

MIDWIVES' EXPERIENCE OF THEIR CLINICAL EDUCATION
AT A NURSING COLLEGE IN SWAZILAND

by

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MAY GOD BLESS US ALL.

Fortunate Nomsa Thwala.

ABSTRACT

Poor quality of midwifery care has been of major concern in Swaziland. This has been attributed to a number of reasons of which one is the education of midwifery students. The research question has been, "To what extent has the clinical learning of midwifery students produced competent midwives in the country?" The question has been answered by exploring the clinical learning experience of the midwifery students in a college in Swaziland. Data were collected by means of a focus group interview. Two groups each comprising of five participants were interviewed separately. Data was analysed following the steps provided by Tesch (1990) as quoted by Creswell (1994:153-155). From the findings factors that impacted either positively or negatively on the clinical learning of students were discovered. Because of the presence of more negative factors the conclusion was that the clinical learning of midwifery students produces competent midwives to a lesser extent. Recommendations to form the basis for the strategies to improve the clinical learning of the students were outlined. Validity and reliability has been maintained through out the study. Ethical standards for researchers as stipulated by DENOSA have been considered in the whole study.

ABSTRAK

Die lae standaard van sorg wat deur vroude in Swaziland gelewe word is kommerwekkend. Dit kan aan 'n aantal redes toegeskryf word waarvan een die opleiding van vroeuvroue is. Die navorsingsvraag is dus "Tot watter mate het kliniese opleiding van vroeuvrou studente vaardige vroeuvroue in die land verseker". Die vraag is ondersoek deur die kliniese leerervaringe van studente aan 'n kollege in Swaziland te verken. Data is versamel deur middel van 'n fokus groep onderhoud. Onderhoude is gevoer met aan twee groepe wat onderskeidelik uit 5 lede elk bestaan het. Data is volgens die stappe van Tesch (Tesch 1990 en Creswell 1994: 153-155) ontleed. Uit die analise is faktore gevind wat beide negatief of positief, bygedra het tot die studente se kliniese leerervaringe. As gevolg van die teenwoordigheid van meer negatiewe faktore kan daar tot die gevolgtrekking gekom word dat die kliniese opleiding tot 'n mindere mate bygedra het tot die opleiding van vaardige vroeuvrou. Aanbevelings is gemaak wat as basis kan die kliniese opleiding van studente. Geldigheid en beskikbaarheid is in die studie verskeen. Etiese standaarde vir die navorsing soos bepaal deur DENOSA is in die studie nagevolg.

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Addendum 1: 1st and 2nd focus group interviews.

Addendum 2: Letter for research request.

Addendum3: Letter for research permission.

CHAPTER 1

1.1 INTRODUCTION

The midwifery profession is at a crucial stage in its history. The quality of maternal care services is of great importance world-wide. Maternal, infant and perinatal mortality remain a threat in most countries especially those in the third world. Swaziland still has unacceptably high levels of infant mortality rate, 99/1000 live births (Development plan, 1996: 50). Maternal mortality is 229/100,000 births (Safe Motherhood Initiative Audit, 1997; as quoted by the Government Report, 1998: 12). Perinatal mortality rate is 34.7/1000 live births (1996 Review of hospital and health centre records). With the pressure of HIV/AIDS infection, the situation is more challenging than before. Programs such as "Safe Motherhood", "Child birth" and others have been introduced to improve the maternal and child care services globally. Midwives are therefore, faced with a challenge to use their skills to the full.

The midwifery profession still faces problems that hinder the utilisation of the above mentioned programs. The quality of midwifery care is below standard. The researcher has observed this while practising in the clinical area. Among other things observed were the lack of privacy for the women who come for antenatal care and those in the first stage of labour are not given anything for pain relief at a particular hospital in Swaziland.

The poor quality of maternal care services may be attributed to a number of factors such as poor infrastructure, midwives' incompetence, deficiency in the education of midwives and others. In the article, "Are nurses not trained?" by *The Swazi Observer* there is a public outcry on the bad attitude of nurses towards patients. ".....to my surprise this satanic behaviour is being done by the young nurses. How are they being trained? You have to think twice before taking your relative to hospital.....you will prefer witch doctors. They have better manners....."(Worried, *Swazi Observer*1999:8).

Research on "women's general satisfaction with antenatal care" has shown that women's dissatisfaction tends to be centred on long waiting times, impersonal care, poor communication and lack of continuity of caregiver (Reid & Garcia; as quoted by Clement, et al 1996: 121). In a study by Tshireletso (1997: 121) on "The experience of women regarding the care they received in maternity care-Botswana" the researcher concludes that women were left out of decisions that affected them. They are not given adequate information to familiarise themselves fully with the expectations and processes of childbirth. In a study by Dlamini (1996: 65) on "The association between management of labour and perinatal mortality in Swaziland" the researcher's findings reveal that the foetal heart rate was not recorded during the second stage of labour, this indicates a high possibility that it was not checked. The researcher further recommends that midwives' constant monitoring of the progress of labour and timely reporting of complications to the obstetrician could prevent some perinatal deaths.

Given that multifactoral issues affect the quality of clinical practice, the researcher has found necessary to examine the clinical education of midwives and explore the extent to which the clinical part of midwifery education produces competent midwives in Swaziland.

The significance of this research is to sensitise the nurse educators, qualified midwives, other health professionals and policy makers on the issues that pertain to the clinical part of midwifery education in a college of nursing in Swaziland. The study should communicate insights on the present state of midwifery clinical practice. It should present issues that are currently not being attended to by the nurse educators, qualified midwives, other health professionals and policy makers in their attempts to improve the delivery of midwifery services. The findings of the study should enhance formulation of strategies to facilitate improved clinical learning for midwifery students in Swaziland. The learning needs of student midwives in clinical settings are paramount and while they may vary, basic midwifery practice and the learning needs of student midwives remain the same.

The study is also needed to generate theory needed for future development of the nursing discipline.

1.2 BACKGROUND

Swaziland is one of the three former British High Commission protectorates (Botswana, Lesotho and Swaziland) of Southern Africa. The country attained its independence on 6 September, 1968. It was the last African former British colony to do so. The Republic of South Africa surrounds the country, except at the Eastern border which adjoins Mozambique. The area of the country is 17,364.4 square kilometres. Swaziland's residential population is 912,876 (Population and Housing Census, 1997: table1). The present population growth is estimated at 3.2% (Development plan, 1996: 49). This means that at the present rate the population of Swaziland will be more than a million by the year, 2000. As it has been noted above, the infant mortality rate is 98/1000 live births; maternal mortality rate is 229/100,000 births; perinatal mortality rate is 34.7/1000 live births and it appears to be growing since in 1986 it was 20.7/1000 live births (Safe Motherhood Initiative Audit, as quoted by UNICEF, 1998: 12-15). These figures show that there is a deficiency in the maternal health service provision in Swaziland and that there is a need for improvement.

The midwifery-education program is offered in two institutions in Swaziland. The nursing college understudy is situated in the Manzini region, which is central of the four geographical regions of the country. It is the most populated region with a residential population of 276,636 (Population and Housing Census, 1997: table1). The college offers both the General Nursing and Midwifery education programs. An average of thirty midwifery students enrol per year in the nursing college. This presents a low number of midwives who qualify per year in the country.

It is also a cause of concern regarding a 50% (RFM hospital records, 1998) increase in deliveries that occur in the hospitals and clinics in the country every year. This status quo presents a great challenge to the care that is provided by midwives in the country. It calls for a high level of competence for every practising midwife.

The midwifery-education program is offered at a diploma level, takes one year and is on a full-time basis. To qualify for registration into the program, the student should be a registered nurse who has served at least for one year in the health field. In addition, he/she should be a member of the Swaziland Nurses Association (SNA).

The program is designed such that each student should complete 383 hours of theory and 1120 hours clinically, to qualify as a registered midwife in the country and internationally. The midwifery students practice in the Raleigh Fitkin Memorial (RFM) hospital maternity units and in other certified health centres in Swaziland. It is among the major referral hospitals and conducts the highest number of deliveries in the country (7182 for the year 1998). This is according to the hospital records. The midwifery tutors and registered midwives in the respective maternity areas conduct clinical instruction and/or supervision of the students.

With such a high number of deliveries per year and a low number of midwives who qualify per year, a great challenge is posed unto the quality of midwives produced by the midwifery education institutions. It would be catastrophic for childbearing women, their families and the midwifery profession if the practitioners currently prepared cannot meet the challenge because they are ill equipped at the task. Swaziland requires highly competent midwives who will perform up to standard so that in the absence of the other factors that contribute to poor quality of midwifery, high quality of maternal-child services may be achieved.

1.3 STATEMENT OF THE PROBLEM

Observation and research prove that the quality of midwifery care is below standard in Swaziland. This has been attributed to a number of causes and the clinical education of midwives is one them. Quality of midwifery care among other things depends on the quality of clinical education of the midwifery student. This is to say that if the quality of midwifery education is at a low standard such that incompetent midwives are produced, then it follows that the quality of midwifery care rendered will decline. Therefore the researcher has found it necessary to explore the clinical part of midwifery education in a nursing college and ascertain the extent to which the clinical part of the midwifery education produces competent midwives in Swaziland. From this, recommendations will be made that will help in the formulation of strategies to improve the quality of midwifery education in the Nursing College.

1.4 RESEARCH QUESTION

The purpose of the study is to answer the question “To what extent has the clinical learning of midwifery students produced competent midwives in a nursing college in Swaziland?” The answer to this question will assist the researcher to come up with recommendations that will form the basis of developing strategies geared towards the improvement of clinical learning of midwifery students in Swaziland.

1.5 OBJECTIVES OF THE STUDY

The study strives to achieve the following objectives:

1. To explore the experiences of midwifery students with their clinical education in a nursing college in Swaziland.
2. To explore and describe the factors that impact either positively or negatively to the clinical learning of the midwifery students in the nursing college.
3. To outline recommendations that will assist in the formulation of strategies to facilitate clinical learning for midwifery students in Swaziland.

1.6 PARADIGM

The study is based on The Theory For Promotion of Health for the Department Of Nursing in the Rand Afrikaans University, 1999.

1.6.1 METATHEORETICAL ASSUMPTIONS

1.6.1.1 PERSON (MIDWIFERY STUDENT)

The midwifery student is seen holistically in interaction with the environment in an integrated manner.

1.6.1.2 MIDWIFERY

Midwifery is an interactive process which facilitates the promotion of health.

1.6.1.3 ENVIRONMENT (CLINICAL AREA)

The clinical area includes the internal (student's bodily, mind and spirit dimensions) and external environment (clinical area's physical, social and spiritual dimensions).

1.6.1.4 HEALTH (COMPETENCE)

Competence is an interactive dynamic process in the midwifery student's environment.

1.6.2 THEORETICAL ASSUMPTIONS

Theoretical assumptions of the paradigm are described under the four central components of the theory which are person, nursing/midwifery, environment and health.

1.6.2.1 PERSON

The whole person embodies dimensions of the body, mind and spirit.

The person functions in an integrated, interactive manner with the environment. In the study's context, the person is the midwifery student and the environment is the clinical area in which she practices his/her skills.

1.6.2.2 MIDWIFERY

This is an interactive process where the midwife as a sensitive therapeutic professional facilitates the promotion of health through the mobilisation of resources.

1.6.2.3 ENVIRONMENT

Environment includes an internal and external environment. The internal environment consists of bodily, mind and spiritual dimensions. The external environment consists of physical, social and spiritual dimensions. In the study context, the internal environment refers to the bodily, mind and spiritual dimensions of the midwifery student. The external environment is the clinical area in which she practices his/her midwifery skills. The clinical area has the physical component which is its infrastructure, the social and spiritual dimensions are those of the midwifery personnel who are in constant interaction with the midwifery student, in the clinical area.

1.6.2.4 HEALTH

Health is a dynamic interactive process in the patient's environment.

These interactions in the person's environment reflect the health status of the patient. The interaction contributes or interferes with the health status of the patient. In the study context, the interactions between the midwifery student and the clinical area will influence his/her competence as a qualified midwife, which will in turn influence the health status of the patient.

1.6.3 METHODOLOGICAL ASSUMPTIONS

The methodological assumptions reflect the researcher's views of the nature and structure of science in the discipline. These assumptions are stated in terms of the aim and methods of research and criteria for validity (Rand Afrikaans University, Department of nursing Paradigm, 1999: 10). The aim of the research is to explore and describe the experiences of midwifery students with their clinical learning in Swaziland. Methods of the research will be guided by the Model for Research in Nursing (Botes, 1998). Guba & Lincoln (1985: 289-331) criteria for determining trustworthiness in research will ensure validity and reliability.

1.7 OPERATIONAL DEFINITIONS

1.7.1 MIDWIFERY STUDENT

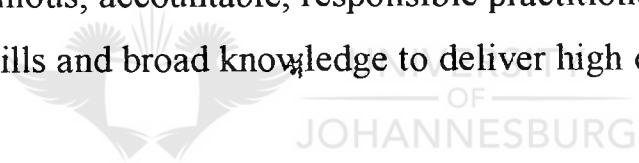
This will refer to a midwife who has graduated from the College of Nursing under study a year or two years ago (July 1997 & 1998).

1.7.2 CLINICAL LEARNING

Refers to the practical part of midwifery training which involves the exposure of the midwifery students to real situations in the maternity units, mobile clinics and home care of the patients.

1.7.3 COMPETENT

Refers to the autonomous, accountable, responsible practitioner who has both practical skills and broad knowledge to deliver high quality midwifery care.



1.8 RESEARCH DESIGN

The research design in the study is described as outlined in the Botes (1998) Model for Research in Nursing.

1.8.1 RESEARCH STRATEGY

The study's overall approach is explorative, descriptive, grounded and contextual. It is explorative in that up to now there is no information available which stipulates the factors that affect clinical learning among midwifery students in Swaziland. The researcher has to dig for this information from the participants and develop new hypotheses for testing in future. The researcher is breaking new ground here. According to Mouton (1996: 103) the aim of exploratory studies is to establish the "facts" to gather new data and to determine whether there are interesting patterns in the data. The study's approach is grounded because it is aimed at discovering problems that exist with clinical learning among midwifery students. Grounded theory research approach is useful in discovering what problems exist in a social scene and the processes persons use to handle them (Burns and Grove, 1997: 31). It is a descriptive study in that it will provide an accurate portrayal or account of the nature of the factors that affect clinical learning of the midwifery students. Descriptive research provides an accurate portrayal of characteristics of a particular individual, situation or group (Sellitz, et al; as quoted by Burns and Grove, 1997: 30). The study is contextual because the results will apply to the students in the College of Nursing under study.

1.8.2 METHODS AND TECHNIQUES FOR DATA GATHERING

Since the study is qualitative, data will be obtained by means of focus group interviews. The researcher will select groups of five midwives who completed their midwifery education at the College of nursing a year or two ago. The number of groups will be determined by data saturation. The researcher, as moderator in the discussion, will open the first session by asking the participants to describe the experience they had with their clinical learning as midwifery students. The interview sessions will take place in a conference room at the Raleigh Fitkin Memorial hospital, which is closer to the participant's work place and is free from distractions. The group discussion will be tape recorded while the researcher with the assistance of an independent recorder will be taking notes. Each session is expected to last for a minimum of one hour. Incentives such as snacks for refreshment will be provided for the group.

1.8.3 DATA ANALYSIS

Mostly in qualitative research, data analysis is done simultaneously with data collection. For this study, analysis will shortly follow data collection. Data will be analysed by utilising the eight steps provided by Tesch (1990); as quoted by (Creswell, 1994: 153-155). This procedure is used to reduce unstructured data, from interview transcriptions, into themes and categories for easier coding.

1.8.4 VALIDITY AND RELIABILITY

Internal validity of a study is important to convince the research consumers of the truthfulness and reality of the findings. External validity confirms the generalisability of the study findings. Reliability is useful in determining the accuracy of the study findings and advancing possibilities of replicating the study.

Guba and Lincoln's (1985: 289-331) quality criteria for "trustworthiness" will be followed in the study to ensure its validity and reliability.

1.8.5 TARGET POPULATION AND SAMPLING

The target population for the study will include all midwives who graduated a year or two ago from the College of nursing under study. Purposive sampling will be used to select five participants for each group.

Focus group interviews are conducted with the aim of obtaining specific information from clearly identified groups of individuals. To achieve this the researcher will make use of the purposive sampling method, where by information- rich participants with both depth and breath of experience and who share commonalties will be identified (Brotherson; as quoted by Devos, 1998: 317). Participants will therefore be purposefully selected according to criteria identified by the researcher.

Purposive sampling is the ideal method for the researcher because out of all the midwives who graduated a year or two ago, those that will be selected to constitute the focus groups will be selected basing on the researcher's judgement. This meant that they were selected according to the criteria set by the researcher and according to their accessibility. The participants will be recruited through physical contact, that is the researcher talking to them face-to-face or through the phone.

1.8.6 ETHICAL CONSIDERATIONS

“Ethical Standards for Nurse Researchers” by Geyer, 1998 (DENOSA) will be used to ensure that “Human rights” and responsibilities that should be employed in every research are adhered to in the study. Rights of the participants will be ensured through beneficence and prevention of harm. The study purpose, objectives and the whole research process will be explained to the participants before obtaining their consent to participate. Should a participant want to discontinue during the course of the research he/she will be free to do so. Confidentiality and anonymity will be ensured by providing privacy and not exposing the participant's names at any stage in the research. Informed consent from the Raleigh Fitkin Memorial hospital administration to use the conference room will be sought. Feedback on the outcome of the research will be made available to the participants by organising a short meeting with them and presenting the findings.

The quality of the research will be ensured in that the researcher being a Master's degree student is supervised through out the research process by a Professor who is not only the Head of the Midwifery Program in the Rand Afrikaans University but has vast experience in the field of research.

1.9 SUMMARY

This chapter mainly described the conceptualisation of the study. It discussed the grounds upon which the study has been undertaken; the setting and the significance of the study in Swaziland and to the nursing profession. The following are detailed in the chapter: Introduction; Background; Statement of the problem; Research question; Study objectives; Paradigm; Operational definitions and Research design.



CHAPTER 2

RESEARCH DESIGN (METHODOLOGY)

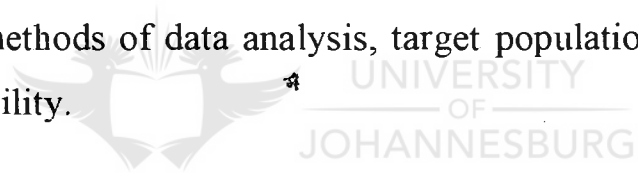
2.1 INTRODUCTION

This is the chapter, which describes the research design in detail. The set of guidelines and instructions to be followed in addressing the research problem will be outlined here.

The problem under study is the poor quality of midwifery care in Swaziland, which is due to a number of reasons of which one of them is the education of midwifery students clinically.

The purpose of the study is to answer the question: "To what extent has the clinical learning of midwifery students produced competent midwives in Swaziland?" The answer to this question will guide the researcher in outlining recommendations, which will form the basis of developing strategies to improve the education of midwives in the country.

The research design is the plan of how the researcher will execute the research problem. The main function of the research design is to enable the researcher to anticipate what the appropriate research decisions should be so as to maximise the validity of the eventual results (Mouton,1996: 107). The research design refers to the overall plan for obtaining answers to the research questions and for testing the research hypotheses. It spells out the strategies that the researcher adopts to develop information that is accurate, objective and interpretable (Polit and Hungler, 1993: 129). The research design is part of the research decisions which the researcher formulates to ensure that the research demands are met. According to Botes Model for Research in Nursing (1998: 9) research decisions, which are made in the design phase deal with the research strategy (overall approach), the methods of data collection, methods of data analysis, target population and methods of validity and reliability.



2.2 RESEARCH APPROACH

The study's overall approach is explorative, descriptive, grounded and contextual. It is explorative in that up to now there is no information available which describes the extent to which the clinical part of midwifery education has contributed in producing competent midwives in Swaziland.

The researcher has to dig for this information from the participants and develop new hypotheses for testing in future. The researcher is breaking new ground here. According to Mouton (1996: 103) the aim of exploratory studies is to establish the "facts" to gather new data and to determine whether there are interesting patterns in the data.

The study's approach is grounded because it is aimed at discovering factors that impact either positively or negatively with the clinical learning of midwifery students. It is a descriptive study in that it will provide an accurate portrayal of the experiences of midwifery students with their clinical learning. Descriptive research provides an accurate portrayal of characteristics of a particular individual, situation or group (Sellitz, et al; as quoted by Burns and Grove, 1997: 30).

The study is contextual in that the results will apply to the students of the College of nursing under study.

2.3 METHODS AND TECHNIQUES FOR DATA GATHERING

Data will be obtained by means of focus group interviews. A focus group interview is one of the methods that is used for data collection in a qualitative research. It is appropriate for this study since it is qualitative.

A focus group is a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment. It is conducted with approximately four to ten people. The purpose is to obtain information of a qualitative nature from a predetermined and limited number of people. Focus groups produce qualitative data that provide insights into the attitudes, perceptions and opinions of participants. (Krueger, 1994: 19).

A focus group interview enables the researcher to develop inductively (that is, from the bottom up rather than from the top down) concepts, generalisations and theories that are grounded in or reflect the intimate knowledge of the people participating in the focus group interview (Devos, et al 1998: 314). The focus group interview like any other qualitative data collection method will help the researcher gather information from the participants who know about the subject. From this data the researcher will move inductively, that is generalise to develop hypotheses.

A focus group interview is the ideal method of data collection for the study because the data that will be obtained will help towards answering the question which is, “To what extent has the clinical part of the midwifery education contributed in producing competent midwives in Swaziland?” The focus group interview will help the researcher gather information from the participants who know about the phenomenon under study. The group interview will enable the participants to share their perceptions and experiences among themselves without being restricted by a number of questions. The participants will be able to discuss the main subject in depth.

Focus group interviews generate data regarding people and consumers perceptions of phenomena, products and services. Focus groups generate qualitative data, that is words, categorisations and expressions that are used by participants themselves (Devos, et al 1998: 315).

The researcher further chose the focus group interview because she will be able to obtain as much information from different participants at the same time. It is also a cheaper method in terms of saving time than it will be in an individual interview whereby the researcher has to talk to one person at a time. The researcher opted for a focus group interview because it will offer a relaxed atmosphere for the participants. They will be able to discuss the phenomenon under study among them other than having to answer a question that may be asked by the researcher whereby the participant might not be relaxed enough when she/he is face-to-face with the researcher. Because of this the participant might yield little information. Krueger (1994: 34) points out that inhibitions are often relaxed in-group situations, and the more natural environment prompts increased candour by respondents.

After written permission from the hospital administration and verbal consent was obtained from the participants, data was collected on the 14th and 22nd June 1999. The reason for the dates to be a week apart is that the other group of participants was not available for the whole week since they were fully involved in the National Immunisation Program. The interview sessions took place in the Raleigh Fitkin Memorial hospital conference room. This setting is ideal because it was convenient for the participants since it is closer to the place of work and free from distraction. The participants were seated around a table on comfortable chairs. This kind of seating was to ensure eye contact of every member with another. This promoted intimacy among the participants and facilitated interaction within the group.

The researcher opened the discussion by introducing herself to the members and later let them introduce themselves to one another. This ensured the relaxation and comfort of the participants. To enhance rapport “tents” bearing their names were placed in front of each participant so that they got to know one another very quickly. The purpose and objectives of the study were described to the participants and what was expected of them. The researcher then explained the procedure of the discussion. In addition to this, the participants were made aware that the opinion of every individual is valued and that they need not reach consensus on the topic under discussion. Only one person was allowed to speak at a time. The participants were also made aware that there will be note taking and tape recording during the discussion. The researcher obtained the participant’s permission on this.

As a form of introduction the researcher asked the participants to mention an incident they will never forget which occurred in the clinical area while they were students. This was to help ease the atmosphere and get everybody in the group to say something. The researcher (moderator) proceeded with an opening question, “To what extent would you say the clinical part of your midwifery education has contributed in making you a competent midwife?” The agenda of the discussion was mainly to find out if the students were able to link the theory part of their education with the clinical part. This was to include discussing availability of material and human resources in the clinical area; the quality of supervision, clinical instruction, role modelling and mentoring. Other questions asked were “What do you think were the shortcomings (if any) of the midwifery education clinically?” “What improvements or alterations do you think can be made to enhance the quality of clinical learning?”

Throughout the discussion the researcher was moderating, and with the aid of an independent recorder the researcher was listening, observing and taking notes. A tape recorder was also used to ensure that the researcher did not miss the important points discussed. Probing techniques were used to ensure clarity of points discussed. Languages used in the discussions were both English and Siswati (vernacular).

The first group session lasted for one hour and thirty minutes while the second group session took two hours. Incentives in a form of snacks were provided as refreshments after the discussion.

At the end of a session, the summary of the main points of view was made to pull together the group interview and verify the information with the participants and find out if there is anything that has been left out. The researcher then discussed a date when the group will meet again and share the research findings. The group was then thanked for their participation and the session was closed.

2.4 POPULATION AND SAMPLE

The target population for the study included all midwives who graduated a year or two ago from the nursing college under study. Purposive sampling was used to select five participants for each group. The researcher decided on five participants per group. This number was decided upon because it would render the group discussion quite effective as it was ideal for a focus group interview. The researcher decided on including all midwives who graduated a year or two ago as the target population for the following reasons:

- ❖ The students who are still undergoing training could not be part of the study because they were still in the process, their experience was limited as compared to those who have already finished their training.
- ❖ The midwives who had graduated more than two years ago could not form the population of the study because the researcher felt that they have been in the practice area for too long such that their experiences as midwifery students will be clouded by the experience they have acquired in the field of practice. Their responses are likely to be inaccurate for the study.

Purposive sampling was the ideal method for the researcher because out of all the midwives who graduated a year or two ago, those that were selected to constitute the focus groups were selected based on the researcher's criteria and judgement. According to Brotherson; as quoted by Devos, et al (1998: 317) focus group interviews are conducted with the aim of obtaining specific information from clearly identified groups of individuals. To achieve this the researcher will make use of the purposive sampling method, whereby information rich participants with both depth and breadth of experience and who share commonalties will be identified.

The participants were recruited through physical contact, that is the researcher talked to them face-to-face and obtained their informed consent verbally. Two groups of five participants each were interviewed on different occasions. There was not a third focus group because of data saturation. The second group confirmed most of what the first group said.

2.5 DATA ANALYSIS

Mostly in qualitative research data analysis is done simultaneously with data collection. It may also be done separately. For this study data analysis occurred shortly after data collection. Since the languages used during data collection were English and Siswati (vernacular), the tape-recorded data was transcribed and translated from Siswati to English with the assistance of a Bachelor of Science graduate who has a knowledge of the Siswati and English languages.

Data was analysed by utilising the eight steps provided by Tesch (1990); as quoted by Creswell (1994:153-155). This procedure is used to reduce unstructured data, from interview transcriptions into themes and categories for easier coding. The eight steps that the researcher used are the following:

- ❖ Get a sense of the whole by reading through the transcriptions and jotting down some ideas as they come into mind.
- ❖ Pick one document, the most interesting and the shortest. Go through it and think about its underlying meaning. Write thoughts on the margin. Do likewise with the rest.
- ❖ Make a list of all the topics. Cluster together similar topics. Form these topics into columns that may be arrayed as major topics, unique topics or leftovers.
- ❖ Take the list and go back to the data. Give the topics codes. See whether new categories and codes emerge.
- ❖ Find the most descriptive wording for the topics and turn them into categories. Group the topics that relate to each other. By so doing the total list of categories will be reduced.
- ❖ Make a final decision on the abbreviation for each category and alphabetise these codes.
- ❖ Assemble the data material belonging to each category in one place and perform a preliminary analysis.



- ❖ If necessary, existing data will be re-coded.

In addition to the above steps the principles of data collection and analysis were utilised to analyse the data. These are: Data reduction, organisation, systemising, categorising, interpreting, consensus and recording (Botes, 1998: class notes).

2.6 VALIDITY AND RELIABILITY (TRUSTWORTHINESS)

2.6.1 CREDIBILITY

This is the criterion that is used to measure the truth value and reality of the study findings. The researcher ensured credibility through the following:

- ❖ Prolonged engagement and persistent observation. The researcher has practised in the study setting for years, that is since she was a student until now when she is employed there.
- ❖ Triangulation. This was ensured during data collection. There was note taking and tape recording during the discussion. The researcher also hired a private recorder to help with taking notes and data interpretation.
- ❖ Referential adequacy. The researcher handed in the raw data so that analysis and interpretations could be tested for adequacy by the research supervisor.

❖ Member checking. This was ensured by making a summary at the end of each focus group discussion and finding out if the points written down were as the participants have said them. Member checking was also achieved by presenting the transcribed data to some of the participants to go over and verify it. Tape recording also helped in member checking because the researcher could always use the recorded material and go back to the participant. The researcher also ensured that there was more than one discussion group used. The number of groups was determined by data saturation.

❖ Keeping a reflexive journal.

2.6.2 TRANSFERABILITY

Transferability of the study is used in qualitative research to determine the external validity of a study. Applicability is the criterion used. The researcher will present sufficient descriptive data for the person who wants to apply the study findings in other situations. It is the responsibility of the person who wants to transfer to ensure whether the study is applicable.

2.6.3 DEPENDABILITY

Dependability of the study findings will be measured by credibility of the findings. If the study is credible then it must be surely dependable.

2.6.4 CONFIRMABILITY

This criteria is used to ensure the study's objectivity. The audit trail will be used to ensure confirmability. Triangulation and keeping of a reflexive journal will also be used to ensure confirmability.

2.7 PILOT STUDY

A pilot study is conducted to ensure the validity of the data collection method and instrument; population and sampling method.

Before actual data collection and analysis took place a pilot study was conducted on five midwives. One question had to be deleted because they failed to answer it in the context of the study. The question was, “What did you like or hated the most with your midwifery education?”

2.8 ETHICAL CONSIDERATIONS

“Ethical Standards for Nurse Researchers” by Geyer (1998); as quoted by (DENOSA: 1998) were used to ensure that “Human rights” and responsibilities that should be employed in every research are adhered to in the study. Rights of participants were ensured through beneficence and prevention of harm. The study purpose, objectives and the whole research process was explained to the participants before obtaining their consent to participate. Providing privacy and not exposing the participants’ names at any stage of the research ensured confidentiality and anonymity. Informed consent from the Raleigh Fitkin Memorial hospital administration was obtained to use their employees and the premises for the study. Feedback on the outcome of the research will be made available to the participants by organising a short meeting with them to present the findings. The hospital administration will also be given a copy of the dissertation.

The quality of the research is ensured in that the researcher is a M. Cur. student who is supervised throughout the research process by a Professor who is not only the Head of the Midwifery Program in the Rand Afrikaans University, but is highly qualified in midwifery and nursing and has vast experience in the field of research.

2.9 SUMMARY

This chapter has focused in depth on the research design (methodology). It has discussed the guidelines and instructions that have been executed in addressing the research problem in order to achieve the goal of the research study. The research design (methodology) has included the research approach, methods and techniques for data gathering, population and sampling, data analysis, pilot study, validity and reliability (trustworthiness); and ethical considerations.

CHAPTER 3

DATA ANALYSIS

3.1 INTRODUCTION

This chapter describes the data analysis of the study.

Data analysis has followed an inductive approach in which the patterns, themes and categories of the analysis emerged from the data rather than being decided prior to data collection and analysis. The eight steps provided by Tesch (1990) as quoted by Creswell (1994:153-155) along with the principles of data collection and analysis were used to analyse data in the study. The above eight steps are discussed at length in chapter 2 of the study. Validity and reliability of the analysis was obtained by asking experienced researchers to review the unmarked transcripts and verify categories. Member checking was achieved by presenting the transcribed data to some of the participants to go over and verify the data.

By exploration of the experiences of clinical learning and discovering factors that impact either positively or negatively on the clinical learning of the students the researcher was able to answer the main question of the study which is, “To what extent has the clinical part of the midwifery education contributed in producing competent midwives at a college of nursing in Swaziland?” The factors that impacted positively will enhance clinical learning thus increasing the students’ clinical competency level by the time they graduate. The factors that impacted negatively will be constraints and impede the students’ clinical learning thus threatening their competency by the time they graduate. In the absence of negative factors the conclusion will be that the clinical part of midwifery education has contributed to a very great extent in producing competent midwives in the college of nursing.

3.2 FINDINGS

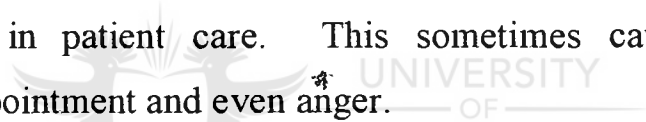
During data collection and analysis nine (9) themes were identified.

3.2.1 Theory and practice articulation

The theory and practice gap was commonly verbalised. The participants revealed that in most cases the situation in the clinical area was different from what they have learnt in the classroom. One of the participants said, “by the time you finished midwifery education theoretically you are competent but clinically you are still not sure.” (p3) Another one said, “the delivery pack in the ward was not the same as the one we had learnt about in class.” (p6) “We were thoroughly fed with the theoretical part than the clinical” (p7)

Chun-Heung and French (1997: 458) in their study revealed that the practice experience was not integrated with the theoretical content presented in the school blocks of study. What has been learnt in the school was different from what was being practised in the wards.

According to Nolan (1998: 623) clinical experiences require difficult adjustment for students as they move from an environment which requires *thinking* to an environment which encourages *doing*. If the area is not supportive of student learning, not only will desired learning be reduced, even if opportunities are there, but there will also be decreased application of skills learnt. Nolan further revealed in her study that the students were constantly moving between reality of practice and the ideal of university as they participated in patient care. This sometimes caused confusion, uncertainty, disappointment and even anger.



3.2.2 Value of clinical experience and responsibility

The participants revealed that the students do not value the clinical experience. They pointed out that the students these days do not want to go to the clinical area. They have lost interest in going to the clinical area. "It is as if someone pushes the student to come to the clinical area. He/she does not see why he/she is there" (p10) Another participant said, "students do not want to go to the clinical area." (p10) The participants also revealed the lack of responsibility among students themselves when they are assigned in the clinical area. "There is lack of responsibility among students" (p9) "At times a student will come and say, *I want to go to the salon*, during working hours" "We really do not know what to do, you ask yourself that who is supposed to instil the responsibility?" (p9)

Jowett et al (1994) as quoted by Way (1998: 702) identified that the brevity of placements in the clinical area was a major problem for students. They (placements) were not valued by the student even when they offered a breadth of experience.

3.2.3 Students as a workforce

The participants pointed out that the students felt that they were being used as a workforce in the clinical area. They felt they were used to cover up for the shortage that is in the wards. They also felt that instead of acquiring skills to make them competent midwives by the time they qualified, they were working as if they were employed. “We have an attitude that we are a workforce.” (p8) Another participant said, “the clinical staff will say, *do it because you are still young and fresh.*” (p2)

Chamberlain (1997: 87) in her study discovered that the need to use students for service because of staff shortages was a fact frequently referred to by many of the midwives and was usually the reason given for not providing adequate teaching. The author discovered that for some midwives, the most important challenge was to orient students to ward routines, so they could be more efficient in the provision of service. The emphasis in such situations was on the service needs of the ward rather than on the educational objectives.

Dunn & Hansford (1997: 1300) found that the clinical nurse in-charge regards the nursing student as a worker rather than as a learner.

Dunn, et al (1995: 19) revealed in their study that the clinical nursing staff often set the students on an unproductive round of menial tasks for the shift due to the staff seeing students as labourers.

3.2.4 Support from clinical staff

During the interview it came out that some of the staff had a positive attitude and were very supportive of the student's clinical learning. They were good role models and afforded adequate supervision as far as the students were concerned. "The midwife was supportive in my learning." (p1) "The clinical staff would welcome us, they are okay" (p7) "They really try their best" (p8). The participants also revealed the staff in the clinical area displayed good role modelling that. "---You learn a lot from them" (p8).

On the other hand the participants revealed lack of support from the clinical staff. A number of times poor attitude and lack of supervision was verbalised during the interview. "They start developing an attitude--- they end up saying, *where are your tutors?*"³ We were neglected, no one oriented us, there was no welcome and we felt lost" (p1). "You find yourselves (students) helping each other" (p3). "The ward sister ends up forgetting about the student" (p8). "One time I had to deliver a still birth due to such negligence" (p8). The participants also cited poor role modelling in some areas. "Some of the clinical staff were not competent with some of the procedures" (p3). "At one of the community health centres sometimes you will be left with a very old midwife and being a student you will feel a lot better than her in your performance" (p6).

Sawatzky (1998: 111) in her study on *understanding nursing students' stress* pointed out that the reason why most students left the education program was related to the negative attitude of the nursing staff toward the learners.

Chamberlain (1997: 87) in her study revealed that lack of supervision was a common problem during the students' course. Most students were supervised in the early months of their program but the amount of supervision and intensity varied with the clinical area and midwife. The question of supervised teaching for extended periods left many students feeling uncertain about their skills once they qualified.

Polifroni, et al (1995); as quoted by Nolan (1998: 624) in their study found that 75% of student time was unsupervised.

Nolan (1998: 625) pointed out that feelings of inadequacy (on the student's side) have much to do with the attitude and practices of staff. One student revealed that it is not the hospital or the patients, it is usually the staff that makes your placement good or bad.

3.2.5 Clinical staff overworked/shortage

The participants felt that the clinical staff could not provide enough instruction and supervision to the students because they were short-staffed, thus they end up not coping with the extra duty laid upon them of helping the student to learn the clinical skills. “Ward sisters are limited in number, they cannot manage students together with the workload---they cannot cope” (p8). “Even those who want to assist you are busy” (p3).

Chamberlain (1997: 87) in her study pointed out that the constraints of insufficient staff usually meant that the needs of the students were ignored.

Jarrat (1983); as quoted by Dunn & Hansford (1997: 1299) referred to issues that have created recurrent problems for nursing students including---areas of high workload in which students are resented as learners when workers are needed.

In a study by Dunn and Hansford (1997: 1300) it was found that the clinical nurse in-charge was too busy with more important matters to be able to spend time with the students.

Schott (1995: 5) stated that from the midwife’s point of view, a medical student/midwifery student, even one who is enthusiastic, can be just one more pressure in an environment where there are already multiple demands competing for her attention. It is hard to be *with the woman* and at the same time focus on teaching a medical/midwifery student.

3.2.6 Support from faculty

Participants verbalised the deficiency of support from the faculty with their clinical learning. They mostly cited that the faculty will not be available to instruct and supervise them. This they said affected them a great deal; they ended up not knowing exactly what to do. They revealed that the tutors will demonstrate some procedures while others will not be demonstrated until they had to go and do them on their own in the clinical area. “The procedure was not well demonstrated while you were in class” (p3). “Tutors will not be available----you find yourself not knowing whom to turn to” (p3). “You go to the next tutor she would say, I am not responsible for you” (p5). “The tutors will not be there-----it became very frustrating” (p3, p5). “During the beginning of the year the tutors will be available and demonstrate the procedures to us” (p6).

Chamberlain in her study revealed that it has been noted that the midwifery teachers were finding it more difficult to spend time in clinical settings owing to increased administration tasks. One of the participants in the study said, “Tutors will not be available not because they were not doing anything but they were also busy with other college duties” (p3).

Research has concluded that few nurse teachers adopt a hands on approach. In the main most nurse teachers see their role as a *link teacher*, visiting, supporting and liaising with students and placement staff (Jones, 1987; as quoted by Newton & Smith, 1998: 497).

3.2.7 Faculty-staff-students relations

The participants revealed that there were poor relationships among faculty and the clinical staff resulting in the clinical staff refusing to supervise and instruct the students. "Tutors did not believe in the clinical staff--- they will say the ward staff is teaching us short-cuts" (p3, p7). "The clinical staff will start saying, *where are your tutors since they know better than we do?*" (p3, p7). "The tutor will turn to blame the ward staff---the ward staff would turn to develop an attitude toward us" (p7). It was also discovered that the students come with a poor attitude in the clinical area. Once the sister in the ward notices this attitude he/she resents the student and decides not to give him/her the clinical support the student requires. One participant said, "the students' attitude is so poor---they look up to midwives as people they can manipulate" (p1, p10). "The attitudes come both ways, that is from student -to-ward sister and vice versa" (p8). "The problem at times would arise from us students, we come with a certain attitude" (p8).

Fretwell (1980) as quoted by Dunn & Hansford (1997: 1302) noted that poor staff relationships and a lack of staff commitment to teaching presented a major constraint to student learning.

Jarratt (1983) as quoted by Dunn & Hansford (1997: 1300) stated that the students often found themselves losers in the *faculty-staff-student* triad on nursing units. She asserted that maintenance of a good working relationship between unit staff and faculty was crucial to the development of a good clinical learning environment.

Dunn, et al (1995: 20) asserted that the lack of a well-established relationship with the clinical staff was a major hindrance in the students' attainment of the learning goals.

3.2.8 Clinical placement

The participants felt that most of the clinical areas where they were assigned for their clinical learning were not up to standard. This was mainly a result of lack of equipment. One participant said, "You see a complete delivery pack in class and next meet it in the exams" (p2, p9). "I remember when we were doing home visits, ---there was no transport" (p5). The participants also revealed clinical placements, which were very supportive to their learning. "The best clinical area was Family Life Association of Swaziland, the environment is very conducive for learning---you come out of there feeling a competent midwife" (p2). "That is the part (home case management) we enjoyed the most---that was where you could say, *yes I am a midwife, I have control*" (p4).

Snadden & Yaphe (1996); as quoted by Nolan & Man Cheung Chung (1999: 123) found that students especially valued placements where they were made welcome and supported were allowed some freedom for experimentation under supervision.

Nolan (1998: 623-624) revealed in her study that due to financial constraints on health care the staff becomes frustrated and despondent with their lack of resources, leaving them with little energy to deal effectively with students.

Ademan (1989); as quoted by Nolan (1998: 624) questions the effectiveness of today's clinical settings claiming that they fail to provide students with positive examples of behaviours they are learning.

2.9 Case book

Some participants voiced that the casebook is not helpful in their clinical learning. They complained that it is not well explained to them and they do not understand its importance in their clinical learning, all they know is that they have to fill in a certain number of cases and submit it at the end of their education. "You end up copying from previous students' case book for the sake of submitting it" (p4). "Once we (students) are through with the number of cases we want we stop going to the clinical area" (p8).

Chamberlain (1997: 89) revealed in her study that it was quite common for students to refer to the number of times they had practised skills as if this automatically conferred an expertise on them----some midwives would ask at a first meeting students how many times certain skills have been signed off in their book. Once past the number of cases the midwife would make an assumption that the students were competent to continue on their own.

Scott (1995: 5) stated that some students regarded obstetrics as merely another speciality to be completed and another set of criteria to be met, and expect to walk in at the end of second stage, catch the baby and then leave.

3.3 SUMMARY

This chapter has fully discussed the data analysis. It has presented the findings and the existing literature to which the findings are linked. From the findings emanate the factors that enhance clinical learning of midwifery students and those that inhibit it. From the findings and the literature it is apparent that there are problems with clinical learning of the midwifery students world-wide even though there is limited or no research in the area that has been done so far in the Southern African Region.



CHAPTER 4

DISCUSSION OF FINDINGS

4.1 INTRODUCTION

This chapter entails the discussion of findings.

Clinical learning involves an interactive network of forces influencing the student's outcomes in the clinical setting. Clinical education is a major component of the curriculum. In order to practice safe midwifery care, new graduates must have developed not only the theoretical knowledge on which to base their care, but the practical application of skills required to implement that knowledge.

Clinical education prepares the students for their professional role, provides them with the opportunity to apply knowledge, skills and concepts introduced in the classroom. It is generally accepted as the arena in which synthesis of classroom, laboratory, and other learning experiences occur. (Dunn, et al 1995: 16).

According to Napthine (1996); as quoted by Nolan (1998: 623) the quality of nursing/midwifery education is dependent on the quality of a student's clinical experience. The clinical placement experience is central to the development of nursing/midwifery practice skills. This is where students integrate knowledge from the rest of their program. The acquisition of these skills subsequently facilitates a smooth transition of new graduates into the workforce.

4.2 DISCUSSION

According to the findings of the study it is evident that the clinical part of midwifery education in the college of nursing is not without problems. These are not just problems but are those obstacles or barriers that interfere with the student's desired learning and eventually threaten their (students') competency in the clinical area when they qualify as midwives. The participants supported this upon responding to the question that, "when you finish your midwifery education were you in a position that you could handle any midwifery situation you encountered?" The response was, "not exactly." When asked the main question that, "To what extent would you say the clinical part of midwifery education has contributed in making you a competent midwife?" The response was, "to a lesser extent" (p1, p7).

From the findings it is apparent that the midwife who graduates at the college of nursing under study is not as clinically competent as he/she is supposed to be. The reason being that the clinical learning environment is not quite ready for the students since there are more factors which impact negatively to the learning of the student in the clinical area. These are discussed below.

4.2.1 Difficulty in theory and practice articulation

From the findings it is evident that there is difficulty in the transference of the theoretical content of midwifery to the practical skills required. The students cannot link what they have learnt in the classroom with what they are supposed to do in the clinical area. This is due to lack of equipment, poor supervision, poor mentoring and poor role modelling. As a result of this the student ends up confused and overcome by anxiety which impedes the clinical learning. By the time the student qualifies he/she is not fully skilled to function as a competent midwife. Anxiety because of inadequate instruction and supervision and poor communication interferes with the learning and the students feel ill prepared to function as midwives.

Chamberlain (1997: 85) pointed out that clinical midwives need to be educated to facilitate the transfer of theoretical learning into clinical practice.

4.2.2 Lack of value and responsibility of clinical learning

The midwifery students do not value their midwifery experience and also lack responsibility towards their clinical experience. Students' lack of responsibility can be linked to students not valuing their clinical learning. Lack of responsibility and commitment may emanate from lack of value. Value and responsibility are part of the internal environment. If a student lacks these for his/her clinical experience, learning will be difficult even if he/she can be placed in a conducive clinical environment. Hence the saying that, "You can take horse to the river but you cannot make him drink." Responsibility is one of the characteristics of professionalism, which without it a midwife cannot function competently. In the absence of responsibility there is lack of accountability and the midwife cannot function autonomously.



4.2.3 Students as a workforce

The students strongly felt that they were used as a workforce in the clinical area. This impeded their learning because instead of the clinical staff giving them support for their clinical learning, they were looking up to them as one of them. Once the student adapts to the routine of the ward, it would be enough for the sister in-charge. The student will be left on his/her own without supervision until he/she finishes the clinical experience in that particular area.

However other researchers have a different view on this. Dunn & Hansford (1997: 1305) felt that students need to be valued and included as members of the ward team. The nurse manager was perceived as vital in the acceptance of the student as learner and patient care provider.

By valuing and giving the students the opportunity to demonstrate their ability to function as nurses, the staff displays acceptance of the students (Streubert, 1994; as quoted by Nolan, 1998: 625-626). This in-turn develops the student's self-confidence, which encourages further participation and skill development. It may be concluded from this that in as much as the students feel they are used as a workforce it may to a larger extent be to their advantage.

4.2.4 Lack of support from clinical staff

There is lack of supervision and poor role modelling in the clinical area where the midwifery students practice. This is often due to the poor attitude of the staff towards the student, lack of equipment and shortage. Most of the time the student will be left alone. They (students) felt neglected. This became an obstacle to their clinical learning. The importance of good clinical supervision for student nurses/student midwives is also essential in order to create competent practitioners (UKCC, 1986; as quoted by Newton & Smith, 1998: 497).

It is imperative that midwives know how to facilitate effective learning and provide learning opportunities, which will enable students to become independently functioning midwives. While students have control over what they want to learn they have limited control over access to opportunities for learning. A major aspect of the role of clinical midwives is to ensure that the students are provided with access to appropriate learning opportunities when and where they are needed. It is critical that midwives help students to become effective midwives because insufficient or inappropriate clinical education and role modelling could lead to an erosion of the midwifery role.

4.2.5 Clinical staff shortage/overworked

Clinical staff shortage, which eventually led to being overworked, came out from the findings. This is a factor, which impacts negatively to the clinical learning of the students. The students find themselves competing with the staff workload for the attention they require from the midwives on duty. Due to being overworked the midwives tend to loose temper, they fail to supervise the students and instruct them. The student becomes an extra burden to the midwives/staff.

4.2.6 Lack of faculty support

There is sometimes lack of faculty support experienced by the midwifery students while they are in the clinical area or preparing for their clinical experience. Some of the procedures are not demonstrated to them in class. At times there would not be return demonstrations. The tutors most of the time are not available for clinical instruction and supervision. This results in the student failing to learn due to loss of confidence and anxiety.

In studies with non-health students, Schon (1988); as quoted by Chamberlain (1997: 90) noted that when students are placed in a situation of carrying out a task without the appropriate knowledge, feelings of loss are experienced--- --with feelings of loss come feelings of decreased competence and confidence and increased anxiety, vulnerability and stress. Such feelings are likely to continue beyond the student phase of education and colour the new midwife's approach to midwifery care.

Although the midwifery teachers were rarely in evidence, both the service side and the students expected to receive more input from them than was forthcoming.

Chamberlain (1997: 90) revealed that students and midwives perceived a more active role for the midwifery teachers to ensure some continuity of teaching for the students in the clinical area where midwives were too busy to provide it. According to Sobol (1978); as quoted by Sawatzky (1998: 112) it is difficult for students to develop autonomy, self-realisation and self-direction when faculty does not encourage it. This came out even in this study. One of the participants said, “those procedures which I did with my tutor supervising me I felt very competent with them” (P7).

4.2.7 Poor faculty-staff-students relations

There are poor faculty-staff-students relationships. There is a breakdown in communication most of the time. This results in the faculty blaming the clinical staff for the students' poor performance and the staff blaming the faculty and the student. The student blames both the staff and faculty. With all this emanates poor attitudes and the clinical learning of the student suffers. At the end nobody takes responsibility for the student's clinical learning. All this creates an unpleasant learning environment, which results in the student failing to achieve their learning goals.

Dunn, et al (1995: 20) state that of major concern in all format groups is the development of a rapport or productive relationship with the clinical nurse and clinical facilitator. Newton & Smith (1998: 496) recognised that effective communication, good interpersonal relationships and teamwork are necessary factors in the creation of an environment conducive for learning. Riseborough (1994); as quoted by Newton & Smith (1998: 498) observed that good interpersonal relationships between students and teachers result in increased motivation and confidence of the students. Therefore faculty, midwives and students need to work collaboratively toward the learning of the student in the clinical area.

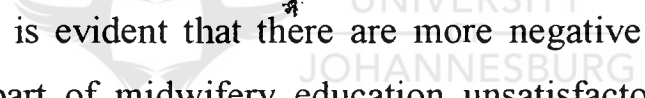
4.2.8 Inefficient clinical placement

Some of the areas where the students were assigned (allocated) for their clinical learning were unproductive. This was mainly a result of limited resources, both human and material. There is shortage of staff and equipment. They end up improvising. This resulted in the students lacking competency to function in well-equipped environments. They also end up having difficulties during the examinations. For an example, during the examination they will be required to set up a complete delivery pack, which they are not used to seeing in the clinical area.

Greenwood (1993); as quoted by Nolan (1998: 624) states that students can become desensitised to human needs after repeated exposure to poor nursing practice in the clinical environments. This means that they become incompetent in their delivery of midwifery care.

4.2.9 Case book inefficiency

The casebook appears to be of less gain in the students' clinical learning. Most of the time the students together with the clinical staff base the student's experience and competence on filling the book with the number of required cases for each midwifery procedure. That is why once the book is filled with the required number of cases the student stops coming to the clinical area or starts acting irresponsibly. The midwife also leaves this student and puts his/her attention on students who still have to fill in their books. With this the student does not learn the skill he/she just goes through it. This is why others will even copy from past students' casebooks for the sake of submission.



From the findings it is evident that there are more negative factors which render the clinical part of midwifery education unsatisfactory to produce competent midwives in the college of nursing.

A supportive learning environment is of paramount importance in securing the required teaching and learning process. Therefore nurse educators, clinical venues, midwives and all others participating in the midwifery student's clinical education must collaborate to create a clinical learning environment which promotes the development of well educated, competent midwives capable of providing safe-cost-effective patient care.

4.3 SUMMARY

This chapter has dealt with the discussion of findings. From the findings the research question has been answered and the purpose of the research has been achieved. It is apparent that the presence of negative factors outlined in the chapter impedes the clinical education of the midwifery students. This eventually leads to incompetence in practice after the student has graduated. Recommendations to assist in formulation of strategies to alleviate the situation follow in the next chapter.



CHAPTER 5

RECOMMENDATIONS AND LIMITATIONS

5.1 INTRODUCTION

This chapter discusses the recommendations and limitations of the study.

From the discussion of findings the researcher has come up with the following recommendations from which strategies to improve clinical education in the college of nursing can be formulated. This will ensure that competent midwives are produced at the end of the midwifery education program. This will in-turn uplift the standard of midwifery care in Swaziland.

5.2 RECOMMENDATIONS

- ❖ A good rapport should be developed and maintained between faculty, midwives and students so that they work collaboratively toward the learning of the student.
- ❖ Faculty should always be available for the supervision and clinical instruction of the students to ensure integration of the theoretical component with the clinical component. If faculty cannot be available clinical instructors should be employed.

- ❖ Clinical staff (midwives, obstetricians and paediatricians) should devote themselves into supporting students with their clinical learning. In-service education and other forms of continued education must be accessible for the clinical staff to enable them to take a clinical teaching role as well as maintain competency in clinical nursing practice.
- ❖ Students should learn to value and be responsible for their clinical learning. Those supporting the student should make every effort to promote student's motivation for clinical learning so that they can learn to be responsible and committed.
- ❖ The casebook requires a review. It should come out clearly how it benefits the student in his/her clinical learning so that a consensus may be reached whether it should still be part of the curriculum of midwifery clinical learning.
- ❖ The hospital administration where the student midwives do their practice together with the midwifery faculty should ensure the hospital is well equipped for creating a desirable clinical learning environment for the midwifery students. This includes both material resources and manpower.

5.3 LIMITATIONS OF THE STUDY

- ❖ The study only focused on Midwifery education in the college of nursing. Due to financial constraints, it could not cover the other midwifery education institution in Swaziland. This therefore means that the study findings are contextual, they cannot be generalised to the education of midwives in the whole of Swaziland.
- ❖ The study only focused on the clinical part of midwifery education, in future other studies may be done which will focus on both the theoretical and clinical part of the midwifery education program in depth.
- ❖ The study focused only on the clinical experiences of midwifery students. Other studies may be done which will focus on the experiences of the clinical staff and/or midwifery tutors.

5.4 SUMMARY

The study aimed at answering the research question, which is “To what extent has the clinical part of midwifery education produced competent midwives in a nursing college in Swaziland?” To answer this question the researcher had to explore and describe the clinical experiences of the midwifery students and come up with the positive or negative factors that impact on the students’ clinical education. The negative factors were revealed, which prompted the presentation of recommendations that will direct the formulation of strategies to improve the clinical education of the midwifery students in Swaziland. With improved clinical education of midwifery students, highly competent midwives will be produced and the quality of midwifery care in Swaziland will improve.



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ADDENDUM 1

M- Moderator.

P-Participant.

FIRST FOCUS GROUP INTERVIEW

M- QUESTION: Mention an incident that occurred in the clinical area while you were a midwifery student that you will never forget.

P- ANSWER: When we arrived at Mkhuzweni (health center) we were neglected, no one oriented us, there was no welcome, and we felt lost.

P- We were not told what to do; we wanted to come back.

P- Still at Mkhuzweni, I was supposed to suture the perineum. I had not come across such an extensive tear. The midwife I was with was supportive in my learning, which was a good experience for me.

M- QUESTION: To what extent has the clinical part of the midwifery training in making you a competent midwife?

P(all)- ANSWER: To some extent. We faced some problems.

M- QUESTION: What sort of problems?

P- ANSWER: Sometimes it will depend on your attitude as a student and that of the clinical staff. People differ; one will be willing to assist you the other won't be. At times they will ask you "Where are your tutors?" "Go and find out from your tutors" is the response you will get from the doctors.

P- They sort of expected us to know everything.

M- QUESTION: So they expected you to know everything?

P(all)-ANSWER: Yes everything.

M- QUESTION: Would you find the situation in the clinical area the same as you have been taught at the college?

P- ANSWER: No!(all participants). Most of the time the problem will be with the equipment.

P- At times you are not even sure of the procedure itself, you find the tutor blaming you as if she demonstrated the procedure well.

P- Some things you will come across them during the exams for the first time.

P- The best clinical area was FLAS (Family Life Association of Swaziland). The environment is very conducive for learning. It is clean and you are well oriented. You come out of there a competent midwife. Even the way they do the procedures it was excellent.

M- QUESTION: Is this the same experience you all had?

P- ANSWER: Yes (all participants). Even the sterilization of the instruments was properly done as compared to the one in our labor ward where you could come in without HIV and come out with it. (Laughter)

M- QUESTION: So there was a problem of equipment?

P(all)- ANSWER: Yes.

M- QUESTION: So it was not that the clinical staff was not role modeling the right way, the problem was with the equipment?

P(all)- ANSWER: Exactly.

M- QUESTION: Did you feel that your clinical instructors and supervisors were qualified enough, were you happy about the supervision?

P- ANSWER: Some of them think that when you come in the clinical area you know everything.

P- There was also this attitude that “do it because you are still young and fresh”

P- This is the person you are looking up to assist you. We felt we were overworked.

M- QUESTION: During the whole time were you gaining any experience?

P- ANSWER: Not enough. The problem was with equipment. We were not competent with using some of the instruments and other equipment. Almost all trays for procedures will be incomplete, even just a simple TPR tray.

P- The other problem was that the procedure itself was not well demonstrated while you were in class.

M- QUESTION: What about the clinical instruction?

P- ANSWER: Not always. The tutors will not be there. The tutors did not believe in the clinical staff. They will say that the ward staff is teaching short cuts. The clinical staff will then develop a bad attitude and start saying: where are your tutors to teach you since they know better than we do.

P- Even those who want to assist you are busy, you find yourselves helping each other as students.

P- You will be left alone and the one who is supposed to be instructing you will say, " proceed, I will see you when you have finished". You become stuck.

P- By the time you finished midwifery training, theoretically you are competent but clinically you are still not sure of how to deal with other midwifery situations.

P- Some of the clinical staff were not competent with some of the procedures.

M- QUESTION: What else can you say?

P- ANSWER: Tutors will not be available, not that they were not doing anything but they are also busy with some other things. You find yourself not knowing whom to turn to.

P- Or maybe it is because there is a shortage of tutors, because in my opinion if you are students in the clinical area the tutors should be available so that you come out of training the best midwife.

M- QUESTION: What about home visiting, were you all right with that part?

P- ANSWER: That is the part that we enjoyed the most. That was where you could say, yes I am a midwife and I have all the control.

M- QUESTION: What improvements or alterations do you think should be made to improve the quality of clinical learning in midwifery?

P- ANSWER: The midwifery tutors should only teach in midwifery and not overlap to General Nursing to ensure their availability for clinical instruction of their students.

P- Tutors should schedule their ward visits. It will be much better to be with your tutor for those one or two hours than not to see her at all for the whole week.

P- Tutors should be with the students at least for the first two days in the clinical area to relieve your anxiety. Most of the time in the wards we just do things anyhow without supervision and luckily you see yourself getting away with it not knowing how, whether it was right or wrong.

P- The CaseBook is not well explained to us. You end up copying from previous students' CaseBooks for the sake of submitting it.

P- The R.F.M. Hospital has the problem of resources otherwise it is quite busy. You see every kind of midwifery condition. You can acquire as much as you could if only there were enough resources.

P- The matrons in charge are the ones who should ensure that they fight for availability of resources to be priority no: 1.

FOCUS GROUP INTERVIEW- 2

M- QUESTION: Mention an incident you will never forget that occurred in the clinical area while you were still a midwifery student.

P- ANSWER: It was before we wrote exams. One tutor came and wanted us to do more than one procedure at the same time.

P- I remember one when we were doing home visiting. Visiting the client antenatal was no problem, but postnatal it became a problem. I was told there was no transport and the tutor who was supposed to accompany me was not available.

P- I remember doing a procedure that was thoroughly demonstrated in class. I felt very competent, and my tutor was with me instructing me throughout the procedure.

P- At times the tutors were not available when we were supposed to do return demonstrations.

P- It was around exam time, the tutor said she was not available, her child was sick.

M- QUESTION: Are you saying that the tutors will not be available for clinical instruction?

P- ANSWER: Yes (all participants), it became very frustrating.

P- One tutor decided to go on leave when we were about to do the return demonstrations, we entirely depended on her. She was at the college but when you go to her she would say, I am not available, I am on leave go to sister so and so. When you go to the next tutor, she would say, I am not responsible for you.

P- We felt we were a neglected class. Even when our end of year results came out poor as they were we knew it was because nobody assisted us.

P- I remember my first day in the labor ward, I did not know what to do. All of a sudden my tutor called upon me to do a procedure which I have never seen being demonstrated. I did not know what to do and the tutor kept on scolding me. I don't know whether she thought I was already a qualified midwife, she had high expectations from me.

P- Even the delivery pack in the ward was not the same we had learnt about and used to seeing in the college, which had every item in it. I had never used this one but my tutor expected me to do everything correct. I ended up confused until one of the ward sisters intervened.

P- During the beginning of the year the tutors will be able to demonstrate the procedures to us. Things went wrong towards the exam.

P- In cases where we had done return demonstrations we could feel competent. With those that were not demonstrated we were poor and did not know what was happening.

P- I had a bad experience when I went to Mkhuzweni. I had never conducted a delivery and the other student I was with had some experience with a delivery. I was left alone in the labor ward with no one to instruct nor supervise me. I ended up being assisted by the other student who was also not very sure. I couldn't suture the perineum the patient bled until she went into shock. I would like to make a recommendation that when students are sent to Emkhuzweni (for community midwifery) they should have acquired enough experience on the basic midwifery procedures.

M- QUESTION: So you are saying there is not enough supervision of students at Emkhuzweni?

M- ANSWER: Yes, there is just none! At times you will be there with one of the very old midwives and as a student you will feel a lot better than her in your performance.

P- The problem with Emkhuzweni they take it as though we had come for internship. Most of the time the ward sisters will agree with whatever a student is doing, they will say everything is correct. You will turn to wonder if it is really correct as they say because you cannot know everything while you are still a student. The good thing with Emkhuzweni is that they have

enough equipment, for example: the delivery pack is exactly the same as the one we learned about in class.

M- QUESTION: Most of the things you have said somehow have answered the main question which is, to what extent would you say the clinical part of the midwifery training has contributed in making you a competent midwife?

P- ANSWER: To some extent it did. What I realized was that there were problems on my side at the beginning of the year but towards the end of the year some light started showing and I discovered it was already end of the year. Maybe the content is too much for one year I don't know. (Nodding from the rest of the participants).

M- QUESTION: So you are saying that to some extent you felt you were ready to handle any midwifery situation?

P- ANSWER: To some extent, yes. What I can say is that maybe we were an unlucky class since we were more than the previous class, and the tutors could not handle us. For it is important that whenever you do a return demonstration your tutor is with you. The procedures I did with my tutor I am very competent in doing.

P- What I can say is that we were thoroughly fed with the theory part of midwifery than the clinical. This is what even boosts you up when you are in the clinical area, when you come across a midwifery situation the theory part will help you to some extent.

M- QUESTION: What about the quality of supervision from the ward sisters?

P-ANSWER: They would welcome us, they are okay, though not all of them. The problem at times would arise from us as students; we come with a certain attitude. Even the tutors at times come with an attitude. When a tutor is supervising you and you start messing things up, the tutor will turn to blame the ward staff and say, sister so and so what are you teaching our students? (Yet she never even demonstrated the procedure in class). The ward staff will turn to develop an attitude towards us. When we want their help they will say, why can't your tutors come and help you themselves? (Nodding from the others).

P- At times due to that the ward sisters are limited in number they cannot manage the students together with the workload. They end up overworked and burned out; they start developing an attitude because they cannot cope. They end up saying: are we now your tutors?

P- For example you will be having a problem examining a woman in labor and say, "I think it is a breech" She would reply not even coming near you, "yes, it is what you feel midwifery is a closed book"--(Laughter). One time I had to deliver a stillborn due to such negligence.

P- At times the problem is with us students. We have an attitude that we are a workforce. Once we are about through with the number of cases we want we stop going to the clinical area and say "call me only if there is a delivery" At the end of it the ward staff tend not to assist the students because there will be the attitude that students want to benefit yet they do not want to work in the ward. The attitudes come both ways, that is, from student-to-ward sister and visa versa.

P- This situation is getting worse as the years go by. There is lack of responsibility among students. Even if the ward sister is willing to assist the student will be cold. The ward sister ends up forgetting about the student whether she/he (student) is around or not. When the ward sister feels that the student is not doing the right thing, instead of instructing the student, she simply takes over the procedure.

M- QUESTION: What can you say about the qualifications of your clinical instructors and/or supervisors?

P- ANSWER: Professionally they are okay. You can tell that they know midwifery to an extent that you learn quite a lot from them if you are willing. They even assign highly experienced midwives to work in the maternity wards.

M- QUESTION: What about the role modeling?

P- ANSWER: They really try their best it is the equipment that is a problem and also the shortage of staff as we have already mentioned.

P- I want to add something maybe it will fall under recommendations. Let me take you back to the qualifications and competence of the ward staff.

They are competent but they still need in-service training and refresher courses. Because with time the staff gets too much experience such that they take other procedures for granted and they tend to perform poorly. For example, someone recording, "urine-clear" after testing the urine antenatal, something which does not make sense.

P- Even when new equipment comes one or two people know how to operate it. It ends up not being used.

M- QUESTION: What more would you like to say?

P-ANSWER: You see a complete delivery pack in class and next meet it in the exams or unless you go to Emkhuzweni, you will not see it in the maternity ward.

P- Because of deficiency of equipment some nurses end up buying their own equipment when they come for delivery. This becomes unfair for the patient who is not informed of the situation, let alone the one who cannot afford.

M- What improvements or alterations can be made to enhance the quality of clinical learning?

P- ANSWER: Communication among students and tutors. There should be a good rapport between students-tutors-ward staff.

P- Dedication. Everybody should be dedicated in his/her work so that each one benefits from the other.

P- Tutors should always be available for supervision of the students. Because students are not supervised they lack responsibility. They come late in the wards and when they are in the wards they do what they like. The ward staff ends up distancing themselves from the students.

P- It was better during our time the situation is getting worse to such an extent that the students do not know a thing. They come in the wards they do not know what to do; they do not even know the theory. You really cannot understand what is happening.

P- There is lack of responsibility among the students; we really do not know what to do. You ask yourself the question that, "who is supposed to instill

the responsibility?” At times a student will come and say, “I want to go to the salon” during working hours. It is as if someone pushes the student to come to the clinical area he/she does not see why she/he is there.

P- The students these days do not want to go to the clinical area yet during our time of training we preferred the clinical area than the college.

P- The students’ attitude is so poor in that they do not even respect the ward sisters. They do not look up to them as supervisors but as friends. They look up to the sisters as people they can manipulate for their own gain.

M- QUESTION: Is there anything more you will like to add?

P- ANSWER: We wish your study becomes a success because all of us will benefit from it, for it is quite a good study.

P- Because this is the only time where we can communicate such important things, which are most of the time, overlooked yet they affect our practice drastically.



P. O. BOX 551
MATSAPHA
SWAZILAND

02 JUNE 1999

THE HOSPITAL ADMINISTRATOR
RALEIGH FITKIN MEMORIAL HOSPITAL
P. O. BOX 14
MANZINI
SWAZILAND

Dear Sir

RE: REQUEST TO CARRY OUT A RESEARCH STUDY.

I am a second year Masters in Midwifery (M Cur Midwifery) student in the Rand Afrikaans University, South Africa. I am conducting a research study as a partial fulfillment of my program of study.

The purpose of the study is to explore and describe the extent to which the clinical part of the midwifery training has contributed in producing competent midwives in Swaziland. From the results of the study strategies to facilitate the clinical part of midwifery training in Swaziland will be formulated. Data will be collected by means of a focus group interview. Participants of the study will be obtained through purposive sampling. The target population will be all the midwives who have graduated from the Nazarene College of Nursing in the past one-to-two years. Research ethics will be considered in the study. The hospital will get a copy of the dissertation once complete.

I am asking for your permission to conduct the focus group interview in the hospital conference room on the week of the 14th June, 99.

Yours faithfully
Fortunate Nomsa Thwala.

Contact phone numbers: 5184851 or cell phone no: 6047447.



CHURCH OF THE NAZARENE

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15.06.1999

Fortunate Thwala
R.F.M. Hospital
P O BOX 14
MANZINI

Dear Madam

RE: REQUEST TO CARRY OUT A RESEARCH IN THE HOSPITAL

Your application on the fore mentioned endeavours has been duly considered and permission is granted on the following conditions please:

- a) That confidentiality is strictly observed
- b) That the hospital receive a copy of the report on the proposed research.

Again thank you for considering the Institution for such a task and wishing you all the best.

Sincerely yours

A handwritten signature in black ink, appearing to be 'L.S. Dlamini'.

Leonard S. Dlamini (Mr)
HOSPITAL ADMINISTRATOR

CC: CMO
Chief Matron