency.

I: Thank you Sr anything else that you would like to mention? P: No

Appendix 20: Language editing certificate

11 April 2017

Dear Madam/Sir

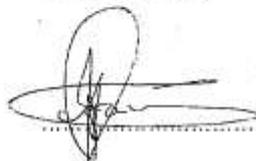
This is to certify that Archibald J. Groener, Language Practitioner in the employment of the Parliament of the Republic of South Africa, effected a grammatical edit to the research report titled – ***Develop a framework to align Theory and Practice to improve Midwifery Education in the Western Cape*** by Ms Wendy Augusta Phiri. This report, as Doctoral Thesis, is being submitted in partial satisfaction of the requirements for the degree of Doctor of Philosophy in Nursing.

The onus is, however, on the author to make the changes suggested and to attend to the queries.

Please direct any queries regarding the editing of this article to me.

Yours sincerely

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