FACTORS INFLUENCING CLINICAL TEACHING OF MIDWIFERY STUDENTS IN A SELECTED CLINICAL SETTING IN TANZANIA

by

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DECLARATION

I declare that **FACTORS INFLUENCING CLINICAL TEACHING OF MIDWIFERY STUDENTS IN A SELECTED CLINICAL SETTING IN TANZANIA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

SIGNATURE   DATE ....

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ABSTRACT

A quantitative, descriptive non-experimental design was used to identify the factors that influence clinical teaching of midwifery students in selected postnatal clinical settings in Tanzania.

Structured questionnaires were used to collect data from midwifery tutors/preceptors. The major findings of the study showed that both the professional and educational qualification of tutors was low; tutors and preceptors were overworked due to shortage of staff; the school skills laboratory and postnatal wards lacked equipment and necessary supplies; there were no clinical accompaniment guidelines, and overcrowding of postnatal patients. Recommendations included developing the clinical teaching guidelines, employing more tutors, preceptors and clinical staff; improving the tutors'/ preceptors' educational and professional qualifications and updating the qualifications of ward supervisors and clinical facilitators.

KEY TERMS

Accompaniment, clinical experience, clinical learning, clinical teaching, clinical setting, clinical preceptors, student midwife, midwifery, midwifery students and midwifery tutors.

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Dedication

I dedicate this dissertation to my husband,
Amos Michael Ayo, my sons Anton and Edwin,
my daughters Penina, Tumaini and Ezelder for their
constant prayers, understanding, patience,
support and love.

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Chapter 1

Orientation to the study

1.1   INTRODUCTION

In Tanzania, midwifery education is aimed at the individual and professional development of student midwives. In other words, developing midwives who are critical thinkers, analytical, able to interpret scientific data for midwifery and nursing actions, solve problems and exercise independent clinical judgement in clinical settings. Accompaniment of midwifery students is essential to realise these aims, to facilitate the integration of theory and practice, and to prepare competent professional midwives. Midwifery tutors and ward supervisors are expected to accompany student midwives in clinical settings for guidance and support (Ministry of Health (MOH) 2002a:15). Accompaniment is a dynamic interactive activity, with midwifery tutors, ward supervisors and student midwives as active participants in clinical settings. It occurs within the relationships between the skilled and knowledgeable midwifery tutors, ward supervisors and the neophyte student midwives (Billings & Halstead 2005:333).

Accompaniment of student midwives in clinical settings would enable the achievement of most of the aims of midwifery education in Tanzania. In the researcher's experience, however, accompaniment and clinical teaching of student midwives in clinical settings is not done. This study aimed to describe the factors that affect clinical teaching of student midwives in the postnatal ward.

1.2   BACKGROUND TO THE STUDY

The researcher's interest in midwifery education and, in particular, the accompaniment of midwifery students motivated her to undertake this study. Midwifery is theoretical and practical science. The theoretical knowledge is gained in the classroom and the practical skills in the clinical setting.

In 1966 there was only one integrated diploma nursing school in Tanzania. In 1975 the number had increased to eleven, and by 2003, there were fourteen. Of these, the last two to be established do not yet offer a midwifery course. The current nursing diploma

programme is an integrated one. Students study general nursing for the first three years and in the fourth year either midwifery or psychiatric nursing is offered.

The Tanzanian government has committed itself to improve the quality of health care to all its citizens. According to the 2002 census (MOH 2002b:6), Tanzania had a population of 34 443 603, of whom 16,45% were aged 0-4 years and 24% were women aged 15-49 years. One of the strategies used to improve the country's health care was to increase the number of the nursing and midwifery schools. The purpose was to increase the number of qualified registered nurses and midwives, and thereby to reduce the high maternal morbidity and mortality rate, which was 578/100 000 in 2005 (Demographic Health Survey 2005:15). Although the number of integrated nursing diploma schools with student midwives has increased, the number of tutors has remained the same. According to the MOH, Nursing Training Unit (2005:2), the acceptable admission number of student midwives was 25 per year for integrated diploma schools. Each nursing diploma school should maintain three or more full-time midwifery tutors (MOH, Nursing Training Unit 2005:26). On average, 36 student midwives are admitted in a class with one to two midwifery tutors. Only one school has four and the others have three midwifery tutors (see table 1.1). Between 1998 and 2006 the MOH annually reported that a shortage of tutors has been a major concern. Most schools, particularly government ones, meet only 50,0% of the required number of tutors (MOH 1998-2006:5). This shortage has limited the available tutors to classroom teaching. According to the Tanzania Nurses and Midwives Council (TNMC) (2005:3), the recommended midwifery tutor/student ratio for both nursing and midwifery schools and clinical setting is 1:8. Table 1.1 illustrates the government and privately owned nursing and midwifery schools, number of midwifery tutors and student midwives in Tanzania in May 2006.

Table 1.1   Integrated diploma nursing schools, midwifery tutors and students, May 2006

No	Name of school	Number of midwifery tutors	Number of midwifery students	Owner
1	Bugando	3	32	Government
2	KCMC	2	28	Government
3	Lugalo	4	36	Private
4	Haydom	2	35	Private
5	Huruma	3	34	Private
6	Ifakara	2	38	Private
7	Muheza	2	34	Private
8	Ndolage	1	44	Private
9	Nkinga	2	30	Private
10	Sengerema	1	30	Private
11	Kolandoto	1	34	Private
12	Ndanda	1	26	Private
12	Sengerema	1	24	Private
13	Muhumbili	3	40	Government
14	Ilembula	2	24	Private
	Total	**30**	**496**	

(MOH 2002b:6)

From table 1.1 it is clear that the midwifery tutor/student ratio is 1:17. With regard to clinical settings, in 2002 and 2005 at Zanzibar and Morogoro, respectively, the regional nursing officers reported a shortage of registered nurses ranging from 60,0% to 78,0% in the government hospitals, including Muhimbili National Hospital. They reported further that student nurses and student midwives complained that they were not accompanied by their tutors.

According to the MOH (2002a:7), there is a severe shortage of nursing and midwifery professionals in the health facilities. The shortage has been compounded by the non-replacement of retired and deceased professional staff as well as staff who resign. For example, there are six registered nurse midwives and seven enrolled nurse midwives in the postnatal ward at Muhimbili National Hospital. On the morning shift there are two registered nurse midwives and two enrolled nurse midwives while on the night shift there is one registered nurse midwife and two enrolled nurses. On average there are 40 patients daily in a postnatal ward. A midwife needs to be multi-skilled to meet the health needs of the women of Tanzania.

Due to the restructuring of the Tanzanian nursing education system since 2003, and the resultant decrease in midwifery tutors who could accompany students in the clinical

field, midwifery tutors and clinical nursing instructors view clinical teaching as "extra work". In addition, student midwives complained that their requests for appropriate supervision, guidance and accompaniment were not being met. This raised the question of whether registered midwives as accompaniers of student midwives' learning during clinical placement understood and accepted their role as facilitators of learning. The researcher therefore wished to explore the concept of accompaniment.

Accompaniment has long been practised. Hinchliff (2005:147-149) and Mellish, Brink and Paton (2000:161-162) describe mentorship and supervision (which, in essence, is also accompaniment) as a means by which an expert practitioner (midwifery tutor) in the art and science of midwifery guides and directs the work of someone who is less expert (midwifery student). In accompaniment, by example and facilitation, an experienced midwife guides, assists and supports the student midwife in learning new skills, adopting new behaviour and acquiring new attitudes (Quinn 2001:188). It is a long-term relationship that extends throughout the student's programme. The aim of accompaniment is to facilitate learning, aiming at developing a competent midwifery practitioner. Accompaniment is used to develop competent midwives; it also provides professional socialization (Quinn 2001:188).

Not only is the midwifery tutor expected to accompany students in the clinical field, but registered nurses and clinical instructors in the units also have a threefold role, namely patient care, management, and teaching.

- **Patient care**

The main role of registered midwives is to provide care to patients or clients entrusted to their care. To achieve quality care in her ward, the registered midwife has to ensure that student midwives or newly qualified staff, to whose care she entrusts her patients or clients, are capable of providing it. If they are not able to provide the care it is her responsibility to teach them (Mellish et al 2000:209).

- **Management**

The midwifery role requires management skills at various times. The dramatic changes in midwifery require midwives to learn and utilise managerial skills in the clinical field

appropriately. Managerial skills include planning, organising, directing, monitoring and control, supervision and evaluation. One function of management is enabling managers to become coaches and mentors as they move beyond empowering (Marquis & Huston 2000:18). Effective managers influence others by restating things that are not understood, giving student midwives or other learners time to respond to questions and practise solving patients' problems during their learning experiences. Marquis and Huston (2000:255) assert that managers and tutors share the student midwives' educational and training responsibilities.

The skill to manage a unit or department, to control and organise personnel and to coordinate the health care of the patient must be mastered. Clinical learning increases growth in professional expertise and enables the rendering of compassionate, skilled attention whether preventive, promotive, rehabilitative, maintenance or terminal care (Mellish et al 2000:208).

Managers learn from experience how many of the objectives set for the unit were achieved and what were the enabling factors or the reasons for failures. This enables them to use what they learn in further decision-making.

- **Teaching**

It is the duty of registered midwives to teach student midwives assigned to their ward how to encounter and cope with situations, which will facilitate their clinical learning (Mellish et al 2000:209). Registered midwives have an expanded role of teaching student midwives during their clinical learning (TNMC 2005:10).

Due to staff shortages, nurses and midwives in clinical settings concentrate only on patient care. Their morale reported to be low due to the workload and inadequate or unavailable working equipment (MOH 1999:9). Retrenchments and no replacements of retired or deceased staff or staff who resigned have resulted in vacant posts and added to the workload of the remaining staff (MOH 1999:67, 2002b:7).

The researcher found that student midwives evaluated by ward supervisors at the end of their clinical rotation were dissatisfied and complained that:

- Tutors examined them in clinical settings but did not accompany them during clinical practice.
- They were corrected on the spot when they made mistakes, even in front of patients.
- They were not comfortable with the provision of feedback on practical performance because it was given only after examinations and, above all, in the presence of clinical staff members.

Tutors were only seen in clinical settings during practical examinations and no designated persons accompanied midwifery students during their clinical learning experience in the postnatal wards of the hospitals attached to the integrated diploma schools under study. Regarding the clinical accompaniment of students, the regional nursing officers indicated that there were problems in most of the teaching institutions. There appeared to be little respect and mutual trust between tutors and students.

According to the MOH (2002a:4), one of the expanded roles of registered nurses and midwives is to teach student nurses and midwives in the clinical settings during their learning experience. To fulfil this role, each ward usually identifies two or three registered midwives who act as clinical instructors, also called mentors or preceptors, for student midwives during their clinical practice.

The challenge facing midwifery tutors and clinical instructors today is to produce a corps of self-reliant, efficient professional midwives who are competent in both the clinical and the theoretical fields of midwifery.

Against this background, the researcher decided to examine the factors that influence clinical teaching of midwifery students in selected clinical settings in Tanzania.

1.3   PROBLEM STATEMENT

Due to the restructuring of health services and nursing education in Tanzania and the resultant shortage of midwifery tutors at integrated diploma nursing/midwifery schools and clinical midwives in the respective teaching hospitals, midwifery tutors do not accompany student midwives during their clinical placements in the hospitals and clinics.

1.4   PURPOSE OF THE STUDY

The purpose of the study was to describe the factors that contribute to the decline in clinical teaching of midwifery students in the postnatal wards during their clinical learning experience.

1.5   RESEARCH QUESTIONS

According to Polit and Beck (2003:731), a research question is a statement of the specific query the researcher wants to answer. Research questions are concise, interrogative statements worded in the present tense and usually with one or two variables. This study attempted to answer the following question:

What are the factors that contribute to the decline in clinical teaching of midwifery students in the postnatal ward during their clinical learning experience?

1.6   OBJECTIVES OF THE STUDY

According to Polit and Beck (2003:65), objectives are specific accomplishments the researcher hopes to achieve by conducting the study. Burns and Grove (2005:156) describe objectives as clear, concise declarative statements expressed in the present tense, focusing on only one or two variables and indicating whether these variables will be identified or described. Objectives include obtaining answers to research questions and making recommendations for changes to nursing practice based on the study result.

The objectives of the study were to

- describe factors that contribute to the decline of clinical teaching of student midwives in the postnatal ward during their clinical learning experience
- make recommendations to promote clinical facilitation for student midwives in the postnatal ward during their clinical learning experience

1.7   SIGNIFICANCE OF THE STUDY

No research findings were found on postnatal wards in Tanzania on the factors that could contribute to midwifery tutors and clinical instructors not being able to accompany midwifery students. It was therefore envisaged that exploring the factors that might contribute to the decline of student accompaniment would assist to identify the problems in order to improve student education in the clinical field (postnatal wards). Assisting midwifery tutors and clinical instructors to accompany the students in postnatal wards would indirectly influence the quality and standard of clinical teaching, and better equip midwives on completion of their course. The research findings could also stimulate future research.

1.8   RESEARCH DESIGN AND METHODOLOGY

Methodology describes the design used in a study. Burns and Grove (2005:211) describe a research design as the plan, structure and strategies of an investigation.

A quantitative descriptive, non-experimental design was used to identify the factors that contribute to the decline in clinical teaching of student midwives in clinical settings. The population and sample comprised midwifery tutors from six integrated diploma nursing schools in the Eastern and Northern zones of Tanzania (see table 1.1 and figure 1.1). The clinical instructors from the teaching hospitals where the six integrated diploma nursing and midwifery schools are attached were included. These nursing schools are geographically closer to the researcher, which minimised the distance and costs involved. The terms *preceptors*, *mentors* and *clinical instructors* are used differently in these hospitals. Ideally, they should be used where student accompaniment is to be implemented.

Figure 1.1

Map of Tanzania showing the teaching hospitals where data was collected

Source: MOH and SW (2006:7)

1.8.1 Research design

The researcher used a descriptive survey design in order to give a detailed description of the factors that contributed to the decline of clinical teaching of student midwives by midwifery tutors and clinical instructors.

According to Brink (2006:111-112), a descriptive survey design may be used to study characteristics in a population for the purpose of investigating probable solutions to a research problem.

1.8.2 Population and sample

The population is the total group of persons that meets the designated set of inclusive criteria established by the researcher. The sample refers to the small portion of the population that the researchers are studying in the particular site or setting (Burns & Grove 2005:160). Brink (2006:123) describes a population as the entire group of persons or objects that is of interest to the researcher.

The accessible population for this study was the midwifery tutors and clinical instructors at Bugando, Lugalo, Muheza, Huruma, KCMC, Haydom and Ifakara hospitals in Tanzania. These facilities were selected because each nursing school only had a few midwifery tutors and the clinical instructors at the hospitals were included in the population.

Non-probability convenient sampling was used. The sample consisted of 18 midwifery tutors and 17 clinical instructors of the selected nursing schools and hospitals, making a total of 35 respondents. A sample should contain at least 30 subjects (Burns & Grove 2005:354).

To be included in the study, the respondents had to be involved in the clinical teaching of midwifery students in postnatal wards in the selected nursing schools in Tanzania.

1.8.3 Data collection

Data collection is a systematic way of gathering information relevant to the research purpose or questions (Burns & Grove 2005:60).

The researcher used a structured questionnaire to collect data from the respondents. In a structured questionnaire all the respondents are asked consistent questions and data yielded is easy to analyse (Polit & Beck 2003:35).

1.8.4 Data analysis

A professional statistician used the SPSS computer program to analyse the data and the data was presented by means of frequencies and percentages.

1.9   VALIDITY AND RELIABILITY

According to Brink (2006:209), validity shows the ability of the instrument to measure the variables that are intended to be measured. Reliability of a research instrument (questionnaire) shows the extent to which the instrument yields the same results on repeated measures. It is concerned with consistency, accuracy, precision, stability, equivalence and homogeneity (LoBiondo-Wood & Haber 2002:319).

The researcher focused on content validity, which is the degree to which the items in an instrument adequately represent the universe of the content. For validity and reliability of the questionnaire, midwifery tutors who are teaching midwifery to the certificate programme at Kahama Nursing school were requested to review, verify and determine whether the items in the questionnaire measured the factors that contributed to the decline of clinical teaching of student midwives by the midwifery tutors and clinical instructors.

The reviewers supported the assertion that the components of the questionnaire accurately reflected the essence of the concepts being studied and that the questions were appropriate to the factors which influence clinical teaching of student midwives (Polit & Beck 2003:36). This also supports the other authors indications for validity and reliability. Detailed information about research methodology adopted for data collection for this study is given in chapter 3.

A pretest, which is a smaller version of the study, was carried out to obtain information to improve the questionnaire and to assess the feasibility of the study. The respondents in the pre-test were similar to those in the study and were done under similar settings, but they were not included in the final study. Conducting a pre-test assisted the investigator to identify problems with the questionnaire. It also gave an estimate of the time to interview each individual, which was important in obtaining consent to participate (Brink 2006:106).

1.10   ASSUMPTIONS

Assumptions refer to basic principles that are believed to be true without proof or verification (Burns & Grove 2005:728; Polit & Beck 2003:13). According to Brink

(2006:25), assumptions are the basic underlying truths from which theoretic reasoning proceeds. Assumptions are based on a positivistic perspective.

1.10.1 Methodological commitment

With regard to methodological commitment, it was assumed that:

- A questionnaire could be designed in such a way that the items included in it sufficiently defined the phenomenon under investigation.
- Given specific statements, individual respondents could indicate the degree to which such statements applied to them.
- Individual respondents would be free to express their feelings, give their suggestions and opinions according to the open-ended questions provided.

1.10.2 Ontological commitment

In this regard it was assumed that all the respondents had cognition of clinical teaching. Indicating clearly that clinical teaching is characterised by guidance, facilitation, support, encouragement, and counselling as it occurs in clinical settings ensured a common understanding.

1.10.3 Epistemological assumption

It was assumed that knowledge entails measurable empirical referents.

1.11 ETHICAL CONSIDERATIONS

Pera and Van Tonder (2005:4) define ethics as "a code of behaviour considered correct". According to Pera and Van Tonder (2005:152), the relevant ethical principles are autonomy, informed consent, permission and veracity, non-coercion and non-exploitation, and the maintenance of the scientific integrity of the research.

The researcher obtained written permission to conduct the study from the directors of the teaching hospitals and heads of the integrated diploma nursing schools providing

clinical learning experience to student midwives in the Eastern and Northern zones of Tanzania.

Informed consent was obtained from each respondent. To ensure confidentiality and anonymity, neither the respondents' nor the institutions' names were requested on the questionnaires. No physical or psychological risks were involved, as the study was non-experimental. The researcher kept a list of the respondents' names for sampling purposes safe to ensure confidentiality and anonymity.

1.12   DEFINITIONS OF KEY CONCEPTS

For the purposes of this study, the following concepts or terms are used as defined below.

- **Accompaniment**

Accompany means "to go along with, so as to be in company with or escort" (*Collins English Dictionary* 1991:9).

Accompaniment is "facilitating, guiding and supporting the development of midwifery students" (Potgieter, Dürrheim & Du Toit 2000:69). The South African Nursing Council (SANC 1994:2) defines accompaniment in midwifery education as "the directed assistance, guidance and support by the midwifery tutor or registered midwife to student midwives with the aim of developing a competent, independent practitioner, accompanied by relevant guidelines and teaching aids. Accompaniment is planned, deliberate intervention by midwifery tutors and clinical instructors in clinical settings, to enable student midwives to progress from a state of dependency towards a state of independency both in their learning and professionalism. The process of accompaniment helps students grow from passiveness to independent with direct involvement and physical presence of the midwifery tutor and clinical instructors."

- **Learning**

Learning is a process of acquiring knowledge, skills and attitudes by studying, or from being taught or from experience like imitating, role modelling by expert midwives or repeated practice or by individuals' response to specific situations (Mellish & Brink 2001:79). Hinchliff (2005:63) describes learning as any event that brings about a relatively permanent change in behaviour, resulting from either experience or practice. Nursing/midwifery education wants to enhance and improve care for patients. Learning occurs at any time or in any place as a result of exposure to environmental stimuli (Bastable 2003:11).

- **Clinical experience**

Clinical experience refers to the "know-how" gained through clinical practice. Clinical experience takes place when theoretical knowledge is refined, challenged, or disconfirmed by actual clinical evidence that enhances or runs counter to the theoretical understanding (Benner 2001:294).

- **Clinical learning**

Clinical learning is the acquisition of nursing or midwifery technical skills through the application of theoretical knowledge to practice in a ward as postnatal or any other practicum site. According to Craven and Hirnle (2000:1400), clinical learning is a multidimensional process of acquiring knowledge through experience or actual practice in the clinical setting.

- **Clinical setting**

"Clinical" refers to giving care to clients regardless of whether they are confined to bed or not (Mellish et al 2000:207). Clinical settings are places where patients/clients are examined and treated or given care. These are practical sites where midwifery students put their acquired knowledge into practice to gain specific midwifery skills. Such practical sites are antenatal clinics/wards, labour, delivery, and postnatal and neonatal wards/units. In the clinical settings students learn to solve clinical problems, access and

link knowledge and make appropriate clinical judgements. It is in the clinical setting that, with guidance by midwifery tutors and clinical instructors, student midwives learn to practise the cognitive, affective and psychomotor skills demonstrated during a given period of exposure. For the purpose of this study, the clinical setting was the postnatal ward.

- **Clinical teaching**

Mellish et al (2000:207) define clinical teaching as the means by which student nurses midwives learn to apply the theory of nursing so that an integration of theoretical knowledge and practical skills in the clinical situation becomes the art and science of nursing.

- **Mentor**

A mentor is an appropriately qualified and experienced first-level midwife who, by example and facilitation, guides, assists and supports the student (midwife) in learning new skills, adopting new behaviour and acquiring new attitudes (Quinn 2001:181).

Mentorship is a long-term relationship that extends throughout the student's programme. In this study, *mentorship*, *facilitation* and *preceptorship* in clinical teaching are used interchangeably.

- **Clinical preceptors**

Clinical preceptors are professional nurse midwives within the clinical settings who act as resource persons and role models for student midwives who are assigned to them for a specific time in a formalised training programme. Usher, Nolan, Reser, Owen and Tollefson (1999:507) describe clinical preceptors as experienced practitioners who teach, instruct, supervise and serve as role models for student midwives for a set period in a specific training programme. Clinical preceptors take active roles in the development of student midwives and are selected on the basis of their expert clinical knowledge, ability and willingness to accompany student midwives in clinical settings.

- **Clinical instructor or clinical teacher**

The role of the clinical instructor supplements the teaching role of the professional nurse in charge of the ward. The clinical instructor is allocated to a number of wards. The clinical instructor is a skilled practitioner of midwifery, has and maintains up-to-date theoretical knowledge, instils confidence in those she/he is guiding and should possess professional standards, honesty and integrity (Mellish et al 2000:211). Clinical instructors are active in clinical teaching in the midwifery units and are selected on the basis of their experience, clinical knowledge, ability and clinical teaching skills. In this study, "clinical instructor" describes those midwives who participate in clinical teaching for student midwives.

- **Midwifery**

Midwifery is the art and science of providing preventive, curative and rehabilitative care to women and their families during pregnancy, labour and puerperium. This includes the care of the newborns and infants in a holistic way and where life-saving skills are required, the midwife employs such skills (De Vos 2002:3; Tiran 2000:172; TNMC 1997:4).

- **Student midwife**

The TNMC (1999:4) describes a student midwife as a person enrolled in a fully recognized and registered midwifery education programme of not less than one year. On successful completion of her/his training programme he/she can register as an enrolled or registered midwife. Student midwives in the integrated diploma nursing programmes become "Registered Midwives".

- **Midwifery tutor**

A midwifery tutor is an individual who is trained beyond the level of registered midwife in a recognized and registered teaching programme of not less than two years, and authorized to practice as a specialist in teaching (TNMC 1999:4). According to Reilly and Oerman (1992) in Mellish et al (2000:71), midwifery tutors are knowledgeable and clinically competent, have teaching skills, have positive relationship with students and

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appropriate personal characteristics. Mellish et al (2000:03) and Billings and Halstead (2005:331) point out that midwifery tutors are expected to help, guide, facilitate, encourage, support and counsel midwifery students in the process of their learning.

1.13   ABBREVIATIONS

The following abbreviations are used in this study:

APA	American Psychological Association
ENB	English National Board
FTE/WTE	Full/Whole-Time Student Equivalent
ICN	International Confederation of Nurses
KCMC	Kilimanjaro Christian Medical Centre
MOH	Ministry of Health
RSA	Republic of South Africa
SANC	South African Nursing Council
SPSS	Statistical Package for Social Sciences
SSR	Tutor/Staff-to-Student Ratio
TNMC	Tanzania Nurses and Midwives Council
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing Midwifery and Health Visiting
USA	United States of America
WHO	World Health Organization

1.14   OUTLINE OF THE STUDY

This chapter introduced the study and briefly discussed the background to the problem, the purpose and objectives of the study, the research design and methodology, ethical considerations, reliability and validity of the study, and defined key concepts used in the study.

Chapter 2 discusses the literature review on clinical teaching of student midwives in clinical settings.

Chapter 3 describes the research design and methodology.

Chapter 4 presents the data analysis and interpretation.

Chapter 5 concludes the study, indicates its limitations and makes recommendations.

1.15   CONCLUSION

This chapter outlined the problem and the purpose, objectives and significance of the study. The validity, reliability, methodology, assumptions and ethical considerations were briefly discussed and key concepts defined.

Chapter 2 discusses the literature review undertaken for the study.

Chapter 2

Literature review

2.1   INTRODUCTION

This chapter discusses the literature review conducted by the researcher on the factors which may influence clinical teaching of midwifery students in selected postnatal wards in Tanzania.

2.2   RATIONALE FOR A LITERATURE REVIEW

In the research process a literature review helps the researcher to identify the research topic by identifying gaps in the existing research and to develop a conceptual framework and conduct of research. A literature review is done before, during and after the research to build on existing research and compare the findings. The main purpose of a literature review is to find similar studies; familiarise oneself with practical and theoretical issues related to the phenomenon of interest; generate a picture of information available on the topic, and prevent unintentional duplication. It also assists the researcher to compile a written report on what is known about the topic (Burns & Grove 2005:133; Polit & Beck 2003:127). The literature review informed the researcher of research on the clinical teaching and accompaniment of student midwives in clinical settings (Polit & Beck 2003:63).

2.3   CONCEPTS OF CLINICAL TEACHING AND ACCOMPANIMENT

The literature review revealed the following significant concepts related to *clinical teaching and accompaniment*, which individually or in combination could be reflected in the process of accompaniment:

- Background on training of midwives
    - o   Training of midwives both internationally and nationally
    - o   Training of midwives in the United States of America (USA), the United Kingdom (UK), the Republic of South Africa (RSA), and Tanzania
        - ▪   Regulations and midwifery education

- Midwifery as an art and science
- Accompaniment
  - Definition
  - Preparation and planning for clinical accompaniment
  - How clinical accompaniment is done
    - Facilitation, preceptorship, mentorship, role modelling.
- Clinical learning environment
- Clinical supervision
- Student midwife
  - Effective clinical education

2.4   BACKGROUND TO MIDWIFERY TRAINING

The background describes midwifery training from the past to the present, including a historical review of clinical training of midwives both internationally and nationally.

2.4.1 Midwifery training

2.4.1.1 Internationally

Historically, midwifery training was more oriented to practice than to theory, and was carried out in hospitals where student midwives were under the supervision of senior midwives (WHO 1997:87). It is a condition in most countries that nurse/midwifery teachers are qualified health professionals with clinical experience and hold a teaching qualification so that they can teach in class and accompany students in clinical settings (WHO 1997:80).

2.4.1.2 The United States of America (USA)

In the USA, newly graduated nurses experienced stress when they were expected to function independently. They attributed this stress to a lack of clinical experience and organisational skills. In the late 1960s and early 1970s preceptors were made available to guide newly qualified nurse midwives. Standardisation of the curriculum was introduced with routine reviewing, review of students' learning needs, limitations and

strengths as well as decentralisation of clinical instructions and examinations. The student/midwifery tutor ratio was 1:5 (Quinn 2001:4).

2.4.1.3 The United Kingdom (UK)

Supervision of midwives was introduced early in the 1900s with the passing of the Midwives Act of 1902. The first supervisors were not registered midwives. Later, medical supervisors were employed to supervise midwives. Courses for supervisors of midwives were introduced in 1978. In 1994, the Midwives Code of Practice (UKCC 1994:963) was revised to include a section that emphasised the relationship between midwife and supervisor of midwives as a partnership.

2.4.1.4 South Africa

In South Africa, the midwife is recognised as a practitioner in her own right and is accountable and responsible for her own acts and omissions. In terms of the Nursing Act, 50 of 1978 (as amended), the midwife must be registered with the SANC to practise midwifery. Midwifery is an autonomous, independent profession that bases its practice on scientific principles.

According to Brennan and Williams (1993:35-36), the concept of preceptorship was introduced in South Africa in the 1980s for accompanying students who were following the comprehensive course. Preceptorship was introduced in the RSA to ensure that students are accompanied during their practice in clinical settings.

2.4.1.5 Tanzania

In 1949 when formal midwifery training courses started in Tanzania, midwifery tutors taught student midwives in the classroom and accompanied them in clinical settings. In 1952, the concept of clinical instructors was introduced. In 1965, the tutor/student ratio was 1:12.

The integrated diploma for registered nurses and midwives in Tanzania is a four-year full-time training programme conducted at 14 schools (see table 2.1). The midwifery course starts from the third year of the training programme. Midwifery students are

required to cover 504 hours of theory and 1 508 hours of practice. They are also required to perform 20 normal deliveries and 5 abnormal ones under the supervision of registered midwives and obstetricians. The curriculum states that midwifery tutors should ensure that students acquire and demonstrate the required competencies in critical and reflective ways (MOH, Department of Human Resources for Health Development 2001:8; Muhimbili School of Nurse Teachers 2005:8). However, although clinical accompaniment of midwifery students by clinical instructors was good, it was not promoted throughout the country.

2.4.1.6 Regulations and midwifery education

Regulations for midwifery aim to protect the public welfare by improving standards of education, practice and care of patients/clients (Ralf 1993:58 in Searle 2000:6). Both classroom and clinical instruction are under the control of qualified nurse/midwifery tutor (WHO 1996:3). Although the Tanzanian integrated diploma curriculum emphasises the need for accompaniment of student midwives, the standards of, and regulations for, implementation of clinical accompaniment are not stipulated (MOH, Department of Human Resources for Health Development 2001:1). Regulations for clinical accompaniment ensure that student midwives apply the science of midwifery in the clinical setting to develop the art of midwifery.

2.5 MIDWIFERY AS SCIENCE AND ART

Midwifery is a blend of science and art. According to Smith (1981:5), biological, physical, chemical, nutritional and social sciences were the basis of the concept of science in nursing and midwifery. The patient who receives health care is entitled to effective actions based on the science (knowledge) and the art of midwifery (the skills) to provide the care (Searle 2000:70). The professional practice of midwifery exists to serve women, their newborn babies and families.

2.5.1 Midwifery as a science

Midwifery is viewed as a science because it requires the systematic application of scientific knowledge. Fraser, Cooper and Nolte (2006:13) cite Enkin's definition as "the extent to which care is based on evidence that is effective; that it achieves the desirable effect".

According to Burns and Grove (2005:8), science determines the accepted process for obtaining knowledge within the midwifery field. A scientific method is a systematic problem-solving process, which includes problem identification, data collection, hypothesis formulation, planning of action, hypothesis testing, interpretation of results and evaluation of results and conclusion. Midwifery is said to be scientific when the practice focuses on giving effective client care based on sound rationales from midwifery knowledge generated through study or research performed and theory development (Taylor, Lillis & Le Move 1993:50). Thus, the underlying principles of midwifery care depend on knowledge of biological science such as anatomy, physiology, microbiology and chemistry (Fraser et al 2006:85). Brink (2006:13) refers to Burns and Grove (2005) who state that greater emphasis should be placed on the use of research findings in practice aiming at midwifery care science becoming an evidence-based profession. It also requires the midwife to use methods that have been tested in sound research. This is natural science, which includes the observations made and experimentations done to find out what works better as an alternative in relation to nursing interventions for specific conditions. Measuring facts or specimens, such as urine output or body temperature, is categorized under natural science. Kerlinger and Lee (2000) (in Burns & Grove 2005:8) emphasise that information gained from one study is not sufficient for its inclusion in the body of science. A study must be replicated several times and must yield the same findings before that information can be considered appropriate empirical evidence. Only after being proved that it is scientific knowledge can it be applied in caring for clients thereby developing the art of midwifery.

2.5.2 Midwifery as an art

Midwifery is an art because the midwife must develop skilled techniques in the performance of the various procedures required for giving adequate care to women and their infants and families (Sanga 1994:18). Fraser et al (2006:13) define art as "those essential but measurable components of care that count even though they cannot be counted: the empathy and judgement that permits care to be personalised for each woman and her family".

Human science is concerned with human/client/patients needs, under which the specific care is planned and implemented. According to Orem (1980:5), the skills developed and used by midwives as they practise their intelligence in creative designing of the care for

individuals and groups are the art of midwifery. This implies that the ultimate result in the application of knowledge is the creative production of care. The notion of midwifery as an art has implicit in it the ideal of midwives as creators, the makers of midwifery under prevailing conditions. Midwifery is a human service. The clients are attended to or viewed holistically while receiving the care and within a given context of their lived experiences.

According to Mellish and Brink (2001:67), when clinical procedures are done skilfully clinical knowledge is also developed. Nursing/midwifery judgement based on knowledge and skilled observation must become part of the armamentarium of every would-be midwifery practitioner. This makes clinical accompaniment of midwifery students in the clinical setting crucial so as to ensure that student midwives not only learn the practice of midwifery, but the standards of patient care are maintained and improved, and that competent practitioners of the art and science of midwifery are produced.

2.6   CLINICAL ACCOMPANIMENT AND TEACHING

The focus of this study was the clinical accompaniment and clinical teaching by midwifery tutors to student midwives following the integrated diploma in nursing and midwifery in Tanzania.

2.6.1 Definition

Clinical accompaniment refers to the direct assistance, guidance and support given to a student by the midwifery tutors and registered midwives aimed at development of a competent independent practitioner (Potgieter et al 2000:69).

Accompaniment is planned, deliberate intervention by midwifery tutors and clinical instructors in clinical settings to enable student midwives to progress from a state of dependency wards or state of independency both on their learning and professionalism. The purpose of clinical accompaniment is to ensure that clinical learning objectives are met and student midwives develop personally and professionally and acquire the necessary midwifery technical skills. According to Quinn (2001:185), learning in clinical areas requires a conducive environment and appropriate support from skilled educationists   and   practitioners.   Midwifery   tutors   in   the   schools/colleges,   ward

supervisors and registered midwives in the clinical setting are the main persons responsible for accompanying student midwives in the clinical setting.

2.6.2 Preparation and planning for clinical accompaniment and clinical teaching

Planning for clinical accompaniment is a prior activity, which should be done by involving all key players. Gerrish (1992) (in Quinn 2001:186) maintains that teaching in practice placement requires a commitment by the teacher, collaboration between education and service staff, and staff development for teachers in their new role in relation to practice. The accompanists and the student midwives should participate in planning and preparation for clinical accompaniment. A plan for the process of accompaniment should be drawn up and followed (Mellish et al 2000:218). The key features of effective clinical education are that it is designed and conducted according to learners' characteristics and the use of appropriate teaching and learning strategies.

Providing clear guidelines for the implementation of clinical learning is important. Guidelines are necessary to maintain good clinical accompaniment standards.

Midwifery tutors, as controllers of clinical instruction, should ensure that the students, preceptors or clinical instructors or mentors and postnatal ward supervisors are well prepared. Midwifery tutors together with the postnatal supervisors should identify the clinical instructors or preceptors or mentors, considering the staff-to-student ratio. Three factors need to be taken into consideration when identifying the preceptors (Quinn 2001:347):

- Full/whole-time student equivalent (FTE/WTE): a part-time student is less than half a full-time equivalent.
- Tutor/staff-to-student ratio (SSR)
- Teacher contact time: the amount of time the tutor is actually in contact with students in a week. Hours for administration and other non-student contact activities are not included.

The TNMC (2005:3) recommends a tutor/clinical instructor/student ratio of 1:8. This means one tutor per eight students, so there is a need to apportion the available hours carefully to ensure that each student gets a chance. The accompanists should have the

desire and time to work with student midwives, be proficient in midwifery delivery skills that are consistent with what is being taught, and possess organisational, teaching and interpersonal communication skills. Student midwives are taught in the classroom and practise the technical skills in the skill laboratory and later in the clinical settings.

Midwifery tutors should

- visit the postnatal ward where students will be assigned, to see whether there are any problems or questions
- check with the clinical instructors/preceptors/mentors or ward supervisors about any issues that need to be discussed and ask about learning opportunities existing in the postnatal ward at that particular time
- ensure that student midwives know where to go when they have questions

Several factors need to be considered when drawing up a plan. According to Kerr (1968) (in Quinn 2001:268), the curriculum has an influence on midwifery education by accommodating the essential principles and features for an educational proposal in such a form that it is capable of effective translation into practice. Therefore the planning team should consider what has been described in the curriculum in fulfilling clinical teaching and learning. The planning team includes midwifery tutors, other clinical accompaniers, ward supervisors and midwifery students.

The clinical learning objectives should be taken into account when practising. Chun-Heung and French (1997:458) caution about students spending most of their time doing routine work and menial tasks thus wasting time for clinical learning. Midwifery tutors and preceptors/other accompaniers should select and agree on appropriate methods and materials, ensuring that they are available and relevant to learning outcomes.

According to Knowles (1990:119) and the WHO (1996:71, 74) appropriate clinical learning facilities, equipment and supplies should always be made available and maintained regularly. These clinical learning resources include workbooks, curriculum, manuals, midwifery standard guidelines, reading material, computer, portable video recorders, pamphlets, equipment and supplies. Such equipment and supplies in the postnatal ward include apparatus for checking vital signs, weighing scale, tape measure, personal protective gears, dressing and suture removal, resuscitation

equipment, analgesics, anti-anaemia, anti-malarial and ant-diabetic agents, provision for baby care including immunisation and adequate space for individual counselling of clients, for carrying out client's physical examination and all other requirements for providing general nursing care. If students are to be guided towards self-directed learning, then availability of resources is fundamental (Hinchliff 2005:100). Lack of such materials in clinical settings causes uncertainty and loss of confidence to student midwives. According to Carlson, Kotze and Rooyen (2003:30) and Klein (1999:10), local resources like well-folded banana leaves or clothes are useful in the absence of intended materials since they can be used as pillows in cases of emergency. In this way student midwives learn to be innovative and creative during their practice.

Planning should be systematic and realistic to ensure that students know what is expected of them and when. The plan should allow for flexibility in order to meet unforeseen eventualities. Quinn (2001:63) suggests that, in order to select strategies that enable deep holistic learning to take place, midwifery tutors should be aware of student differences, ways that keep students motivated and interested. According to Smith and Fitzpatrick (2006:85), leaders in academic nursing/midwifery should plan and try to balance their busy schedule to include teaching, writing, researching and advising students at all levels. In their view, it is important to have priorities that benefit the greatest number of people like student midwives. Mellish et al (2000:76) emphasise the importance of involving students in mutual planning regarding their learning needs, objectives, subject content, methods and assessment and evaluation procedures.

Daft (2000:511) stresses the value of maintaining a good working relationship with ward personnel with special expertise like medical and paramedical in a formal clinical education programme, so that they can be consulted when there is a need.

Division of the time available and allocation of personnel so that all students have an equal opportunity to benefit is essential (Quinn 2001:347). Specific times should be set aside when students are released from the wards for formal activities, such as demonstrations. Ward personnel should be consulted in the choice of suitable times. The number of students allocated to the postnatal ward during a particular shift should be considered. Gibbon and Kendrick (1996:52) maintain that the number of students allocated to a clinical setting should be controlled so as to avoid overcrowding, which is not conducive to teaching and learning.

Midwifery tutors or accompanists must keep systematic records so that all students have the opportunity to benefit from the clinical education and maximize clinical practice experience. Moreover, records to be maintained by students should be identified, such as case books/work books/delivery notebooks, self-assessment tools and standard performance report forms for providing feedback on major skills. These clinical records should show how they link up with staff records and college administrative records (Quinn 2001:432).

Nursing and midwifery procedures should be standardised in order to facilitate nursing care and clinical teaching. Unit professional midwives as well as clinical instructors must be provided with an outline of the clinical education programme. On-going in-service programmes should be organised to keep personnel aware of their responsibilities as well as teaching techniques and evaluation methods. Qualified personnel, especially ward managers, in the clinical settings are a key factor in influencing the learning environment in hospital placements (Quinn 2001:182).

2.6.3 Process of clinical accompaniment

The process of accompaniment involves facilitation, mentorship, preceptorship, supervision, and role modelling (Craven & Hirnle 2000:216). When midwifery tutors are in clinical settings with student midwives, they not only inform student midwives, but form them by guiding them towards independency. Guiding students towards independent learning depends largely on the planned teaching and learning activities and the way the guidance is done (Hinchliff 2005:101). Guidance to student midwives helps them perform their independent functions in the knowledge that they are responsible for their actions and omissions (Mellish et al 2000:213).

In the RSA, accompaniment of student midwives requires midwifery tutors to be physically present in clinical settings, since it is a conscious and purposeful guidance and support of student midwives based on their unique needs (Mellish & Brink 2001:226; SANC 1992:6). According to the SANC (1992:7), unit/ward supervisors should accompany student midwives in clinical settings by indicating that in clinical settings all registered midwives are indispensable in the accompaniment of midwifery students. Midwifery education takes place largely in clinical settings, although theoretical knowledge is acquired in formal classroom settings.

Role modelling is widely used as a method of teaching student midwives in clinical settings. Midwifery tutors, preceptors, mentors and ward supervisors (accompaniers) should be role models to the student midwives in whatever they do and say in the clinical settings. Role modelling provides an observable image for imitation, demonstrating skills and qualities for student midwives to emulate (Morton-Cooper & Palmer 2000:43).

The SANC (1992:2) emphasises that the education and training of student midwives shall be directed specifically to the development of student midwives on a personal and professional level. Furthermore, the principle should be observed that learning leads to changes in the cognitive, affective and psychomotor aspects of behaviour, through the active involvement of student midwives. Student midwives are expected to develop from passiveness during pedagogy to active involvement during andragogy, implying progress from the student to the professional midwives' level.

In Tanzania, meetings are usually conducted locally between the midwifery tutors and ward supervisors to discuss student placement and accompaniment. This is done to ensure that four to six students are allocated to a ward to prevent congestion leading to fewer learning opportunities. According to the TNMC (2005:3), the teacher/student ratio for nursing and midwifery schools is 1:8. The school staff also communicate with the ward supervisors to emphasise the need for registered midwives to take their expanded role of teaching students during their clinical practice. In wards where there are preceptors/mentors of clinical instructors, they are informed about student midwives' clinical placement.

Mellish and Brink (2001:69) maintain that it is essential for registered midwives in training hospitals to be active members of the teaching team and that the staff establishment should provide for the optimal guidance and support to student midwives.

2.6.3.1   Clinical teaching

Clinical teaching is the means by which student midwives learn to apply the theory of nursing so that theoretical knowledge and practical skills are integrated in the clinical situation. Being taught the theory of nursing in the classroom situation enables the

student to learn, assimilate and store knowledge for future use and apply it in nursing care.

A midwife must be able to put into practice what she has learned in theory, to apply the knowledge obtained in the classroom to exercise educated judgement and make skilled observations throughout the giving of patient care (Mellish et al 2000:207). This correlation of theory and practice and the building of meaningful experience must take place in the field of clinical practice, whether in the hospital ward, special department, casualty department, out-patients department, day hospital, clinic, or a patient's home. It is only in the clinical situation that nursing care becomes a reality and the midwife can observe the responses of patients to obstetrics, to nursing and to medical care and treatment. It is in the clinical situation that midwives encounter the human side of nursing. The nurse comes into contact not only with the patients, but also with their relatives and friends. The nurse learns to interact skilfully with these people and other members of the health team. Mellish et al (2000:207-208) emphasise the following with regard to clinical teaching:

- Clinical teaching occurs in the *real-life* situations; it translates theory into reality.
- The midwife is an *active* participant.
- It is a *small group activity*. Physical limitations make the number of midwives who can be involved very small. It may even occur on the basis of one patient, one teacher and one student.
- The midwife is given the opportunity to develop *self-confidence* by performing under expert guidance.
- It affords the midwife opportunities for *observation* and *decision-making*.
- It allows *assessment* of the degree to which educational objectives have been attained.
- It centres on *patient care*.
- The real-life situation necessitates careful handling to prevent both patient and midwife from being placed in a difficult position.
- It is an invasion of the privacy of patients and therefore can be carried out only with their consent.

2.6.3.2 Aim of clinical teaching

Clinical teaching aims at producing a competent registered midwife capable of giving expert nursing care based on sound knowledge and practised skill. A great deal of formal and informal clinical instruction rests in the hands of unit professional nurses, clinical instructors and midwifery tutors. The care given involves interaction between two or more people: the recipients of care and their family on the one hand, and the nurse or nurses on the other (Mellish et al 2000; Quinn 2001:444).

In order to achieve its aim, clinical teaching must be based on theory and applied in practice. It must include teaching such skills as leadership and administration, teaching, organising and controlling staff, determination of work methods and procedures, economical use of equipment and materials, drawing up of appropriate nursing care plans, supervision, and control of the unit as a whole.

Clinical teaching must also deal with the practical aspects of methods of clinical teaching, so that the student can become proficient in peer group teaching and later be ready to take her place as a teacher of students in the clinical field (Mellish et al 2000; Quinn 2001:445).

2.6.3.3 Facilitation

Chabeli (1998:26) defines facilitation as a goal-directed and dynamic process in which professional and student nurses interact in a clinical learning environment of genuine mutual respect. Facilitation assists midwifery students to make clinical learning as easy, quick, and comfortable as possible. Cameron (1998) and Heron (1999) (in Morton-Cooper & Palmer 2000:166) indicate that facilitation forms an important part of the learning process and is effective in providing a non-directive, non-confrontational, flexible environment to assist student learning and development. According to Potgieter et al (2000:31, 34) and Mellish et al (2000:75), the emphasis in facilitation in clinical settings is on the application of knowledge in real situations so as to render safe and effective midwifery care to patients. Facilitators make actions happen by participating in and enabling the actions of student midwives during their clinical learning experiences (Mellish et al 2000:130). They make it easier for student midwives to participate in

events in the clinical settings by anticipation, assistance, reassurance and encouragement.

Facilitators should accept and value student midwives as unique and worthwhile individuals. During facilitation, supporting and guiding them towards holistic development through the integration of cognitive, psychomotor and affective processes should nurture student midwives. Facilitators should change from being motivators and catalysts for ideas to being constructive critics and evaluators.

Facilitators should assist in clarifying various approaches, facilitate exploration, encourage analysis and promote interpretation in clinical settings. Quinn (2001:202) state that facilitators encourage self-directed learning skills by constantly challenging student midwives to identify their learning needs and abilities to assess their own performance accurately.

According to Quinn (2001:201), facilitators inform and advise student midwives particularly in relation to course work and assessment, and encourage critical thinking and enquiry. Hinchliff (2005:101) stresses that facilitators encourage student midwives to be active participants in clinical learning rather than passive learners.

Facilitators should assure and make student midwives feel free to ask questions, allowed to experience success, and seek help without fear of loss of confidence, esteem or grades. They should positively reinforce and promote actions and discussions about learning experiences. Facilitators should not only allow experiences of success but also reinforce expectation of success and foster student midwives' self-confidence (Hinchliff 2005:102).

Facilitators are supportive to student midwives during their clinical learning by recognising the need for encouragement and the positive effect of being there for student midwives, not forgetting that learning psychomotor nursing requires technical expertise (Craven & Hirnle 2000:215-216).

Learning support can be in the form of human or material resources, information, psychological and emotional and environment fitness. Human resources are people who accompany midwifery students during their clinical practice. Midwifery tutors are

the main people involved in these processes; but in many cases they are not able to be with students long. Preceptors or mentors or clinical instructors, peers or other expert professionals can accompany midwifery students in clinical settings in the absence of their midwifery tutors.

Fraser et al (2006:271) found that psychological support of midwifery students promotes behaviour, physical and mental health. Clinical supervision provides support to midwifery students, so that they do not internalise emotions, which may lead to maladaptive behaviour. Preceptorship is also commonly used in implementing clinical accompaniment.

2.6.3.4 Preceptorship

According to Billings and Halstead (2005:338), preceptors are experienced practitioners who teach, instruct, supervise and serve as role models for students for a set period in a formalised educational programme. Preceptors are experienced professional nurses/midwives within clinical settings who act as role models and resource persons for student midwives (Quinn 2001:189).

Mellish et al (2000:201) refer to preceptors as persons who enable student midwives' learning in clinical practice while promoting and participating in the delivery of nursing and midwifery care. Preceptorship is a one-to-one reality-based clinical experience in which midwifery students are taught directly by a professional midwife. Jooste and Troskie (1995:12) contend that many preceptors who participate in the accompaniment of student midwives are experienced and do not need to rotate shifts. This promotes some stability in the student nurses' programmes. Bond and Holland (1998:21) are of the opinion that preceptors should have at least twelve months' experience within a clinical field.

Preceptors are selected on the basis of their expert clinical knowledge, ability to maintain good interpersonal relationship, ability and willingness to accompany student midwives in clinical setting. Their supervisors regard them as knowledgeable and skilled in guiding students in clinical settings (Billings & Halstead 2005:340). Preceptors act as resource persons for the students and are responsible for seeing that they receive the maximum benefit from their allocation to the ward, while caring for a mother

and eventually for her newborn baby during midwifery training (Mellish et al 2000:200). A preceptor is concerned with the teaching and role-modelling aspects of the relationship.

According to Cele, Gumede and Kubheka (2002:41), preceptors act as role models and resource people for student nurses/midwives; provide clinical teaching; orientate them in clinical areas; allay their fears and anxiety by providing guidance, support and encouragement; demonstrate procedures; help them solve problems and do formative and summative evaluation of student nurses/midwives. Billings and Halstead (2005:446) describe preceptors' main responsibilities as clinical supervision of student midwives, which involves verifying their competencies in performing selected clinical skills, and facilitating their development.

Preceptors facilitate student midwives' learning of the technical skills important to the postnatal care of patients (Mellish et al 2000:212). Such technical skills include history taking, performing physical examinations, observation of vital signs, interpreting such findings to identify postnatal women with problems and planning their care accordingly, caring for breasts to prevent engorgement, caring for those with inverted nipples or breast infection, care for genitals including those with infected episiotomies and tears, incontinence, prolapsed uterus or rectum, care during puerperal sepsis, fever, anaemia, haemorrhage as well as giving health advice when necessary (Fraser et al 2006:485).

Preceptors assist in identifying student midwives' learning needs, providing feedback to them and communicating with midwifery tutors regarding the progress of student midwives in clinical settings, as midwifery tutors might not be immediately available to accompany all student midwives. In a study on students' perceptions of clinical accompaniment at community health clinical settings, Setswe (2002:33-36) found that open communication between them and the preceptors was important and that they were satisfied with the educational strategies used by the preceptors in clinical teaching. Preceptors increase their clinical communication and teaching skills through experience (Billings & Halstead 2005:339).

Preceptors work closely with midwifery tutors to ensure that no gap is created between the schools and service areas that can hinder good progress in clinical accompaniment of student midwives. This role increases their self-esteem, as preceptors are recognised

for their clinical expertise, teaching ability and professionalism, which enhances their appropriateness as role models for student midwives in clinical settings. Cele et al (2002:41) recommend that for the preceptor to function effectively, some of the ward or clinical roles like ward administration should be assigned to other staff.

2.6.3.5 Mentorship

Mentorship and *preceptorship* are used interchangeably. According to Morton-Cooper and Palmer (2000:36), the term "mentor" originates from Classical Greek. Mentor, the son of Alimus, was a trusted friend of Odysseus and a tutor of Telemachus, his son. The relationship between Mentor and Telemachus was nurturing, protective and educative. According to Watson (1999:255), Telemachus developed personally, socially and professionally. Thus mentorship is associated with a relationship between accompaniers or experts in midwifery practice and student midwives. Billings and Halstead (2005:572) describe mentoring as an enabling and cultivating relationship between two people in which one with greater rank, experience, and/or expertise teaches, guides, helps and counsels the other to develop both professionally and personally. Morton-Cooper and Palmer (2000:42) specify the elements of mentoring as a repertoire of helper functions, mutuality and reciprocal sharing, duration, identified stages and the transitional nature of the relationship.

Mentors are selected from the clinical settings to facilitate, guide and support students during their clinical learning. Mentors are selected on the basis of their willingness to participate and their availability to meet student midwives on a regular basis. According to Hinchliff (2005:148), in the UK mentors are prepared in terms of communication methods, facilitation ways, role modelling, assessment procedures, ability to create a conducive environment, planning and reviewing courses, acting as resources in terms of knowledge base, initiating change and how to support good practices. Student midwives are encouraged to choose a student midwife whom they trust and respect to be a peer mentor so as to maintain rapport.

According to Billings and Halstead (2005:217), mentors possess appropriate professional attributes, knowledge, good communication skills and the motivation to teach and support and assess student midwives. Mentors are role models, energisers and visionaries so, in contrast to a preceptor, a mentor is more concerned with building

close personal relationships with students, thereby creating a long-term relationship which lasts as long as students are in training. Mentors serve as friends, advisors, professional role models and resource persons, good listeners and provide feedback to student midwives.

Mentors should plan the learning experiences, be available, be good listeners, identify learning opportunities, encourage the application of enquiry-based learning and problem solving, and encourage students to work in partnership with multiprofessional teams (Hinchliff 2005:147). Quinn (2001:426) describes mentors as ideal professionals, role models, and charismatic figures. Therefore student midwives want to follow in the footsteps of the mentors and are willing to be shaped by them.

Quinn (2001:397) found that the varied support offered to pre-registration students combined aspects of preceptorship, clinical supervision and mentorship. Through effective clinical accompaniment by mentors, student midwives are assisted to develop personally and professionally from dependency to independency.

2.6.3.6 Role modelling

According to Pera and Van Tonder (2005:49), role models hold certain positions in particular social systems, act or behave in a manner expected of persons who hold such positions, enact their roles in ways that can be observed and have certain expectations. Pera and Van Tonder (2005:50) add that role models have undergone role socialisation and have definite views of components of the specific role. Chabeli (1998:27) emphasises that role models should be open-minded, have self-awareness, be able to analyse and synthesise feelings, and should have the ability to evaluate and motivate student midwives in clinical settings.

Bastable (2003:390) states that role modelling is often overlooked as an instructional method, whereby the learner acquires new behaviours and social roles by identification with the role mod. Role models are exemplary in aspects such as academic, professional and social, and in their administrative and management styles

Pera and Van Tonder (2005:53) point out that role models should be knowledgeable, competent, concerned, compassionate, good teachers and supervisors and should

provide a health care climate that is conducive to learning, as the student midwives are the role models' main concern. Role models must have integrity, personal bearing, neatness, empathy, sympathy and willingness to assist student midwives and wherever their knowledge and skills are needed, and to be collaborative. The image portrayed by role models should at all times be positive and acceptable to student midwives (Billings & Halstead 2005:25). It is important for midwifery tutors to further their academic and professional qualifications to enable them to teach midwifery students at the required or set quality standards (Hinchliff 2005:35).

Morton-Cooper and Palmer (2000:43) stress that role modelling provides an observable image for imitation, demonstrating skills and qualities for student midwives. In this way, student midwives benefit directly from "hands-on" experience. This practice is recommended and seen as a part of the expanded role of the midwifery tutor (MOH 2002a:7).

Quinn (2001:97) maintains that if midwifery educators work in the postnatal ward, it makes the midwifery tutor aware of the climate in which the student midwives practice, including the shortage of staff and low morale. They are then able to exercise a good working relationship, which acts as a tool for role modelling. As role models, tutors demonstrate effective relationship with students, preceptors, clinical staff and patients/clients, maintaining an environment in which effective teaching, learning, and practice is fostered, implemented and evaluated (Hinchliff 2005:149).

Clinical accompaniment and clinical teaching, then, is concerned with encouragement, guidance, supportive relationships among student midwives, ward supervisors, and midwifery tutors with the maintenance of trust and mutual respect. Preceptorship is done by experienced, competent professional midwives, who are unit-based and not required to rotate shifts, promoting stability in the student midwives' clinical learning whereas mentorship is done throughout the programme on an advisory, counselling and friendly basis and also by peers. Both preceptors and mentors focus on the professional development of student nurses/midwives. The main difference is that preceptorship is a short-term arrangement compared to mentorship. Students need to see, observe, imitate, and conceptualise as learning takes place.

2.7   CONDUCIVE LEARNING ENVIRONMENT

Physical comfort and emotional state affect the attention and concentration that student midwives can give to their clinical learning experiences. Student midwives need an environment without disturbance, stress or anxiety-causing factors. Accompaniment of student midwives in the clinical setting involves ensuring that the environment is conducive to learning. Quinn (2001:182) stresses that ward managers' leadership styles and personality are important determinants of an effective learning environment since they have control of the area and serve as role models for nursing practice.

The environment includes adequate physical environment to deliver quality care, facilitates development of competencies, and provides teaching and learning opportunities, resources, space, equipment, and reference materials including books, which enhance the teaching-learning process. When the learning environment is conducive, teaching and learning becomes comfortable and effective (Hinchliff 2005:90). An effective and conducive learning environment is characterised by a humanistic approach to student midwives during clinical accompaniment by midwifery tutors or preceptors or mentors or ward supervisors (Quinn 2001:182). Students are supported physically and psychologically, treated with kindness, respect and understanding, and interest is shown in them.

Craven and Hirnle (2000:215-216) describe being supportive in clinical learning as recognising the need of encouragement and the positive effect of being there for student midwives, not forgetting that learning psychomotor nursing and midwifery requires technical expertise. The value of psychological support of midwifery students is that it promotes behaviour, physical and mental health (Fraser et al 2006:7). Kirwan (2000:2) states that clinical supervision provides support to midwifery students so that they do not internalise emotions, which may lead to maladaptive behaviours.

Human or material resources should be sufficient both in quantity and quality for support to student midwives during their clinical practice. With regard to the needs of first-year student nurses in the clinical learning environment, Carlson et al (2003:30-39) found that students felt uncertain and anxious about staff shortages or inaccessibility, shortage or absence of equipment to fulfil patient care, and their learning needs.

Midwifery tutors are the main people involved in accompanying student midwives in the clinical setting, yet in many cases they are not able to be with students long. Preceptors, mentors or clinical instructors, peers and other expert professionals can accompany students in the clinical setting in the absence of midwifery tutors. Adequate equipment should be available for students.

A team spirit is fostered so that students form part of the team by creating and maintaining good relationships (Quinn 2001:182). Factors that promote team spirit include orientation of student midwives in the postnatal ward, being supportive to clinical staff, identifying students' problems in the clinical areas, and communicating effectively with clinical staff and student midwives. Orientating student midwives in the clinical settings makes them aware of their learning environment, the clinical staff, and service management and also motivates them. Billings and Halstead (2005:325) caution about using more than one clinical setting stating that care must be taken because students lose time in being oriented to new staff, physical facilities, hospital regulations, procedures and guidelines.

Good teamwork within the postnatal ward and good communication between the clinical staff, midwifery tutor and the students promotes sharing of feelings, ideas and new information (Fraser et al 2006:40).

Management styles should be effective and flexible in providing good quality care. In their study on the role of the ward manager in creating a conducive clinical learning environment, Bezuidenhout, Koch and Netshandama (1999:46-52) found that the students were dissatisfied because of poor interpersonal relationships, support and exposure to administrative skills like problem solving and decision making, and lack of feedback about their performance. Hinchliff (2005:18) emphasises that clinical accompaniment and supervision should promote instead of impede improved practice.

Teaching and learning support should be provided to midwifery students. They should be given opportunity to ask questions, attend medical staff rounds, observe new procedures and have access to patients' records. An effective environment encourages students to take responsibility for their own learning, critical thinking, clinical judgement and peer support. They can freely ask questions and dissent without feeling guilty or disloyal (Quinn 2001:418).

Cole (1997:27) states that when midwifery tutors get time to practise in the postnatal wards they become aware of the climate in which the student midwives work, including the shortage of staff and low morale. They are then able to create and maintain a good working relationship, which acts as a tool for role modelling.

2.8   CLINICAL SUPERVISION

It is the responsibility of registered midwives in the teaching hospitals and midwifery tutors to supervise midwifery students during their clinical learning experiences (Morton-Cooper & Palmer 2000:142). Clinical accompaniment of midwifery students in hospitals and teaching institutions is facilitated through supervision and role modelling.

2.8.1 Supervision

Clinical training supervision relates to students in practice, where the supervisor is expected to have some responsibility for students' clinical learning experiences in the postnatal wards (Morton-Cooper & Palmer 2000:142). According to Morton-Cooper and Palmer (2000:168), clinical supervision for students that draws two complimentary functions whereby "facilitation" provide enabling aspects of the relationship while "coaching" promotes the ensuring functions that the frame the professional standards and ethical expectations.

Quinn (2001:187) cites the 1993 guidelines of the English National Board (ENB) for Nursing, Midwifery and Health, which refer to supervisors as appropriately qualified and experienced first-level midwives who received preparation for ensuring that relevant experiences are provided for student midwives and facilitating development of competence in student midwives. Billings and Halstead (2005:54) identify aims of supervision as expanding the knowledge base, assisting in the development of clinical expertise and developing the self-esteem and professional autonomy of the student midwife.

2.8.2 Supervisors' role

Supervisors help student midwives to focus on personal and professional development, while providing support and autonomy to student midwives as they facilitate their clinical

learning (Billings & Halstead 2005:55). Quinn (2001:187) emphasises that within the element of support there should be willingness to learn, humanity, trust, openness, thoughtfulness, sensitivity and trust.

According to Mellish and Brink (2001:69), ward supervisors should accompany student midwives in clinical settings by indicating that in clinical settings all registered midwives are indispensable in the accompaniment of student midwives.

Searle (2000:206) emphasises that registered midwives remain responsible for the duties delegated to another registered person under their supervision and are accountable for the way in which delegated duties are performed by student midwives and other personnel, even though they retain their own level of responsibility and accountability.

According to Kirwan (2000:49), supervisors have a duty to help student midwives to reflect on dilemmas, difficulties and success while examining their personal reactions to the situation. Supervisors need to be experts in midwifery with relevant experience, skills in listening, questioning and supervision to meet the clinical learning needs of student midwives.

Ward supervisors supervise student midwives in a supportive way and participate in assessing student midwives' clinical performance and providing feedback to them, whenever necessary. At the same time, however, ward supervisors might find it difficult to maintain confidentiality and trust since they are duty bound to pursue any revealed transgression from code of practice or disciplinary issues (Kirwan 2000:4).

Ward supervisors conduct incidental or situational teaching by utilising teachable moments present in clinical settings. Chabeli (2001:24) states that the teaching role of professional midwives in clinical settings is important and irreplaceable and that unit supervisors are in a favourable position to facilitate clinical learning based on their expert experiential knowledge.

Khadim and Wafer (1993:265) point out that supervisors link the postnatal ward and the school/college staff in assessing the proficiency of the student midwives, and discuss their progress and strategies for helping them when necessary. Khadim and Wafer

(1993:265) add, however, that poor communication between hospitals and training institutions about training matters leads to poor clinical learning. Billings and Halstead (2005:56) found that nurse and midwifery managers often only want the work to be done and do not take the training needs of students into account. Consequently the bureaucratic values of the wards and professional values hamper effective clinical learning. On the contrary, Billings and Halstead (2005:54) asserts that midwifery tutors found supervision valuable for educational, emotional and psychological support for teachers of different courses. Midwifery tutors could learn about supervision itself as well as new and different teaching practices.

According to Searle (2000:159), a registered midwife has a duty to teach those she works with and to prevent unskilled or unauthorized persons from performing functions that may harm a patient. To ensure total safety, teaching of other personnel and subordinates should be an integral aspect of supervision. Mellish and Brink (2001:96) stress that it is essential that registered midwives in training hospitals should be active members of the teaching team and that the staff establishment should provide for the optimal guidance of student midwives. Effective accompaniment of midwifery students in clinical settings contributes positively to the development of practical abilities.

According to Billings and Halstead (2005:55), a certain amount of supervision of student midwives must take place but the emphasis should be on clinical teaching. Student midwives should not function independently in clinical settings with high levels of risk.

2.8.3 Clinical instructor's role

Clinical instructors are midwifery experts allocated to work in postnatal wards as "a clinical teaching setting" with 60 to 80 patients and 12 to 18 student midwives where they provide care to these patients and clinical teaching to student midwives, respectively, to ensure proficiency in technical skills (Mellish et al 2000:210).

In Tanzania, based on their expertise, clinical instructors are not only concerned with clinical teaching but also classroom teaching. According to the MOH (2002b:6), between 35 and 45 patients were admitted to the postnatal ward daily, where 6 to 8 student midwives were allocated for clinical learning experience.

According to Mellish et al (2000:217), because of their rich knowledge of both the theoretical and practical content of the integrated diploma midwifery course, clinical instructors instruct student midwives during their clinical learning experience. They support student midwives as they learn to develop the interpersonal skills necessary to deal with patients, relatives and other members of the health team in the postnatal ward. Clinical instructors facilitate the internalisation of professional ethics, standards and behavioural patterns so that the student midwives become mature professional adults who can act as a role model for the profession.

2.8.4 Qualities of midwifery tutors

Quinn (2001:428) emphasises that tutors/instructors' teaching requires not only formal academic and professional qualifications, but also specialisation knowledge and expert experience in order to contribute to the intellectual and personal development of their students. Billings and Halstead (2005:334) maintain that tutors need expertise in the subject they are teaching if they are to facilitate clinical teaching and learning to student midwives effectively. Tutors with good academic and professional qualifications display confidence, are creative and stimulating, can excite students in the subject and can demonstrate skills with expertise.

Mellish et al (2000:72) point out the midwifery tutors' need for being clinically qualified in order to teach practice effectively. Tutors are never out of practice. Uys and Gwele (2005:173) question the clinical credibility of tutors, when they are fully involved in the theoretical field thereby neglecting the clinical field. This is one of the factors that can influence how clinical accompaniment is implemented. Bailey (1994:156) and Fawcett and McQueen (1994:266) found that tutors encounter problems with students' accompaniment because they have been isolated from ward work. Thus they lack clinical skills and are unfamiliar with documentation, the ward lay out, and practices.

According to Cahill (1997:149), midwifery tutors should have time available to develop and maintain clinical skills, have the opportunity to practise where appropriate, and be involved in clinical teaching for the equivalent of one day per week. By so doing they maintain their competencies and confidence which help them to function effectively during clinical accompaniment of student midwives.

Billings and Halstead (2005:333) state that students value the following qualities in tutors/teachers: neatness, enthusiasm, willingness to admit mistakes, cheerfulness, consideration, honesty, calmness, a sense of humour, control of anger, flexibility, patience and not having annoying mannerisms.

2.8.5 Midwifery tutors' role in clinical accompaniment

Midwifery tutors have a teaching role, which includes guiding, facilitating and supporting student midwives, developing the course and instructional materials, maintaining teaching records, leading a group of students with varied learning needs and learning styles, liaising with other school and clinical staff to discuss about students' clinical learning and accompaniment. Midwifery tutors act as resource persons, encouragers, patient care promoters, and evaluators of students during clinical accompaniment. In addition, they demonstrate respect and establish a climate of trust for student midwives particularly when giving feedback on their performance. Immediate and positive feedback is most valuable in encouraging students to develop self-confidence as nurse/midwives, whereas mostly negative feedback hinders students' development of self-confidence in clinical practice (Mellish et al 2000:72). Raiser, O'Grady and Lori (2003:398) emphasise the need for midwifery tutors to provide constructive feedback and relate performance standards to student midwives' performance.

Midwifery tutors guide student midwives to ensure that they focus their learning on patient care during their practice in the clinical setting (Mellish et al 2000:207). Moreover, the education of midwives should be based on professional practice and its related problems - real situations found in the clinical settings. Midwifery tutors play a direct modelling role by demonstrating procedures and skills to students and indirectly by caring for students, thereby making students show the same caring attitude.

Quinn (2001:183) emphasises that student midwives should be guided and supported towards self-directed, responsible learning. Tutors have to use strategies that increase students' activeness as they guide them during their clinical practice.

Midwifery tutors should counsel student midwives during their clinical learning whenever there is a need. Potgieter et al (2000:27) emphasise that a specialist should take over more complicated problems for appropriate counselling of students.

Midwifery tutors maintain a collaborative and supportive relationship with the clinical setting staff (Billings & Halstead 2005:60). Through this collaborative effort, experienced registered midwives can be identified and developed to be preceptors or mentors or clinical instructors to assist in facilitating clinical learning. Communication between the school and hospital staff is one of the psychological factors for a conducive learning environment. Midwifery tutors have a linking role between the students and clinical facilitators/supervisors (Morton-Cooper & Palmer 2000:142).

Midwifery tutors and preceptors/mentors/supervisors monitor students' progress. Midwifery tutors assess students' clinical competencies. Quinn (2001:248) defines competence as the possession and development of sufficient skills, knowledge, appropriate attitudes and experience for successful performance in life's roles. Quinn (2001:202) emphasises the importance of fostering self-assessment tools so that students can compare their own internal monitoring with that of the tutor or clinical staff.

Midwifery tutors and other clinical facilitators should provide feedback to students on their performance. Raiser et al (2003:398) as well as Billings and Halstead 2005:60) assert that a student midwife in the clinical setting should be given positive feedback immediately because that is the most effective way of learning. Quinn (2001:99) points out that harsh criticism or belittling during correction can discourage rather than spur students on to correct their performance. Students also gain communication skills during evaluation and feedback when tutors use appropriate evaluation and feedback methods (Hinchliff 2005:1330).

In summary, the roles of midwifery tutors, ward supervisors and clinical instructors comprise a wide range of activities which include facilitation, negotiation of learning contracts, profiling, counselling and guidance, encouraging and supporting, informing and advising, liaising/linking and representing, monitoring and coaching.

2.9   STUDENT MIDWIVES

A student midwife is a person enrolled in a fully recognized and registered midwifery education programme of not less than one year (TNMC 1999:4).

According to Knowles (1990) (in Mellish et al 2000:67), student midwives are expected to develop from dependency to independency and develop the ability to think creatively to facilitate the development of self-directed learning. Self-directed student midwives are actively involved and highly motivated, learn how to learn and pursue problems identified as important for learning independently.

Hinchliff (2005:100) states that self-directed learning is one of the teaching approaches whereby students take increasing responsibility for achieving the learning objectives or outcomes. Student midwives assume the primary responsibility for planning, carrying out and evaluating clinical learning endeavours. This type of learning approach draws on previous experience and focuses on the needs of student midwives. Self-directed student midwives apply andragogic principles such as building on their own life experiences and learning best when they decide that they need to learn. Self-directed students work at their own pace while their tutor is expected to guide them as they move from dependent to independent learning in the clinical setting. According to Burns and Bulman (2001:164), self-directed learners go through transitional stages of learning from totally tutor-directed to totally student-directed learner. When such self-directed learners graduate and join the workforce, they are more confident of their own abilities and work without close supervision because they already know what to do (Ewan & White 1996:98).

2.9.1 Student midwives' learning styles

The level of independent learning depends much on the course planners who identify what and how it should be learned with the availability of required resources. During accompaniment student midwives get a chance to utilise their preferred learning styles to achieve the clinical learning objectives. Billings and Halstead (2005:29) emphasise the utilisation of different learning/cognitive styles in ward-based practice to ensure effective clinical learning. According to Bastable (2003:386) and Hinchliff (2005:72), students perceive and process information using different learning styles. These learning styles are biologically or sociologically developed. Bastable (2003:106) refers to Kolb's (1984) four learning styles used by students, namely diverger, assimilator, converger and accommodator, based on Piaget's and Guilford's theories of thinking, creativity and intellect. These learning styles are briefly discussed below.

- **Accommodators** are active in experimentation (busy "doing") and engage in concrete experiences ("feelings"). Such learners are good at carrying out plans and getting things done. They are people-oriented; see and exploit opportunities, and are committed to meeting objectives. They rely on other people for information rather than use their own analytical ability. They are more impatient and bold than other types. According to Killen (2000:31), they benefit from teaching strategies such as problem-solving and ward placement. Writing reports of case studies can be stimulating to such students during clinical accompaniment.

- **Convergers** learn better by active conceptualisation (theorists) ("thinking") and active experimentation ("doing"). They are good at problem-solving, making decisions, setting goals and selecting the best solutions. Killen (2000:128) describe them as being less oriented to people. The teaching strategies that benefit convergers include problem solving, demonstration and ward placement.

- **Divergers** (reflectors) are good in learning through concrete experiences and reflective observation ("watching"). According to Killen (2000:99), teaching strategies such as group discussion and brainstorming are beneficial to student midwives with this learning style, in facilitation of their clinical learning.

- **Assimilators** (pragmatists) learn through active conceptualisation, reflective observation, theory building and inductive reasoning. They are also good at designing experiments, analysing quantitative data and organising information. They benefit from teaching strategies like formal lectures, writing papers, and seminars.

The different learning styles show that students benefit from teaching strategies such as ward placement, problem solving, role-play, small group discussion, audio-visual simulations, and demonstrations in which they have personal encounters. According to Billings and Halstead (2005:308), student midwives should be guided to learn and to perform practical skills in simulation laboratories before they encounter real patients. In such a setting, midwifery tutors may set up problem scenarios, which are stimulating and similar to what student midwives might experience in postnatal wards. Consideration of individual learning styles in clinical teaching helps student midwives

meet the aims of clinical learning. According to Hallett (1997:107), student midwives should be accompanied during clinical learning so that opportunities are provided for them to gain experience, permitting them to progress gradually from dependency to independency.

2.9.2 Student midwives' role

Student midwives should (Bezuidenhout et al 1999:47; Fredericks 2003:14; Hinchliff 2005:147; Mellish et al 2000:67; SANC 1992:4):

- Develop knowledge and skills to be applied in the postnatal ward.

- Use problem-solving and critical thinking to adapt scientific knowledge to the clinical setting.

- Apply emotional skills in providing care to difficult patient care solutions.

- Understand the roles of the preceptor, midwifery tutor and their own with regard to clinical accompaniment.

- Identify their learning needs and competencies to be achieved. Clinical learning outcomes are set in accordance with clinical learning gaps, thereby avoiding waste of time. It is also important for midwifery students to communicate their learning needs to the accompanier to facilitate selection of learning strategies and work schedules.

- Develop collaborative professional relationships with clients, the accompaniers, school staff including midwifery tutors and all other health care professionals. They should take an active role in maintaining a conducive clinical environment through good interpersonal relationships.

- Adhere to school and hospital policies and regulations regarding clinical practice. Student midwives are also expected to demonstrate responsible, accountable and ethical behaviour.

- Seek appropriate learning opportunities throughout the clinical experience in the postnatal ward. These learning opportunities permit them to practise in clinic settings under the supervision of registered midwives.

- Practise clinical skills under the supervision of the accompanier, preceptor or mentor while assuming progressive independence as clinical competence increases.

- Perform only those procedures that the student is competent in and that are within the student's scope of practice.

- Request instruction, supervision, and assistance when required. Seek feedback from the preceptor or midwifery tutor when necessary.

- Complete course requirements and assignments and perform personal assessment. Student midwives should participate actively in learning new practices and performing self-assessment or peer group assessment of their clinical learning progress.

- Participate with midwifery tutors and postnatal ward supervisors in planning their learning experiences.

- Assume responsibility for their own learning and effective use of clinical learning resources.

- Engage in critical and creative thinking, enquiry, analysis, independent decision-making, self-awareness and ability to reflect upon professional practice. They have to practice responsibly and accountably within legal, ethical, professional and educational parameters.

- Participate in the evaluation of course, clinical learning and clinical accompaniment.

2.10   EFFECTIVE CLINICAL EDUCATION

Clinical education is said to be effective when the clinical teaching and learning objectives have been achieved.

According Mellish et al (2000:218), an effective clinical teacher is one who has drawn up a plan for the process that is followed. The key features of effective clinical education are that it is designed and conducted according to learners' characteristics and makes use of appropriate teaching and learning strategies.

2.10.1 Quality assurance of clinical education

The effectiveness of clinical education with regard to clinical accompaniment and teaching of student midwives is revealed through auditing their practice placement.

According to Quinn (2001:184), successful clinical teaching and learning depends on the following factors:

- Provision for orientation, accessible and appropriate learning opportunities, adequate length of placement, appropriate care models, staff commitment, ethos and accompaniment approaches (preceptorship/mentorship systems). With regard to student midwives' perceptions of clinical teaching behaviours of nurse tutors and clinical instructions that enhance learning during clinical accompaniment, Duma (1998:2) found that the resource person, encourager and supportive presence were perceived as highly enhancing, the promoter of patient care as fairly enhancing and the evaluator as hindering clinical learning.

- Academic staff perspectives, the role of midwifery tutors and the knowledge, attitude and skills that they bring to the relationship between themselves, the student midwives and accompaniers as well as how accompaniment is done. This includes commitment to the relationship with placement staff; maintenance of clinical competence; application of theory to practice; monitoring placement evaluation; ward/unit staff development; consideration of student midwives learning styles, and the use of effective methods for enhancing clinical learning experiences.

- Service provider/ward staff perspectives; the type of interactions that occur between midwifery tutors/other accompaniers/ward supervisors and student midwives. This includes a commitment to individualised care, a team approach, multidisciplinary teamwork, communication with the college, commitment by service managers, and appraisal systems.

- Public market needs/purchaser requirements. These include identified and agreed standards and quality assurance mechanisms, as well as the kind of graduate midwives required to manage specific needs of the community.

- Environment, which means having a conducive teaching and learning environment.

- Quality assurance mechanisms. These include congruence of curriculum and placement; unit staff preparation; monitoring and annual review mechanisms; adequate clinical teaching and supervision of students, and maintenance of clinical practice standards and quality care (Daft 2000:654).

2.10.2 Barriers to effective clinical learning

Effective clinical learning is not always achieved because of barriers to good progress in clinical settings.

According to Bastable (2003:14), failure to achieve effective clinical learning could be due to:

- Lack of standard guidelines and policies on clinical accompaniment.
- Lack of time on the part of midwifery tutors or the accompanying person due to workload or other commitments.
- Personnel who are concerned with clinical accompaniment not being interested in clinical teaching and learning.
- Overlapping of instructional materials where two people are involved and lack of coordination or proper communication.
- Midwifery tutors being traditionally prepared to teach and accompany midwifery students in the clinical areas, but inadequately prepared.
- Lack of professionalism has been raised as one of the root causes of midwifery tutors' failure to play a satisfactory clinical role. Midwifery tutors should be well prepared during the nursing/midwifery training course.
- Personal characteristics play a big role in fulfilling one's task appropriately.
- Type of materials available for clinical teaching and learning could be outdated, inappropriate or inadequate.
- Inappropriate curriculum and reference materials.
- Conflict between the education and service areas, which results in time wasting. The service focuses on a student's output as part of a workforce due to staff shortages, whereas midwifery tutors focus on the training needs of students and the necessity for having many and varied learning experiences.

2.11   EFFECTIVE MIDWIFERY TUTORS

The supervision and accompaniment of student midwives is important during clinical practice. Midwifery tutors are required to be effective so that they can contribute significantly to meaningful clinical learning experience for student midwives. Quinn (2001:199) identifies the following qualities and characteristics of effective midwifery tutors:

- Self-awareness, which means having an insight into their own strengths and weaknesses.
- Trust or a climate of mutual trust engendered by appropriate self-disclosure by both parties, and an open, warm and honest approach towards each other.
- Acceptance of and respect for student midwives as persons with their own rights convey respect for the students' worth by treating them as equal persons.
- Retaining individuality by being their natural self; also called "genuineness". The midwifery tutor should come across as real person rather than as a kind of ideal model.
- Personal credibility is crucial as a basis for mutual respect, thus tutors need to be seen not only as good but also as sympathetic tutors.

2.12   CONCLUSION

This chapter discussed the literature review on the training of midwives, clinical learning, and accompaniment of student midwives. The discussion covered the history of midwifery training, both internationally and nationally; the aims and effectiveness of clinical education; the barriers to effective clinical teaching and learning as well as means of overcoming them. Midwifery tutors are required to accompany student midwives in the clinical setting. However, to many midwifery tutors clinical accompaniment of student midwives is a challenge. In order to fulfil this they have to continuously assess their performance, maintain their clinical teaching credibility, commitment and appreciate the value of clinical accompaniment of student midwives.

Chapter 3 discusses the research design and methodology.

Chapter 3

Research design and methodology

3.1   INTRODUCTION

This chapter describes the research design and methodology used in the study, including the population, sample, reliability and validity, data collection and the data-collection instrument, pre-test (pilot study) and ethical considerations.

The study was conducted in three successive and interrelated phases to achieve the objectives (see figure 3.1).

In the first phase the researcher formulated the purpose and objectives of the study as well as the questions that guided it, selected the research design and methodology, and conducted a literature review. The context of the study was the postnatal wards to which students were allocated for their clinical experience in Tanzania.

In the second phase the researcher selected the sample, using inclusion criteria, conducted a pre-test (pilot study) to test and refine the data-collection instrument, and ensured the validity and reliability of the questionnaire. The researcher upheld ethical considerations throughout the study.

The third and final phase entailed data analysis and interpretation, presenting the findings, and making recommendations for practice and further research based on the findings.

3.2   RESEARCH DESIGN

Polit and Beck (2003:165) define research design as the researcher's overall plan for obtaining answers to questions. Burns and Grove (2005:734) describe a research design as a blueprint for conducting a study that maximises control over factors that could interfere with the validity of the findings. For the purposes of this study, the researcher used a quantitative non-experimental, descriptive research design.

Figure 3.1

Phases of the research process

Source: Polit & Beck (2003:47-52)

3.2.1 Quantitative

Quantitative research is a formal, objective, systematic process in which numerical data are used to obtain information about a phenomenon. It describes variables, examines relationships among variables and determines cause and effect interactions between variables (Burns & Grove 2005:747).

The researcher chose a quantitative, descriptive research design in order to give a detailed description of the clinical teaching of student midwives in postnatal wards in Tanzania. The questions were intended to generate knowledge, which would directly improve clinical practice (Burns & Grove 2005:40).

According to Brink (2006:111), a descriptive survey design may be utilized "to study characteristics in a population for the purpose of investigating probable solutions of a research problem".

A survey was chosen for this study for the following reasons:

- It was appropriate for the research objectives as the aim of the study was not to infer cause and effect but to describe the nature of the research topic (Brink 2006:24).
- There was no active intervention on the part of the investigator that might produce research bias (Cohen, Manion & Morrison 2000:171).

According to Brink (2006:111), a survey design may be utilised to study characteristics in a population to investigate probable solutions to a research problem. In this study, the survey method was used because it is impartial; there was no prejudice in the selection of units participating. The research data could be collected in the natural setting and in a short time, using an interview or observation (Brink & Wood 1998:103). The study settings were Bugando, Lugalo, Muheza, Huruma, KCMC, Haydom and Ifakara nursing schools where data was collected from midwifery tutors and clinical instructors, using a structured questionnaire.

3.2.2 Non-experimental

According to Cozby (2004:372) and Brink (2006:108), non-experimental research uses measurement of variables to describe phenomena, and explore and explain the relationship between variables. The objective of this study was to describe the factors that influence clinical teaching of midwifery students in postnatal wards. The non-experimental format and strategy allowed the researcher to determine and examine these factors.

3.2.3 Descriptive

The descriptive component in the design offered a complete description of the phenomenon of clinical accompaniment and teaching without manipulating it (Burns & Grove 2005:232; Polit & Beck 2003:192). The design enabled the researcher to describe the phenomenon accurately, based on the data collected.

The study wished to acquire new information about clinical teaching and accompaniment, which is an unstudied phenomenon in Tanzania, in order to provide a picture of the situation as it naturally occurs (Burns & Grove 2005:734). Descriptive research determines what exists, the frequency with which something occurs, and categorises information.

3.2.4 Empirical

The empirical strategy is grounded in, and the findings based on reality rather than researchers' personal beliefs (Polit & Beck 2003:13). The empirical strategy is verified by analysis of the data obtained from participants.

The intention of this study was to gather information about factors that influence the clinical teaching and accompaniment of midwifery students in postnatal clinical settings through structured questionnaires using face-to-face interviews. The data was analysed using statistical tests to ensure objectivity in identifying and describing the factors.

3.2.5 Contextual

Cozby (2004:111) describes a contextual study as findings valid within the time-space and value context, where the study is done. The natural setting for this study was Bugando, Lugalo, Muheza, KCMC, Huruma, Haydom and Ifakara hospitals where the integrated diploma nursing/midwifery schools are located. This study is contextual because clinical teaching and accompaniment by midwifery tutors and clinical instructors of midwifery students in the postnatal wards cannot be isolated from their context. Therefore they are dependent on both the context and time.

3.3 RESEARCH SETTING

The setting refers to the place where the research data are collected (Brink 2006:64). The study was conducted in the postnatal wards in hospitals attached to the six selected integrated diploma-nursing schools located in the Eastern and Northern zones of Tanzania.

 The nursing schools and hospitals were selected for the following reasons:

- The schools and hospitals have been training student midwives at diploma level for more than five years.
- It was convenient for the researcher in terms of proximity, neighbourhood/vicinity and the availability of easy transportation.

The researcher obtained permission to conduct the study from the directors and principals of the schools (annexures A and B).

3.4 POPULATION AND SAMPLING

A population is all the elements (in this study, individuals) that meet the sample criteria for inclusion in a study (Brink 2006:132; Burns & Grove 2005:746; Polit & Beck 2003:290;). A sample is a subset or a portion of the entire population that is selected for the study (Brink 2006:134).

3.4.1 Population

The population of the study included all midwifery tutors and clinical instructors who teach midwifery in the 14 selected integrated diploma-nursing schools and hospitals in the East, Lake and Northern zones of Tanzania.

3.4.2 Sample

A sample consists of the elements and units of analysis that compose the population (Polit & Beck 2003:291).

Sampling involves a process of selecting a sub-section of a population that represents the entire population in order to obtain information regarding the phenomenon of interest. A sample is a sub-section of the population, which is selected to participate in a study. There are two methods of sampling; one yields probability samples in which the probability of selection of each respondent is assured. The other yields non-probability samples in which the probability of selection is unknown (Polit & Beck 2003:279).

The researcher used non-probability, convenience sampling to select the respondents. A convenient sample consists of using the most readily available or most convenient group of subjects for the sample (Cohen et al 2000:102). This method was chosen because it provided easy access to the respondents. It was simple, practical, economical, quick, and did not require an elaborate sampling frame (Brink 2006:133). The respondents were chosen from six nursing schools and hospitals.

For the midwifery tutors and clinical instructors, the researcher used the unit change lists to identify those who had accompanied midwifery students in the postnatal wards. From the selected midwifery tutors and clinical instructors, the available individuals were selected after obtaining their consent. The sample consisted of 36 respondents available on the day of interviews.

The parameters of generalisability in both these sample are negligible; the study did not seek to generalise to the wider population. The study simply represents itself (Cohen et al 2000:102).

To be included in the sample, the respondents had to be:

- Registered nurse midwives who are qualified nurse tutors in order to minimise qualification variations (LoBiondo-Wood & Haber 2002:246).
- Teaching midwifery students at Bugando, Lugalo, Haydom, Huruma, KCMC, Muheza and Ifakara integrated diploma schools of nursing.
- Expert midwifery clinical instructors responsible for clinical teaching of midwifery students in the postnatal wards.
- Willing to participate voluntarily in the study.

3.4.3 Sampling

Sampling is a process of selecting a representative number of a population for study in a research investigation (LoBiondo-Wood & Haber 2002:240). According to Burns and Grove (2005:354), a sample should contain at least 30 subjects.

The respondents were selected in accordance with the requirements of the research questions. Equal opportunity and fairness ethical principles were maintained during sampling. The sampling method was purposeful with the inclusion of all midwifery tutors and preceptors/mentors/clinical instructors who were teaching midwifery students in postnatal wards (Burns & Grove 2005:354).

A sample of 18 midwifery tutors teaching midwifery in the selected schools and 17 clinical instructors were selected, giving a total of 35 (18 midwifery tutors and 17 clinical instructors).

3.5 DATA COLLECTION

Data collection is a systematic way of gathering information relevant to the research purpose or questions (Burns & Grove 2005:421).

Research instruments refer to the devices used to collect data, such as questionnaires, tests and checklists (Brink 2006:154). The researcher used a structured questionnaire. A questionnaire, sometimes referred to as a pencil format, is a printed self-report form

designed to elicit information through written responses on the subject (Burns & Grove 2005:398; Polit & Beck 2003:349).

3.5.1 Data-collection instrument

The researcher used a structured questionnaire as the data-collection instrument. The questionnaire comprised closed and open-ended questions. The researcher selected the questionnaire because it enabled her to ask consistent questions and the data yielded was easy to analyse with the help of a statistician, using the Statistical Package for Social Sciences (SPSS) computer program (Polit & Beck 2003:345). The respondents were interviewed directly to avoid misinterpretation and to ensure clarity on all issues. Brink (2006:148-151) maintains that a questionnaire is the best method of collecting data especially if the survey strategy is used.

3.5.2 Development of the questionnaire

The researcher followed Polit and Beck's (2003:262) and Burns and Grove's (2005:399) recommended guidelines in developing the questionnaire, namely

- Avoid loaded language.
- Construct short and simple questions.
- Avoid double-barrelled questions.
- Do not use negative items in order to avoid misreading and misinterpretation.
- Use complete items.
- Avoid leading questions because they could provide clues to the answers.
- State questions in the affirmative.
- Avoid ambiguous questions that could be misleading.
- Avoid lengthy questions to facilitate understanding and clarity.
- State a range of alternatives within the question itself, when possible.
- Avoid personal assumptions so as not to influence or interfere with respondents' views.
- Do not use slang, jargon or acronyms, which could be misleading.

3.5.3 Advantages of a questionnaire

As data-collection instruments, questionnaires have the following advantages:

- They save time because a lot of information can be obtained in a short while.
- They provide personal information that is readily given and easy to analyse.
- They ensure anonymity during the data collection since the findings cannot be linked to respondents.
- The format is standardised and not dependent on the mood of the researcher (Brink 2006:153).

3.5.4 Format of the questionnaire

The questionnaire contained five sections with closed questions and an open-ended question at the end of every section. Open-ended questions were included to enable the respondents to give their unique individual opinions or views and/or experiences after the closed questions. The sections were as follows:

Section A: Biographical and educational data of respondents
Section B: Questions on teaching information – theory
Section C: Questions on teaching information – clinical
Section D: Questions on teaching information – clinical accompaniment
Section E: Legal requirements

A covering letter accompanied the questionnaire. The letter explained the purpose of the study, the time required to complete the questionnaire, and how the research information would be handled to ensure confidentiality (Polit & Beck 2003:366) (see annexures C, D and E for copies of the covering letters and the questionnaire).

3.6   VALIDITY AND RELIABILITY

3.6.1 Validity

According to Burns and Grove (2005:376), validity refers to the appropriateness, meaningfulness and usefulness of the specific inferences made from instrument scores

and not the scores themselves. Validity looks at truth, strength and values. It is the ability to obtain the needed data and tells the researcher whether the tool will measure what it is supposed to measure (Burns & Grove 2005:376). In this study, content validity was assessed. Content validity is important to all instrumentation because it assesses whether the instrument adequately measures the domain of interest (Brink 2006:215).

The questionnaires focused on content validity, which was concerned with how accurately the questions tended to elicit the information sought. The researcher gave the questionnaire to the supervisors and clinical staff experienced in clinical teaching to test content validity. A pilot study (pre-test) was carried out to ensure validity.

3.6.2 Reliability

According to Burns and Grove (2005:374), reliability refers to the precision and accuracy of the instrument. If used on a similar group of respondents in a similar context, the instrument should yield similar results.

Burns and Grove (2005:374) state further that reliability represents the consistency of the measure obtained in the use of a questionnaire and is an indication of the extent of random error in a measurement instrument. Reliability testing shows characteristics as dependability, consistency, precision and comparability. The reliability of an instrument depends on stability, equivalence and homogeneity.

Polit and Beck (2003:416) and Brink (2006:213) define reliability of an instrument as "the degree of consistency and dependability with which it measures the attribute it is supposed to measure". When a tool measures accurately, it reflects the true measures of the attributes under investigation. A reliable instrument is one, which, if administered twice under the same circumstances, should provide identical data and should create reproducible results. The researcher took the following steps to ensure reliability:

- The questionnaires were compiled in English, which was understood by the respondents.
- Accurate and careful phrasing of each question was done to avoid ambiguity.
- The questionnaires were pre-tested in a pilot study.

- The respondents were informed of the purpose of the study and the need to respond truthfully.

This means that if similar research instruments were used to collect data, similar results would be obtained.

3.7   PRE-TEST (PILOT STUDY)

Brink (2006:94) defines a pre-test or pilot study as "a small-scale study using a small sample of the population, who will not participate in the final study, in order to test and refine the instrument". In this study, the researcher conducted a pre-test to:

- Evaluate the time needed for completion of the questionnaire.
- Determine whether the questions were correct, clear and understandable.
- Eliminate ambiguities or difficulty in the wording and phrasing.
- Give the researcher experience in administering questionnaires and dealing with respondents.

The pre-test was conducted with five respondents who were not part of the main study (Pera & Van Tonder 2005:160). Following the pre-test, some questions were rephrased for greater clarity. The purpose of the pre-test was to minimize errors, examine reliability, validity and usability, and indicate the adequacy of the questionnaire (Burns & Grove 2005:331; Polit & Beck 2003:103).

3.8   DATA ANALYSIS

Data analysis is "the systematic organization and synthesis of the research data and the testing of research hypotheses, under those data" (Polit & Beck 2003:643). It also entails "categorizing, ordering, manipulating and summarising the data and describing them in meaningful terms" (Brink 2006:178). The completed questionnaires were given to a statistician who used the SPSS computer program to analyse the data. Most of the questions included in the questionnaire were closed questions. These were coded for easy analysis by computer. The researcher categorised the open-ended questions by hand.

3.9   ETHICAL CONSIDERATIONS

Ethical considerations were an essential component in this study because of its sensitive nature. According to Pera and Van Tonder (2005:152), the main ethical considerations are permission to conduct research, the participants' consent, and the research process. Likely risks were continuously examined to increase sensitivity to the respondents.   The researcher was guided by the ethical principles of autonomy, permission, informed consent, confidentiality, anonymity, privacy, avoiding harm, and justice (Pera & Van Tonder 2005:152, 154).

3.9.1   Permission to conduct the study

Permission was obtained from both the respondents and the hospital management (Brink 2006:52). According to Pera and Van Tonder (2005:152), permission to use data from the participants should be sought within the moral framework to maintain autonomy, confidentiality and anonymity; providing informed consent; telling the truth, and guaranteeing non-coercion and non-exploitation of the individuals concerned. The researcher upheld these principles strictly in order to prevent any psychological harm or conflict.

3.9.2 Right to self-determination/autonomy

This is the freedom of individuals to conduct their own lives autonomously without external control, coercion or exploitation through participation in research. For this study, the psychological consequences were of concern to the researcher. The likely psychological problems experienced by midwifery tutors and clinical instructors could be remembered so the researcher was careful in designing the questions to ensure freedom from harm. The researcher approached the respondents purposefully and gave them full information about the study. They voluntarily decided to participate in the study and had the opportunity to withdraw at any time (Burns & Grove 2005:188; Polit & Beck 2003:143).

Prior to signing the consent form, the respondents were allowed to ask questions (see annexure D for consent form).

3.9.3   Right to full disclosure/informed choice

The ethical principles of autonomy, liberty and informed choice support one another. The researcher upheld these principles, including veracity, which involves telling the whole truth and nothing more. The researcher obtained written informed consent from each respondent (Ashcroft 2002:284).

3.9.4   Right to confidentiality and anonymity

Confidentiality is a basic ethical principle while anonymity is one way of maintaining confidentiality. The researcher took special precautions not to disclose any information and ensured freedom from exploitation by not coercing the respondents to participate. Numbers were used instead of names and the respondents were assured that the completed questionnaires would be safely stored by the researcher and destroyed after the study.

3.9.5   Right to privacy

As mentioned previously confidentiality and anonymity were maintained throughout the research. The questions were constructed as objectively to the research as possible to avoid inquisitiveness and transgression of privacy (Burns & Grove 2005:186). Anonymity was assured since linking the completed questionnaires to the respondents was not possible. The respondents were not required to write their names on the questionnaire. Numbers were used for statistical reasons and not for identifying respondents. Confidentiality was ensured in the written agreement and the completed questionnaires were kept safely (Polit & Beck 2003:150).

3.9.6   Avoiding harm

Avoiding harm is another basic human right to be considered when conducting research on human beings. According to Burns and Grove (2005:206), risks that may be encountered in research include physical, psychological, emotional, social and financial ones. In this study, the probable risk the clinical staff could have encountered was psychological harm through periods of long waiting and maintaining confidentiality and anonymity. The researcher minimised the time of interviewing the participants.

Maintaining privacy, confidentiality and anonymity during the interview also prevented psychological harm.

3.9.7   Justice

Justice refers to "the fair treatment of those in the study" (Burns & Grove 2005:705). In this study, the participants were treated fairly by giving them information prior to participation as well as the option to withdraw from the study if they wanted to without any negative consequences. Selection of the sample following the guidelines of the inclusion criteria also ensured that all those who met the criteria had a fair chance of being chosen to participate in the study.

3.9.8   Benefits to participants and training institutions

The study is expected to generate knowledge that will be used by midwifery tutors and clinical instructors to improve the clinical accompaniment of midwifery students in the postnatal wards during their practical experience. Midwifery education will also be improved to develop and equip quality midwives who are able to provide appropriate nursing and midwifery care. These benefits include the description and understanding of the recommended changes.

3.10   CONCLUSION

This chapter described the research design and methodology, including sampling, data collection, the data-collection instrument, and ethical considerations. Chapter 4 presents the data analysis in the form of frequency tables and bar graphs, and interpretation of the findings.

CHAPTER 4

Data analysis and interpretation

4.1   INTRODUCTION

This chapter presents the data analysis and interpretation. The objectives of the study were to identify factors that influence clinical teaching of midwifery students in selected clinical settings in Tanzania and to make recommendations to provide clinical facilitation for student midwives.

The researcher collected data from the respondents using a structured questionnaire consisting of five sections:

- Section A: Biographical and educational data
- Section B: Teaching information – theory
- Section C: Teaching information – clinical
- Section D: Teaching information – clinical accompaniment
- Section E: Legal requirements

Thirty-five respondents participated in the study in 2005. A statistician analysed the data, using the SPSS program version 13.0. Descriptive and inferential statistics such as frequencies, tables and percentages were used in the data analysis and summaries.

A total of 35 respondents were interviewed using a structured questionnaire. In items where not all the respondents responded, the frequency and percentages were calculated according to the number of responses, as in item 3, for example. Missing responses were thus not included.

In some instances the percentage adds up to a decimal larger than a 100,0%. This calculation was rounded of to a 100,0%, for example table 4.14.

4.2   SECTION A: BIOGRAPHICAL AND EDUCATIONAL DATA

The biographical data collected included age, professional qualifications, academic qualifications and current occupation, which might contribute to the decline in clinical teaching in the postnatal wards.

4.2.1   Item 1: Age distribution in years

Figure 4.1 shows that of the respondents, 54,2% (n=19) were between 31 and 45; 17,2% (n=6) were between 25 and 30, and 20% (n=7) were between 46 and 55. Furthermore, 8,6% (n=3) of the respondents would be retiring within the next five years.
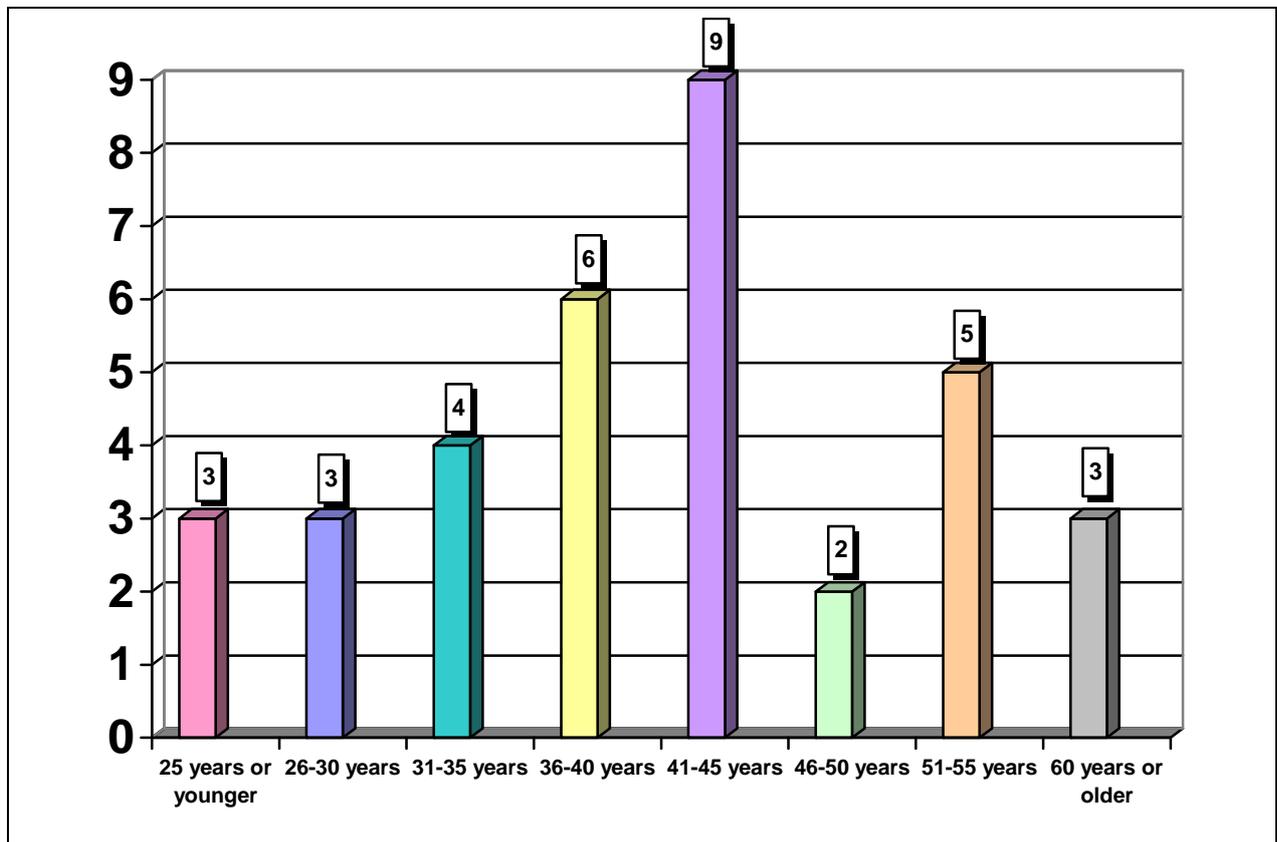
Figure 4.1
Age of the tutors/preceptors (N=35)

4.2.2 Item 2: Respondents' highest professional qualification

All the respondents (N=35) answered this item. Of the respondents, 54,3% (n=19) reported their highest qualification as a Diploma in General Nursing and Midwifery; 25,7% (n=9) possessed the Advanced Diploma in Nursing Education; 11,4% (n=4) had a Diploma in Nursing Education, and 8,6% (n=3) had obtained other qualifications. All the respondents (100%; N=35) had obtained a nursing education qualification, and were thus well-versed in not only the theory, but also in clinical teaching (see table 4.1).

Table 4.1   Respondents' highest professional qualification (N=35)

Professional qualification	f	%
Diploma in General Nursing and Midwifery	19	54,3
Advanced Diploma in Nursing Education	9	25,7
Diploma in Nursing Education	4	11,4
Other qualification	3	8,6
Total	**35**	**100,0**

4.2.3 Item 3: Respondents' highest academic qualifications

A total of 33 (N=33) respondents answered this item. Table 4.2 indicates that 75,8% (n=25) of respondents' highest academic qualification was a Diploma in Nursing and Midwifery; 12,1% (n=4) had a BA in Sociology, and 12,1% (n=4) possessed a BSc in Nursing.

Table 4.2   Respondents' highest academic qualifications (N=33)

Highest academic qualification	Frequency	Percentage
Diploma in Nursing and Midwifery	25	75,8
BSc in Nursing	4	12,1
Other qualifications	4	12,1
Total	**33**	**100,00**

4.2.4 Item 4: Respondents' professional qualifications as midwifery tutors

Only 27 (N=27) respondents answered item 4 on the qualification in general nursing. Of the respondents, 96,3% (n=26) were qualified as general nurses. With regard to the following qualifications, all the respondents (N=35) answered the item. Of the respondents, 82,9% (n=29) had midwifery as a qualification; 48,6% (n=17) were also qualified nurse educators while 14,3% (n=5) were not qualified nurse managers. Of the respondents none were qualified as community health nurses or psychiatric nurses. The latter is important, as midwifery education should currently be community-based (Fraser et al 2006:39).

4.2.5 Item 5: Respondents' current occupation

All the respondents answered this item (N=35). Of the respondents, 42,9% (n=15) indicated their current occupation as ward supervisors; 42,9% (n=15) were mentors; 8,6% (n=3) were nurse educators; 2,9% (n=1) was a clinical instructor and 2,9% (n=1) was a preceptor.
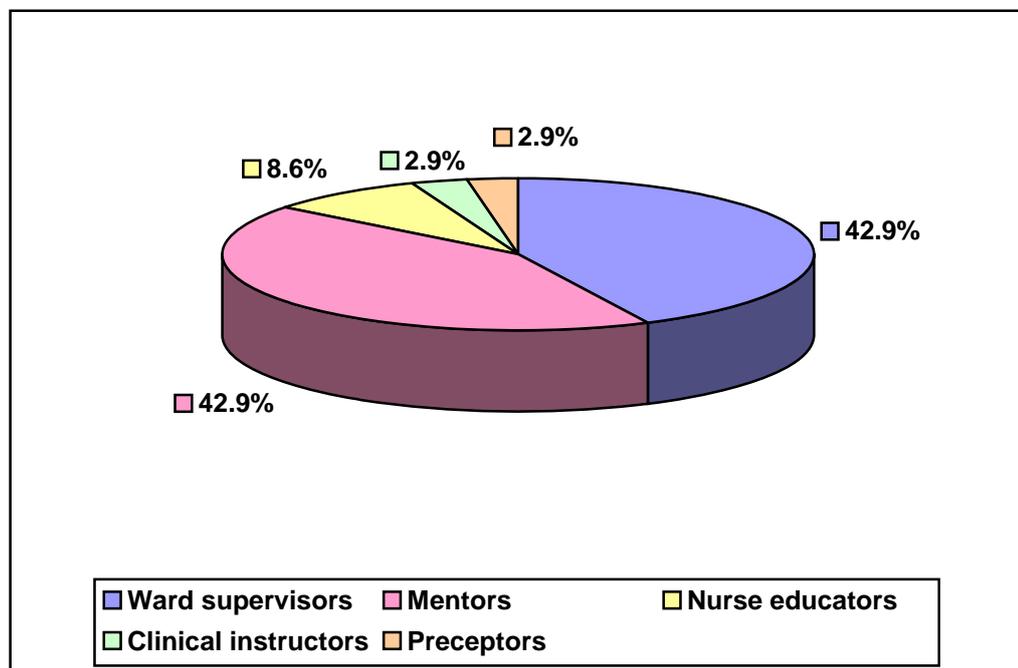
Figure 4.2

Respondents' current occupation (N=35)

4.3   SECTION B: TEACHING INFORMATION

The respondents were asked to indicate the number of years they had been teaching midwifery at a nursing college, the educational system followed at the nursing college and the block and day system as an educational system followed at the nursing college.

4.3.1 Item 6: Respondents' experience in teaching midwifery at the nursing college

A total of 30 (N=30) respondents answered item 6. Of the respondents, 20,0% (n=6) had been teaching at the college for 7 years; 26,7% (n=8) had been teaching for six years or more; 13,4% (n=4) had been teaching for between 4 and 5 years; 10,0% (n=3) had been teaching for 3 years; 23,3% (n=7) had been teaching for two years, and 6,7% (n=2) had been teaching for one year or less (see table 4.3).

Table 4.3   Respondents' experience in teaching midwifery at the nursing college (N=30)

Years of teaching	Frequency	Percentage
1 year or less	2	6,7
2 years	7	23,3
3 years	3	10,0
4 years	2	6,7
5 years	2	6,7
6 years or more	8	26,7
Other	6	20,0
Total	**30**	**100,0**

4.3.2 Item 7: Educational system followed by the college

All the respondents (N=35) answered this item. Of the respondents, 45,7% (n=16) indicated that the college made use of the block system; 5,7% (n=2) reported that the day system was used, and 48,6% (n=17) indicated that other systems (a combination of semester, block and day system) were used (see table 4.4).

Table 4.4   Educational system followed by the college (N=35)

Educational system	Frequency	Percentage
Block system	16	45,7
Day system	2	5,7
Other systems	17	48,6
Total	**35**	**100,0**

4.3.3 Item 8: The block system

Twenty-six respondents (N=26) answered item 8.   Table 4.5 indicates that 88,5% (n=23) of the respondents indicated that two blocks per year, each consisting of four weeks, were used; 7,7% (n=2) reported that a system of two blocks per year, consisting of two weeks per block, were used, and 3,8% (n=1) indicated that a combination of a block and day system was used.

Table 4.5   Number of blocks (N=26)

Number of blocks	Frequency	Percentage
2 blocks per year (2 weeks per block)	2	7,7
2 blocks per year (4 weeks per block)	23	88,5
Other block system	1	3,8
Total	**26**	**100,0**

4.3.4 Item 9: Day system: number of days per week for class attendance

The midwifery training system is arranged that students attended classes to gain theoretical knowledge for a specified number of days in a week; while the rest of the days were spent in the clinical settings to practise clinical skills.

Of the 35 respondents, 57,1% (n=20) indicated that the students attended class three days per week, 42,9% (n=15) showed that students attended one day class per week.

Of the 35 respondents 77,1% (n=27) indicated that the students attended the college for classes for a total number of three weeks per year and 22,9% (n=8) reported that the students attended two weeks class per year when following the day system approach. (see table 4.6).

Table 4.6   Week system: number of weeks per year for class attendance (N=35)

Number of weeks per year		
Weeks	Frequency	Percentage
2	8	22,9
3	27	77,1
Total	35	100,0

4.4.   SECTION C: TEACHING INFORMATION: CLINICAL TEACHING

This section of the study explored the time allocated for midwifery practice. As the study is a dissertation of limited scope, the focus was on clinical teaching in the postnatal ward.

4.4.1 Item 10: Time allocated for midwifery clinical practice

A total of 19 respondents answered item 10. All the respondents (100,0%; N=19) reported that one hour per week was allocated for midwifery practice. The data showed that 100,0% (N=19) indicated that two weeks per year were used for midwifery practice and 100,0% (N=19) respondents indicated one hour per week meaning that about 42 hours per year, which is approximately six days or one week, were used.

Apart from the other 100,0% (N=4), the rest of the data was not indicated. The 100,0% (N=4) indicated on the "other" supported seven hours per day but not known for how many days per week or year.

The purpose of item 10 was to determine the time allocated for midwifery clinical practice in terms of hours per week and weeks per year. The respondents could respond to more than one option. Of the respondents, 100,0% (N=19) answered this item in terms of hours per week allocated for midwifery practice. All of them 100,0% (N=19) responded that only one hour per week was allocated for midwifery practice.

A total of 20 respondents answered the section on time allocated for midwifery clinical practice in terms of weeks per year allocated for midwifery practice. All of them (100,0%; N=20) indicated that two weeks per year were used for midwifery practice.

A total of four respondents (100,0%; N=4) indicated "other" time frames for midwifery practice allocated. They indicated that seven hours per day were spent on midwifery practice, but did not how many days per week or year.

Table 4.7   Time allocated for midwifery clinical practice

Time	Frequency
Hours per week	19
Weeks per year	20
Other	4

4.4.2 Item 11: Time allocated for postnatal clinical experience

A total of 14 respondents answered item 11a. Of the respondents, 100,0% (N=14) indicated that one hour per week was allocated for postnatal clinical experience. Secondly, 26 respondents answered item 11b. Of the respondents, 100,0% (N=26) reported that two weeks per year were allocated for postnatal clinical experience.

4.5   SECTION D: TEACHING INFORMATION: CLINICAL ACCOMPANIMENT

The study explored the respondents' clinical accompaniment with regard to midwifery training of midwifery students.

4.5.1   Item 12: Accompaniment of students

4.5.1.1   *Item 12.1: Involvement in the accompaniment of students in the clinical setting*

Of the 35 respondents, 97,1% (n=34) indicated that they were involved in the accompaniment of midwifery students in the clinical field and 2,9% (n=1) reported no involvement in the clinical accompaniment of midwifery students.

4.5.1.2 *Item 12.2: Time spent on accompaniment*

Of the respondents, 65,7% (n=23) indicated that they accompanied students in the clinical setting between 1 to 5 hours per week; 20% (n=7) spent between 6 and 10

hours per week on accompaniment, and 14,3% (n=5) indicated "other", stating that they spent less than one day on accompaniment. Dunn (in Billings & Halstead 2005:330) found no differences in clinical learning outcomes when clinical assignments occur either 1 or 2 days per week or in alternating 2-week blocks of time.
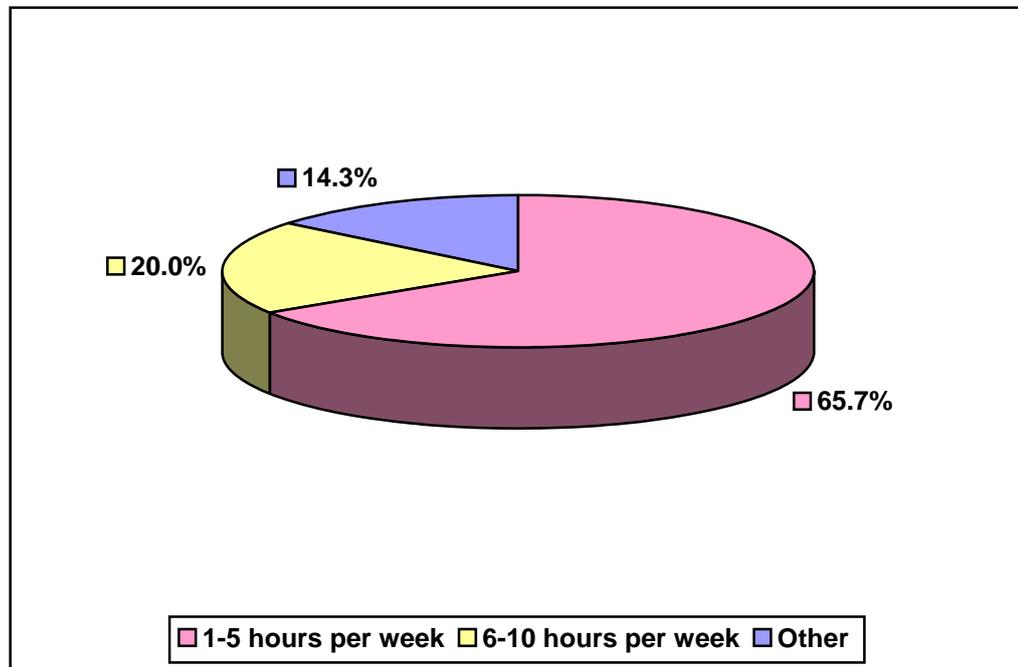
Figure 4.3

Time spent on accompaniment (N=35)

4.5.1.3   Item 12.4: Other staff involved in the accompaniment of the students

All the respondents (N=35) answered this item. In this item the respondents could select more than one option.

Of the respondents, 48,6% (n=17) indicated that clinical facilitators were involved in the teaching of midwifery students; 74,3% (n=26) indicated ward sisters; 65,7% (n=23) indicated clinical instructors, and 40% (n=14) indicated that they were ward mentors for the midwifery students. Furthermore, 77,1% (n=27) reported that nursing officers, doctors, obstetricians, assistant medical doctors and students were also identified being involved in the teaching of midwifery students.

4.5.1.4 Item 12.5: Preparation for roles in clinical accompaniment of students

Item 12,5 determined whether tutors/preceptors/mentors were prepared for their roles of clinical accompaniment of students. Of the respondents, 82,9% (n=29) answered "yes" and 17,1% (n=6) were not prepared for their roles in clinical accompaniment of midwifery students (see table 4.8).

Table 4.8   Preparation of the tutors/preceptors/mentors for their roles as clinical accompaniment of students (N=35)

	Frequency	Percentage
Yes	29	82,9
No	6	17,1
Total	**35**	**100,0**

4.5.1.5   Item 12.6:   Ways in which the tutors had been prepared for students' accompaniment

Of the respondents, 45,7% (n=16) indicated that meetings with college and ward staff were used in preparation for student accompaniment; 65,7% (n=23) indicated that they received information about the students' practica requirements, and only 8,6% (n=3) said that they received information during their training (see table 4.9).

Table 4.9   Ways in which tutors were prepared for student accompaniment (N=35)

		Frequency	Percent
Meeting	Yes	16	45,7
	No	19	54,3
Information	Yes	23	65,7
	No	12	34,3
Other	Yes	3	8,6
	No	32	91,4

4.5.1.6 Item 12.7: Activities in planning for clinical teaching and learning

Table 4.10 shows that of the respondents, 62,9% (n=22) indicated that there was a fair distribution of experienced competent midwives present to accompany the students

through the three shifts; 71,4% 9 (n=25) revealed that both student midwives and clinical staff were involved in preparing a realistic clinical educational plan, and 82,9% (n=29) indicated that time allocation was part of the planning for the clinical programme.

Of the respondents, 85,7% (n=30) indicated that planning the placement of students in the clinical setting was part of their activities. Another vital activity of the respondents was setting outcomes for student learning, and 85,7 % (n=30) indicated that they were involved in this activity. In addition, 77,1% (n=27) indicated that they set standards for the clinical guidelines of midwifery students and 74,3% (n=26) indicated identifying records to be maintained for clinical teaching.

Of the respondents, 40% (n=14) identified providing written outlines of the clinical teaching material for midwifery students to all preceptors/mentors/clinical instructors, and 8,6% (n=3) indicated that "other" activities included organising appropriate equipment and the rotation of tutors between the clinical settings.

Table 4.10   Teaching and learning activities planned by tutors/preceptors (N=35)

Activity		Yes	No	Total
Checking the distribution of experienced/competent midwives in the three shifts	Frequency	22	13	35
	%	62,9	37,1	100,0
Involvement of student midwives, clinical staff in preparing a realistic clinical education plan	Frequency	25	10	35
	%	71,4	28,6	100,0
Time allocation for clinical supervision	Frequency	29	6	35
	%	82,9	17,1	100,0
Planning for students placement	Frequency	30	5	35
	%	85,7	14,3	100,0
Setting outcomes for students' learning	Frequency	30	5	35
	%	85,7	14,3	100,0
Identifying standards guidelines for clinical accompaniment	Frequency	27	8	35
	%	77,1	22,9	100,0
Identifying records to be maintained	Frequency	26	9	35
	%	74,3	25,7	100,0
Providing a written outline of clinical education to all preceptors/mentors/supervisors/ clinical instructors	Frequency	14	21	35
	%	40	60	100,0
Other	Frequency	3	32	35
	%	8,6	91,4	100,0

4.5.2 Item 13: Skills laboratory

4.5.2.1 Item 13.1: The institution has a skills laboratory

Of the respondents, 80,0% (n=28) indicated that the institutions they were involved in had skills laboratories, and only 20% (n=7) indicated that there were no skills laboratories.

4.5.2.2   Item 13.3: Resources to be prepared in the simulation laboratory for postnatal practice

All the respondents (N=35) answered this item. Table 4.14 indicates that the respondents reported the following resources needed for postnatal practice in the simulation laboratory:

- 85,7% (n=30) indicated that apparatus for checking vital signs, weighing scale and tape measure were necessary
- 82,9% 9n=29) indicated the following sources as important to carry out a physical examination of the patient: personal protective equipment and adequate space for individual counselling of clients,
- 80% (n=28) indicated resources needed in the skills laboratory for perineal care, including repairing of the perineum, dressings and suture removal material.
- 77,1% (n=27) indicated that they would include resources for baby care, such as immunization equipment, in the skills laboratory.
- 65,7% (n=23) identified resuscitation equipment, analgesics, anti-malarial and anti-diabetic agents to be included in a skills laboratory.
- 14,3% (n=5) identified "other" resources that could be included in a skills laboratory for post-natal clients: equipment to do postnatal check-up, equipment for testing for HIV and equipment such as speculums for checking the perineal sites in case of tears or episiotomies.

Table 4.11   Resources needed in the simulation laboratory for postnatal practice (N=35)

		Yes	No	Total
Apparatus for checking vital signs, weighing scale, tape measure	Frequency	30	5	35
	%	85,7	14,3	100,0
Personal protective equipment and adequate space for individual counselling of clients, for carrying out client's physical examination	Frequency	29	6	35
	%	82,9	17,1	100,0
Perineal care including repair, dressing and suture removal	Frequency	28	7	35
	%	80,0	20,0	100,0
Provision for baby care including immunisations	Frequency	27	8	35
	%	77,1	22,9	100,0
Resuscitation equipment, analgesics, anti-anaemia, anti-malarial and anti-diabetic agents	Frequency	23	12	35
	%	65,7	34,3	100,0
Other	Frequency	5	30	35
	%	14,3	85,7	100,0

4.5.2.3   Item 13.4: Skills demonstrated to student midwives in the skills laboratory before actual practice in clinical settings

All the respondents (N=35) answered this item. Table 4.12 below shows the following findings:

- 82,9% (n=29) of the respondents indicated that they would demonstrate the physical assessment of the postnatal woman

- 80% (n=28) would demonstrate the assessment of a newborn baby.

- 74,3% (n=26) demonstrated cord care, care of the breast and breastfeeding in the simulation laboratory.

- 57,1% (n=20) demonstrated how to care for women with inverted nipples, engorged breasts and breast infection

- 57,1% (n=20) demonstrated perineal care, episiotomies, suturing of tears and the care of birth injuries to the genitals in the simulation laboratory

- 74,3% (n=26) demonstrated counselling for family planning in the simulation laboratory.

- Only 65,7% (n=23) demonstrated the monitoring of a baby's growth.

Table 4.12   Skills demonstrated to student midwives in the skills laboratory before practice in clinical settings (N=35)

Skills		Yes	No	Total
Physical assessment of the postnatal woman	Frequency	29	6	35
	%	82,9	17,1	100,0
Assessment of the newborn baby	Frequency	28	7	35
	%	80,0	20,0	100,0
Care of the cord	Frequency	26	9	35
	%	74,3	25,7	100,0
Care of the breast and breastfeeding	Frequency	26	9	35
	%	74,3	25,7	100,0
Counselling for family planning	Frequency	26	9	35
	%	74,3	25,7	100,0
Monitoring of growth of the baby	Frequency	23	12	35
	%	65,7	34,3	100,0
Care of women with inverted nipples, engorged breasts/infection	Frequency	20	15	35
	%	57,1	42,9	100,0
Care for genitals including infected episiotomies/ tears/incontinence/prolapsed uterus/rectum	Frequency	20	15	35
	%	57,1	42,9	100,0
Other	Frequency	6	29	35
	%	17,1	82,9	100,0

4.5.3   Item 14: Clinical facilitators' roles

4.5.3.1   Item 14.1: Clinical facilitators' roles during clinical accompaniment of student midwives

All the respondents (N=35) answered this item. Table 4.13 presents the following roles of the clinical facilitator during clinical accompaniment identified by the respondents:

- Interaction of midwifery tutors, professional midwives involved in clinical accompaniment with student midwives in clinical settings (85,7%; n=30)
- Support to student midwives during their clinical experiences (82,9%; n=29).
- Work with the students in the clinical practice (94,3%; n=33)
- Guidance in teaching students their independent functions (82,9%; n=29)
- Clarification of certain conditions encountered in the clinical setting (91,4%; n=32)
- Information provided by the respondents to the students on their course work and assessment approaches to be followed (94,3%; n=33)
- Support to the students with regard to their independent and autonomous roles (57,1%; n=20)

- Other roles included setting clinical objectives, demonstrating skills and supervision of student midwives (8,6%; n=3).

Table 4.13   Clinical facilitators' roles during clinical accompaniment of student midwives (N=35)

The roles		Yes	No	Total
Midwifery tutors, professional midwives involved in clinical accompaniment interacts with student midwives in clinical settings		30	5	35
	%	85,7	14,3	100,0
Student midwives are assisted and supported in order to make clinical learning easy, quick and comfortable	Frequency	29	6	35
	%	82,9	17,1	100,0
Participation in and enabling the action of student midwives in clinical practice	Frequency	33	2	35
	%	94,3	5,7	100,0
Student midwives are guided to meet their independent functions	Frequency	29	6	35
	%	82,9	17,1	100,0
Clarification of various approaches, encourage analysis and promote interpretation of conditions in clinical setting	Frequency	32	3	35
	%	91,4	8,6	100,0
Student midwives are informed and advised in relation to their course work and assessment	Frequency	33	2	35
	%	94,3	5,7	100,0
Students are ascribed appropriate independence and autonomy	Frequency	20	15	35
	%	57,1	42,9	100,0
Other	Frequency	3	32	35
	%	8,6	91,4	100,0

4.5.3.2   Item 14.2: Midwifery tutors as role models in accompaniment of student midwives in clinical settings

Of the respondents, only 42,9% (n=15) indicated that midwifery tutors were role models for the clinical accompaniment of midwifery students in clinical setting (postnatal wards), and 57,1% (n=20) did not agree.

4.5.3.3 Item 14.3: Who orients students to new clinical settings?

All the respondents answered this item (N=35). Of the respondents, 85,7% (n=30) rated the ward sisters in-charge of the shift as role models for the students in the clinical settings; 80,0% (n=28) reported the midwife in charge of the shift as role models; only

60% (n=21) indicated the tutor as the role model concerned with clinical accompaniment of student midwives, and 71,4% (n=25) identified the instructor/preceptors/mentors as role models for clinical accompaniment.
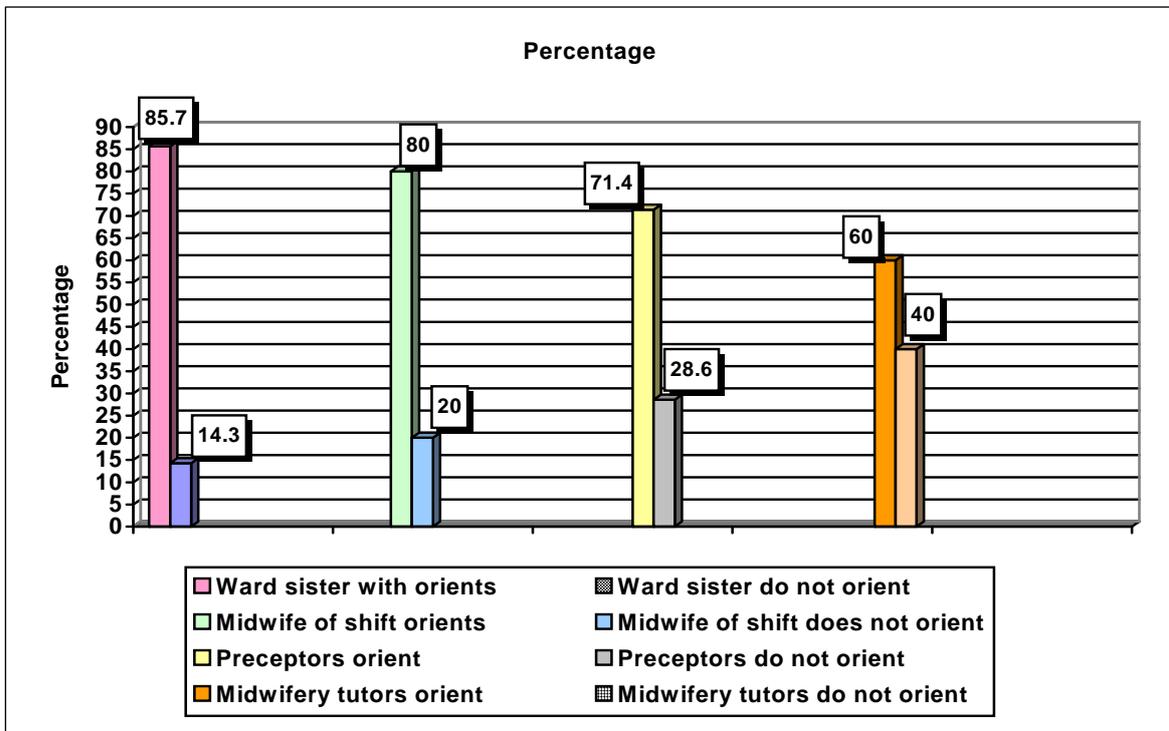
Figure 4.4

Persons who orients students in the clinical settings (N=35)

4.5.3.4 Item 14.4: Accompaniment of students in the clinical setting

All the respondents answered this item (N=35). The respondents were asked whether they accompanied students. Of the respondents, 80,0% (n=28) indicated that they accompanied students in the clinical settings and 20% (n=7) did not.

4.5.3.5 Item 14.5: Time spent on accompaniment of students in postnatal wards

All the respondents answered this item (N=35). Table 4.19 below indicates great diversity of time spent in accompaniment of students in the postnatal wards. Of the respondents, 40,0% (n=14) indicated that they accompanied students in the postnatal wards once a week; 20,0% (n=7) spent more than an hour every day accompanying students in the postnatal wards; 8,6% (n=3) spent less that one hour everyday in

accompaniment, and 25,7% (n=9) accompanied students depending on the students' need and tutors' time availability.

Table 4.14   Time spent in accompaniment of students in the postnatal wards (N=35)

Time spent	Frequency	Percentage
Less than one hour every day	3	8,6
More than one hour every day	7	20,0
Once a week	14	40,0
Once a month	1	2,9
Once per semester	1	2,9
Other	9	25,7
Total	**35**	**100,0**

4.5.3.6 Item 14.6: Reasons for not spending time on student accompaniment

All the respondents answered this item (N=35). This item, which was an open-ended question, required the respondents to state why they did not participate in the accompaniment of students. None of the respondents completed the item as all of them (100%; N=35) were involved in some way (see item 14.5).

4.5.3.7   Item 14.7: Strategies to ensure that student midwives meet their clinical learning needs in the postnatal wards

All the respondents answered this item (N=35). The respondents used several strategies to ensure that student midwives met the clinical practica necessary in the postnatal wards. Of the respondents:

- 37,1% (n=13) reported that some of the clinical teaching tasks were assigned to the ward staff.
- 62,9% (n=22) encouraged student midwives to participate in the planning of the clinical teaching programme.
- 71,4% (n=25) supported and led all the clinical activities in the postnatal wards.
- 40,0% (n=14) made use of mentors in the clinical accompaniment of students in the postnatal wards.

- 34,3% (n=12) provided the student midwives with a lot of theory before going to the postnatal wards for their practica experience.
- 65,7% (n=23) acted as role models for the students in the postnatal wards.
- 2,9% (n=1) gave the students assignments during their clinical experience in the postnatal wards.

Table 4.15   Strategies to ensure that student midwives meet their clinical learning needs in the postnatal wards during practice (N=35)

		Yes	No	Total
By assigning the clinical teaching tasks to ward staff	Frequency	13	22	35
	%	37,1	62,9	100,0
By encouraging them to participate in planning for clinical practice	Frequency	22	13	35
	%	62,9	37,1	100,0
By supporting and leading all clinical teaching activities	Frequency	25	10	35
	%	71,4	28,6	100,0
By using mentors in clinical accompaniment of students	Frequency	14	21	35
	%	40,0	60,0	100,0
By providing them with a lot of theory before practice	Frequency	12	23	35
	%	34,3	65,7	100,0
Act as role model to students	Frequency	23	12	35
	%	65,7	34,3	100,0
Other	Frequency	1	34	35
	%	2,9	97,1	100,0

4.5.4   Item 15: Student preparation for clinical practice

In an open-ended question the respondents were asked to explain the process they used to prepare students for their clinical experiences in the postnatal wards. Table 4.16 indicates the processes the respondents used.

4.5.4.1   Item 15.1: Processes of preparing students for their clinical experiences in the postnatal wards

This open-ended question was included to determine whether the respondents knew all the actions necessary to prepare students for clinical practice. None of the respondents responded to all the options. Of the respondents, 85,7% (n=30) agreed that provision of a midwifery register book/learning guide was necessary to prepare students for their clinical experiences; 71,4% (n=25) indicated giving adequate theoretical knowledge to students; 50,0% (n=17) mentioned demonstrating specific skills and having the students

then demonstrate the skill in the simulation laboratory, and 85,7% (n=30) reported ensuring a conducive learning environment with the ward supervisors as preparation for clinical practice as well as the preparation of clinical objectives for the clinical practice.

Table 4.16   Preparing students for their clinical experiences in the postnatal wards

Process of preparation	Frequency	Percentage
Students are given adequate theoretical knowledge in a block study	25	71,4
Tutors demonstrate specific skills and student do a return demonstration/continue to practise in the skill lab.	20	57,1
Midwifery tutor with the ward supervisors ensures that the a conducive learning environment is prepared for students	18	51,4
Tutors prepare clinical objectives/students groups and rotation with involvement of preceptors/ward supervisors	19	54,3
Letters/information sent to supervisors in postnatal wards	12	34,2
Midwifery register book /learning guides and necessary information is given to students	30	85,7
Tutors introduce students to supervisors who then introduce students in the wards and to the staff	7	20,0
Plan for clinical teaching and follow-up of students and preceptors/ supervisors/other facilitators	10	28,7

4.5.5 Item 16: Formative assessment of students in postnatal wards

In this item, the respondents were required to provide information on the strategies used in formative assessment of the students in the postnatal wards.

4.5.5.1   Item 16.1: Strategies to ensure the progress of students in the postnatal wards

All the respondents answered this item (N=35). Of the respondents, 60,0% (n=21) stated that they had meetings with the clinical staff on the ward; 20,0% (n=7) expected weekly reports on the students' progress; 28,6% (n=10) expected monthly progress reports, and 42,9% (n=15) expected a well-done assignment and a pass rate in the practical examination at the end of the students' clinical experience in the postnatal ward (see table 4.17).

Table 4.17   Strategies for ensuring students' progress in the postnatal wards (N=35)

		Yes	No	Total
Meeting with clinical staff	Frequency	21	14	35
	%	60,0	40,0	100,0
Weekly reports	Frequency	7	28	35
	%	20,0	80,0	100,0
Monthly reports	Frequency	10	25	35
	%	28,6	71,4	100,0
Other	Frequency	15	20	35
	%	42,9	57,1	100,0

4.5.5 2   Item 16.2: Relevant policies on formative evaluation of students

This item was an open-ended question requiring the respondents to state the relevant policies on formative evaluation used in the postnatal wards for the students during their postnatal experience. There were no responses to this item.

4.5.5.3   Item 16.3: Methods used to evaluate midwifery students' progress during clinical accompaniment

All the respondents answered this item (N=35). Of the respondents, 85,7% (n=30) reported that they used continuous evaluation for evaluating midwifery student' progress during clinical accompaniment; 77,1% (n=27) used assessment at the end of each semester; 57,1% (n=20) assessed each student at the end of a demonstration/ simulation and at the end of a role play; 62,9% (n=22) used work books to assess the students' progress; 80,0% (n=28) used a final practica assessment at the end of their stay in the postnatal wards, and 42,9% (n=15) requested written field reports from the ward supervisors to assess progress (see table 4.18).

Table 4.18   Methods used for evaluating student midwives during clinical accompaniment (N=35)

Methods		Yes	No	Total
Continuous evaluation	Frequency	30	5	35
	%	85,7	14,3	100,0
At the end of every semester	Frequency	27	8	35
	%	77,1	22,9	100,0
End of demonstration/simulation/role play	Frequency	20	15	35
	%	57,1	42,9	100,0
Work books	Frequency	22	13	35
	%	62,9	37,1	100,0
Final practical assessment	Frequency	28	7	35
	%	80,0	20,0	100,0
Written field reports from the ward supervisors	Frequency	15	20	35
	%	42,9	57,1	100,0

4.5.5.4   Item16.4: When feedback is given to students on their clinical learning

All the respondents answered this item (N=35). Of the respondents, 88,6% (n=31) reported that they gave feedback to the students at the end of the semester on their clinical learning experiences; 54,3% (n=19) gave students feedback at the end of the year; 57,1% (n=20) gave feedback only at the end of the course; 40,0% (n=14) only gave feedback on request, and 17,1% (n=6) gave feedback after a demonstration or on completion of a given assignment.

Flagler et al (in Mellish, Brink & Paton 2000:72) state that immediate and positive feedback is most valuable in encouraging students to develop self-confidence as midwives (see figure 4.5).

Percentage

Legend:
- ■ Give at end of semester
- ■ Do not give at end of semester
- ■ Give at the end of year
- □ Do not give at end of year
- ■ Give at end of the cours
- □ Do not give at end of the course
- ■ Give when they request
- ■ Do not give even when they request
- ■ Other (give after demonstration, role play, assignment)
- □ Others who did not indicate
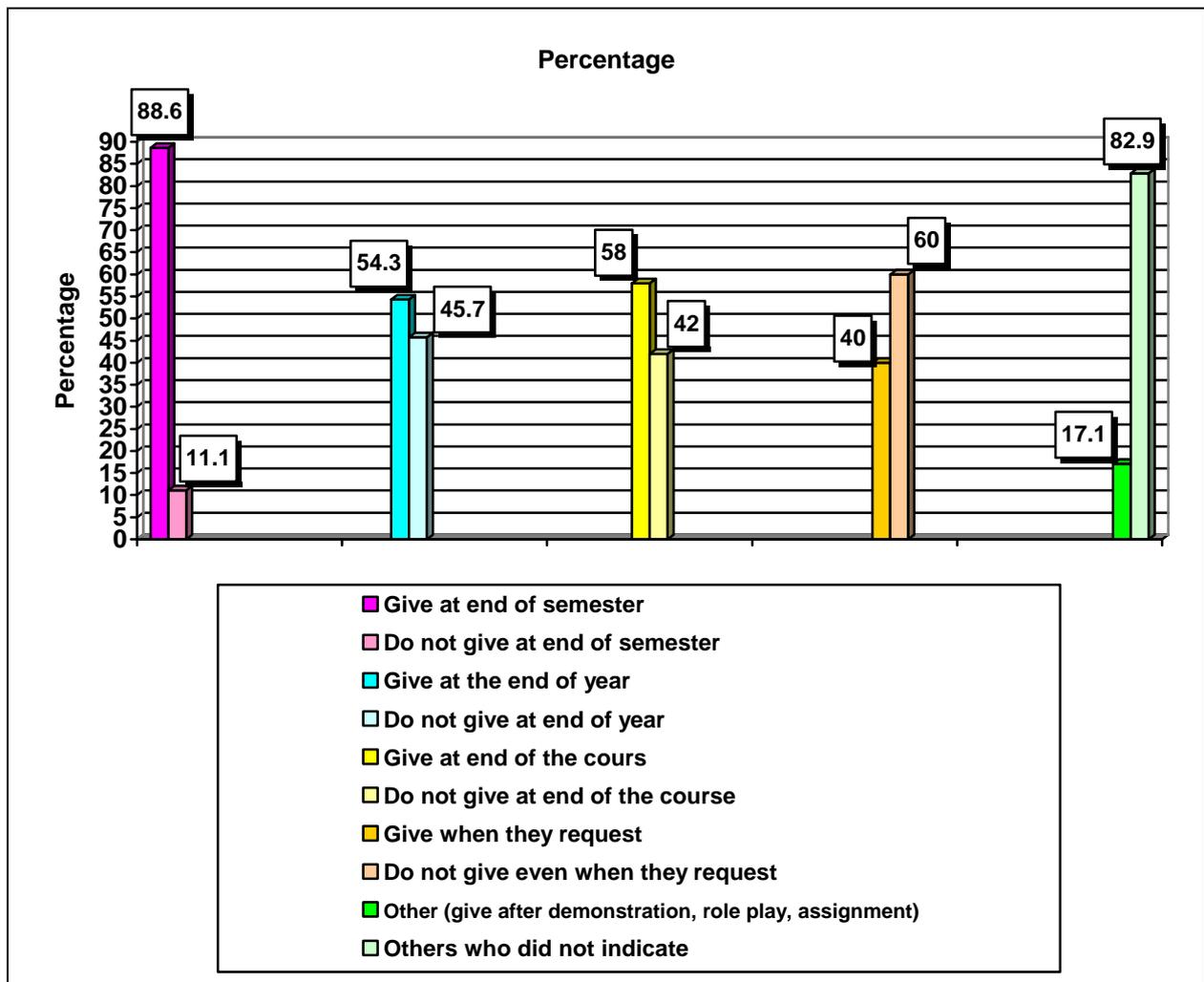
Figure 4.5

Time for giving feedback to student midwives

on their clinical learning (N=35)

4.5.5.5   Item 16.5: Methods used to give feedback on clinical learning

All the respondents answered item 16.5. Of the respondents, 94,3% (n=33) indicated that they gave feedback to the students in a private place. This method of feedback provides privacy as well as trust and respects the student, thus concurs with Billings and Halstead's (2005:57) findings. Of the respondents, 62,9% (n=22) gave feedback to the students in a group in front of fellow students; 34,3% (n=12) gave feedback on the spot, while the student was attending to a client, and 28,6% (n=10) gave feedback in a classroom with the preceptors, clinical instructors, and in the presence of the ward supervisor. Raiser, O'Grady and Lori (2003:398) emphasize that midwifery tutors should provide positive feedback. Billings and Halstead (2005:58) state that students

expect midwifery tutors to correct without humiliating or criticising them in front of others (see figure 4.6).

Percentage

Legend:
- ■ Give individually (privately)
- □ Do not give individually (privately)
- ■ Give in a group of fellow students
- □ Do not give in a group of fellow students
- ■ Give on the spot when attending clients
- □ Do not give on the spot when attending clients
- ■ Give in a class with preceptors/mentors
- □ Do not give in a class with preceptors/mentors
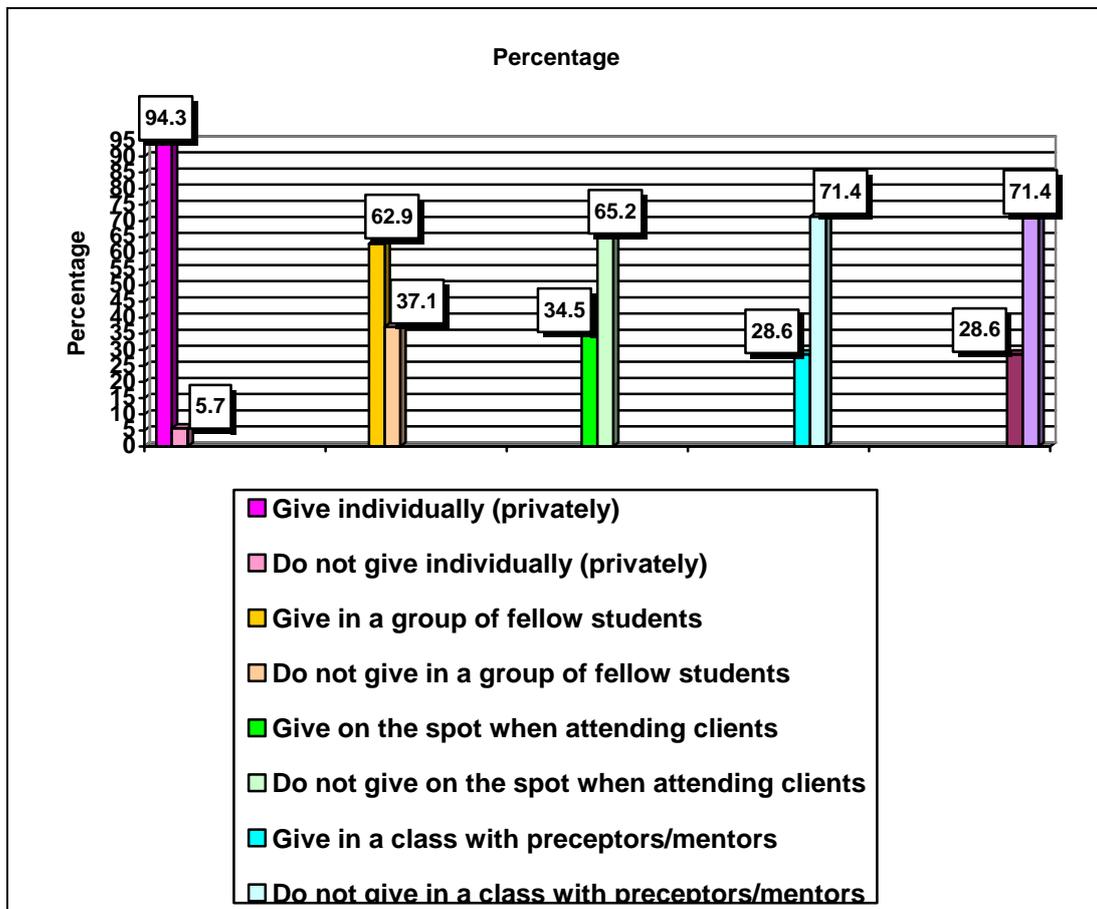
Figure 4.6

Methods of giving feedback to students about their clinical learning (N=35)

4.5.6 Item 17: Teaching strategies used during clinical accompaniment

In this item, the respondents were asked to state the teaching strategies that they used during clinical accompaniment of student midwives during their clinical learning experiences.

4.5.6.1   Item 17.1: Teaching strategies used during clinical accompaniment

All the respondents answered this item (N=35). Of the respondents, 94,3% (n=33) stated that they used demonstration as a teaching strategy. Demonstration is the most widely used method in clinical teaching by showing the learner how to perform certain psychomotor skills (Quinn 2001:348). Of the respondents, 87,5% (n=30) used ward

rounds; 74,3% (n=26) used case study presentations; 65,7% (n=23) used problem-solving strategies; 54,3% (n=19) used situational teaching (that is, making use of teachable moments during their clinical teaching sessions), and 40,0% (n=14) used the clinical meeting as a teaching strategy. Only 20,0% (n=7) used clinical judgment as a teaching strategy. This method is based on reflective practice teaching, which is one of the key strategies in experiential learning and consists of brief written descriptions of situations that can be used as the basis for reflection later (Quinn 2001:435) (see figure 4.7).
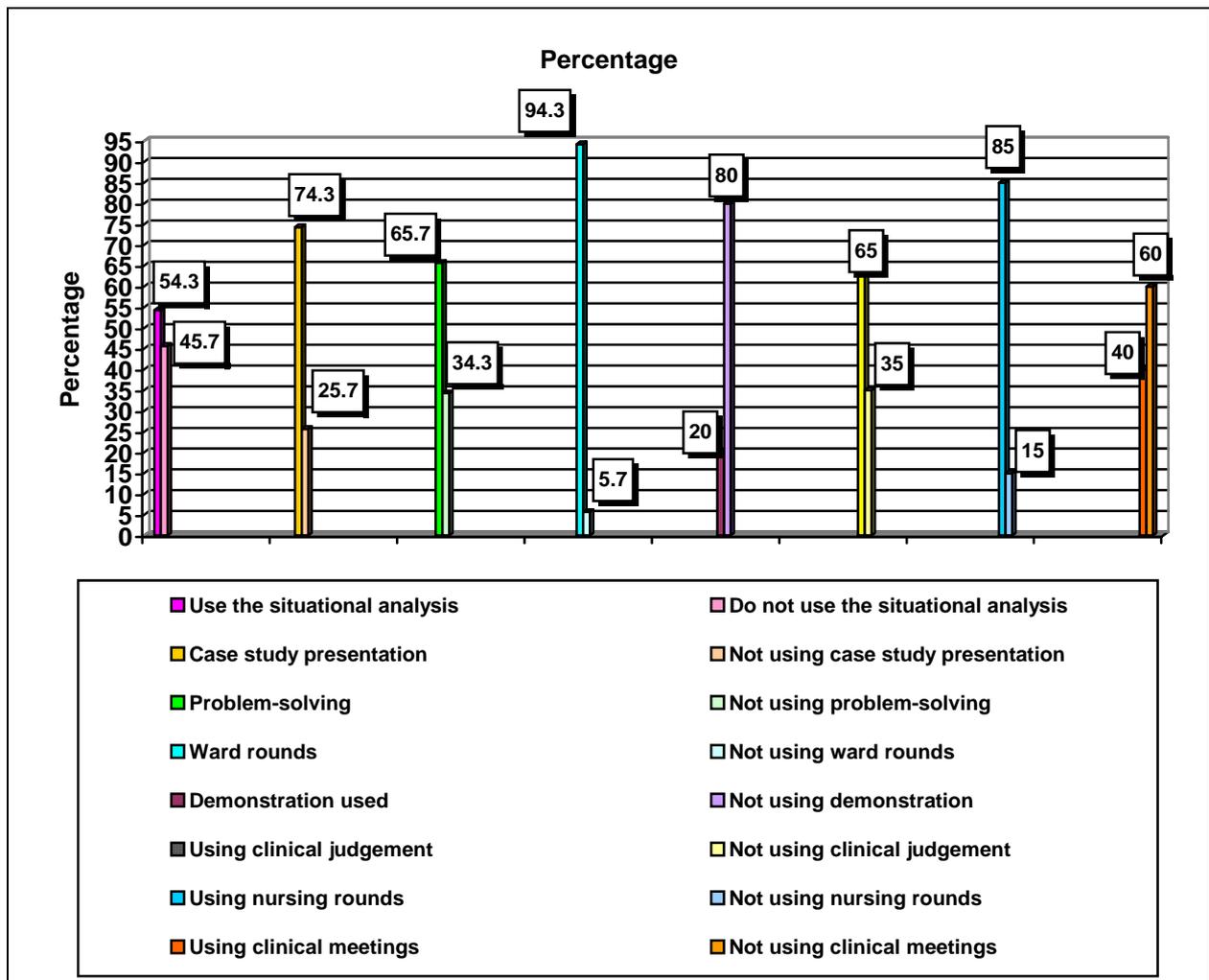
Figure 4.7

Teaching strategies used during clinical accompaniment (N=35)

4.5.7 Item 18: Conducive clinical learning environment

For this part of the study, the respondents were expected to describe an environment conducive to learning.

4.5.7.1 Item 18.1: Description of a clinical environment conducive to learning

All the respondents answered this item (N=35). Of the respondents, 88,6% (n=31) described an adequate physical environment conducive to deliver quality care and to facilitate the development of clinical competencies for student midwives. Furthermore, 94,3% (n=33) stated that to provide quality care and to facilitate the development of competencies for the student midwives, the environment should be such that the learning could take place. Of the respondents, 88,6% (n=31) reported that adequate resources such as space and equipment were necessary requirements to enhance the teaching and learning process in the clinical setting for student midwives; 71,4% (n=25) indicated a humanistic approach and teamwork as vital for learning; 60% (n=21) maintained management styles should be effective and flexible to provide good quality care; 82,9% (n=29) emphasised providing teaching and learning support to student midwives so that they can become responsible for their own leaning, critical thinking and judgment, and 82,9% (n=29) indicated that a clinical laboratory should be available for student midwives in order to learn some of the competencies needed in the simulation laboratory (see table 4.19).

Table 4.19   Description of a clinical environment conducive to learning (N=35)

Description of a conducive clinical learning environment		Yes	No	Total
Adequate physical environment to deliver quality care and facilitate development of clinical competences	Frequency	31	4	35
	%	88,6	11,4	100,0
Provide adequate and varied teaching and learning opportunities	Frequency	33	2	35
	%	94,3	5,7	100,0
There are adequate resources as space, equipment and other requirement which enhance the teaching and learning process	Frequency	31	4	35
	%	88,6	11,4	100,0
Appropriate humanistic approach	Frequency	25	10	35
	%	71,4	28,6	100,0
Team work is fostered	Frequency	25	10	35
	%	71,4	28,6	100,0
Management styles are effective and flexible in providing good quality care	Frequency	21	14	35
	%	60,0	40,0	100,0
Teaching and learning support are provided to midwifery students such that they become responsible for their own learning, critical thinking and judgment	Frequency	29	6	35
	%	82,9	17,1	100,0
Provide a clinical laboratory	Frequency	29	6	35
	%	82,9	17,1	100,0

4.5.8 Item 19: Clinical supervision

All the respondents answered this part on clinical supervision (N=35).

4.5.8.1 *Item 19.1: Responsibilities of the postnatal ward supervisor in accompanying student midwives during their postnatal practical*

Table 4.25 indicates that 74,3% (n=26) of the respondents reported that the postnatal ward supervisor should provide support to the midwifery tutor and the student midwives during their clinical practice in the postnatal ward; 85,7% (n=30) stated that student midwives should be guided to achieve their independent functions; 80% (n=28) indicated that the postnatal ward supervisor should provide technical skills based on theoretical knowledge and practice to the student midwives; 22,9% (n=8) indicated that the students should be part of the multidisciplinary team in the ward to reduce the workload of the staff in the ward; 34,3% (n=12) considered it the responsibility of the postnatal ward supervisor to plan for the students' clinical rotation programme, and 80% (n=28) also indicated that the postnatal ward supervisor should evaluate the students' clinical performance in the postnatal ward.

Table 4.20   Responsibilities of the postnatal ward supervisor in accompanying student midwives during their postnatal practical (N=35)

Responsibilities		Yes	No	Total
Providing guidance on students' independent functions	Frequency	30	5	35
	%	85,7	14,3	100,0
Providing technical skills depending/based on knowledge and practice	Frequency	28	7	35
	%	80,0	20,0	100,0
Evaluating students' clinical rotation	Frequency	28	7	35
	%	80,0	20,0	100,0
Providing support to midwifery tutor and student midwives	Frequency	26	9	35
	%	74,3	25,7	100,0
Plan for students' clinical rotation	Frequency	12	23	35
	%	34,3	65,7	100,0
Assign students to reduce the workload on staff	Frequency	8	27	35
	%	22,9	77,1	100,0
Other	Frequency	3	32	35
	%	8,6	91,4	100,0

4.5.8.2 Item 19.2: Preceptors/clinical instructors/mentors' roles

Table 4.21 shows that of the respondents, 91,4% (n=32) indicated that one of the roles of the preceptor/clinical instructor is to act as a resource person for the student midwife in the postnatal ward and 88,6% (n=31) stated that the preceptor/clinical instructor should facilitate the teaching and learning of technical skills. The respondents identified the following further roles of the preceptor/clinical instructor:

- Participation in planning and preparation for clinical teaching and learning (80%; n=28)
- Act as role models, energisers and visionaries for student midwives (85,7%; n=30)
- Support to students in developing communication skills (85,7%; n=30)
- Providing support to student midwives in developing the ability to manage the postnatal ward and its personnel (85,7%; n=30)
- Facilitate the internalisation of professional ethics, standard and behavioural patterns to student midwives (71,4%; n=25)

Table 4.21   Roles of the preceptors/clinical instructors/mentors (N=35)

Roles		Yes	No	Total
Acts as resource persons for the student midwives	Frequency	32	3	35
	%	91,4	8,6	100,0
Facilitate learning of technical skills to student midwives in the clinical setting,	Frequency	31	4	35
	%	88,6	11,4	100,0
They are role models, energisers, and visionaries for student midwives	Frequency	30	5	35
	%	85,7	14,3	100,0
Support students in developing communication skills	Frequency	30	5	35
	%	85,7	14,3	100,0
Provide guidance to student midwives in developing abilities for managing the postnatal ward/unit and personnel	Frequency	30	5	35
	%	85,7	14,3	100,0
Participate in planning and preparation for clinical teaching and learning	Frequency	28	7	35
	%	80,0	20,0	100,0
Facilitate the internalisation of professional ethics, standards and behavioural patterns to student midwives	Frequency	25	10	35
	%	71,4	28,6	100,0
Other	Frequency	2	33	35
	%	5,7	94,3	100,0

4.5.8.3   Item 19.3: Barriers experienced during clinical accompaniment of midwifery students in the postnatal ward

In an open-ended question, the respondents were required to describe the barriers they encountered during clinical accompaniment of midwifery students in the postnatal ward. The researcher analysed and categorised the respondents' descriptions by hand. The respondents described several barriers experienced during clinical accompaniment (see figure 4.8). The barriers encountered by the respondents are listed as follows:

- The heavy workload due to shortage of staff (82,9%; n=29)

- Inadequate or lack of equipment and supplies (65,7%; n=23))

- Overcrowding of postnatal mothers in the ward (54,2%; n=19)

- Poor communication between the college and hospital staff (42,9%; n=15)

- Students not being prepared or adequately guided towards self-directed learning (45,7%; n=16))

- Lack of updating of knowledge (40,0%; n=14)

- Assigning students to non-nursing/midwifery interventions (28,6%; n=10)

Bastable (2003:14) found the same barriers to clinical accompaniment.
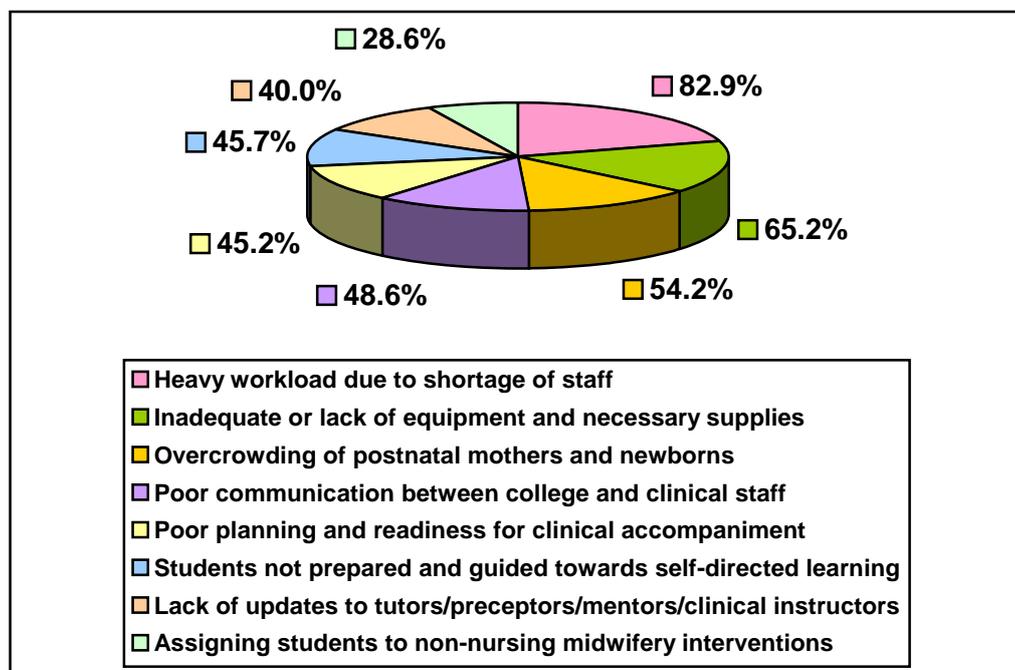
Figure 4.8

Barriers experienced during clinical accompaniment
of student midwives in postnatal the ward (N=35)

4.5.8.4 Item 19.4: Strategies for improving and ensuring that there is a conducive learning environment for students during clinical accompaniment

In an open-ended question, the respondents identified the following strategies to improve and ensure that a conducive learning environment is created for student midwives in the postnatal ward for their clinical practice:

- Employing more nurse/midwives as well as other staff in the postnatal ward (91,4%; n=32)
- Assigning more preceptors and interested midwives in postnatal wards to accompany students in the postnatal ward (82,9%;n=29)
- Improving equipment and supplies in the postnatal wards and skills laboratory (80%; n=28)
- Updating teaching methods to be used by the tutors and preceptors in the clinical field (60%;n=21)
- Developing a programme that describes the follow-up and evaluation of students in the clinical settings (54,3%; n=18)
- Improving all teaching hospitals by extending the buildings and the referral hospitals in terms of all related resources to reduce overcrowding (51,4%; n=18)
- Improving communication between hospital and college staff, by giving incentives for clinical facilitation (48,6%; n=17)
- Advocating for early discharge of postnatal patients (45,7%; n=16)

The strategies are displayed in table 4.22.

Table 4.22 Strategies for improving and ensuring a conducive learning environment for students during clinical accompaniment (N=35)

Strategies for improving the learning environment	f	%
Employ more nurse/midwives as well as other staff in the postnatal wards	32	91,4
Assign preceptors/interested midwives in postnatal wards and prepare them to accompany students as their main function	29	82,9
Improve equipment and supplies in the postnatal wards and skills laboratory	28	80,0
Improve the teaching methods by updating tutors, preceptors and clinical staff involved in clinical supervision	21	60,0
Proper follow-up and evaluation of students in the clinical settings	19	54,3
Improve all teaching hospitals by extending buildings	18	51,4
Improve referral hospitals in terms of resources -human and non-human - to reduce overcrowding	18	51,4
Improve communications between hospital and school staff and students	17	48,6
Give incentives for clinical facilitation	17	48,6
Advocate for early discharge of postnatal patients	16	45,7

4.5.9 Item 20: Student midwife

Here the respondents were required to give information on the roles of student midwives during their clinical learning experiences in the postnatal ward.

4.5.9.1 Item 20.1: Roles of student midwives during their clinical learning experiences

The respondents identified the roles student midwives should have when working in the postnatal ward during their clinical learning experiences in the postnatal ward as follows (see table 4.23):

- Students should be able to perform learning diagnosis (77,1%; n=27)
- Active participation in clinical assignments and practice (94,3%; n=33)
- Self-assessment of the clinical performance (74,3%; n=26)
- Utilisation of learning styles that are critical and reflective (68,6%;)(n=24)
- Student should be responsible, but not accountable (68,6%;n=24)
- Engage in critical and creative thinking, enquiry skills, skills in analysing, independent decision-making, self-awareness and the ability to reflect upon professional practice (77,1%; n=27)
- Maintaining a good interpersonal relationship with the postnatal staff (88,6%; n=31).

Table 4.23   Roles of student midwives during their learning experiences (N=35)

		Yes	No	Total
Active participation in clinical assignment and practices	Frequency	33	2	35
	%	94,3	5,7	100,0
Set a good clinical learning environment by creating and maintaining good interpersonal relationships with postnatal staff	Frequency	31	4	35
	%	88,6	11,4	100,0
Perform learning diagnosis	Frequency	27	8	35
	%	77,1	22,9	100,0
Engage in critical and creative thinking, enquiry, analysis, reflect upon professional practice	Frequency	27	8	35
	%	77,1	22,9	100,0
Self-assessment of clinical performance	Frequency	26	9	35
	%	74,4	25,7	100,0
Utilise learning styles that are critical or reflective	Frequency	24	11	35
	%	68,6	31,4	100,0
Be responsible but not accountable	Frequency	24	11	35
	%	68,6	31,4	100,0

4.5.9.2   Item 20.2: Meaning of self-directed learning

In an open-ended question, the respondents were required to discuss what they understood by the term "self-directed learning". The researcher analysed and categorised the responses by hand. Table 4.24 lists the respondents' definitions.

Table 4.24   Definitions of self-directed learning

Definitions	f	%
Learning directly by her/himself by planning, reading books, doing and evaluating her personal work, tutors are consulted when necessary	15	42,9
Learning without being forced rather self-driven	14	40,0
Learning independently, not relying on tutors	13	37,1
Students learn on their own, with objectives and creatively	12	34,3
Students work on their own but require supervision	10	28,6

4.5.9.3   Item 20.3: Strategies to detect the effectiveness of facilitation for midwifery education

All the respondents answered this item (N=35). According to the respondents, passing both theory and practical examinations indicated the effectiveness of a midwifery education programme (see figure 4.9). Of the respondents, (80,0%) (n=28) indicated that the care given by students/graduates should be of a high standard; 10,0% (n=3)

revealed that the public demand acknowledgement of clients. For effective clinical teaching to take place, an educational plan should be developed indicating the teaching process (Mellish et al 2000:218).
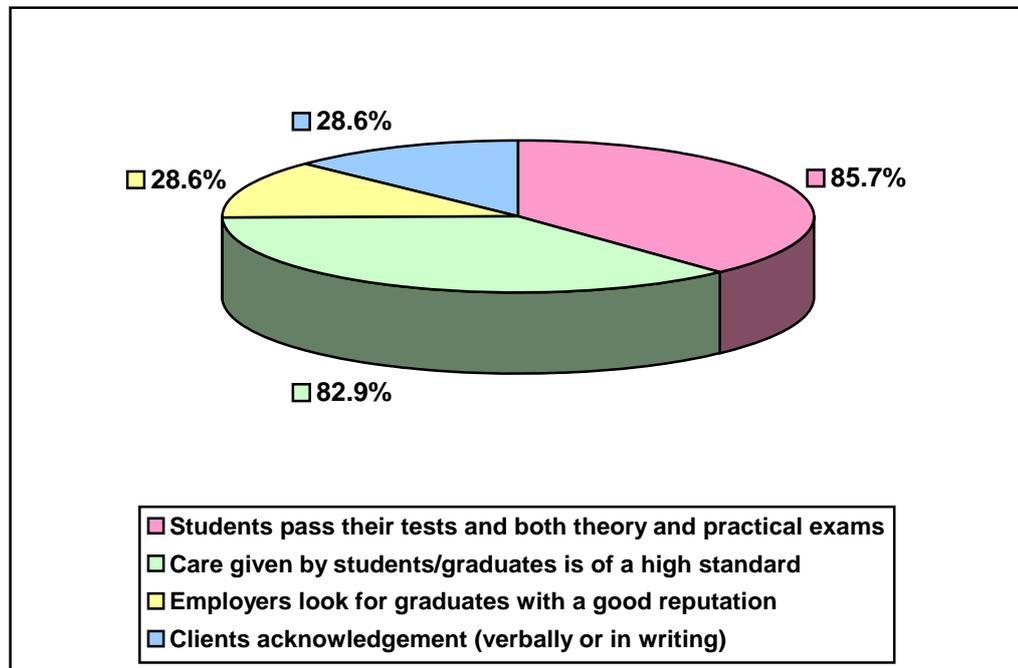
Figure 4.9

Strategies for detecting effectiveness of a midwifery
education programme (N=35)

4.5.9.4   Item 20.4: Suggestions to improve the clinical accompaniment of midwifery students in the postnatal ward

In an open-ended question, the respondents were asked to suggest strategies to improve the clinical accompaniment of midwifery students in the postnatal wards.

Table 4.30 shows that the respondents' suggestions, which included:

- Using qualified preceptors/mentor (80,0%; n=28)
- Adequately qualified staff including tutors be employed to follow-up on students in the clinical setting 74,3% (n=26)
- Using guidelines by midwifery tutors (71,4%; n=25)

- Maintaining good collaboration and communication between college and hospital staff (62,9%; n=22)

- Provision of adequate and up to-date equipment and supplies in the postnatal wards and the skills laboratory (57,1%; n=20)

- Updating theoretical and clinical knowledge of tutors, preceptors, mentors, and clinical staff to ensure a conducive learning and teaching environment, effective feedback given to students and self-directed learning with support encouraged (57,1%; n=20)

- Monitoring and evaluating students' clinical learning throughout the training while keeping records (48,6%; n=17)

Table 4.25   Suggestions to improve clinical accompaniment in postnatal ward

Suggestions	Frequency	%
Use qualified/train preceptors/mentors on clinical facilitation	28	80,0
Employ adequate qualified tutors, midwives and other staff in teaching hospitals	26	74,3
Midwifery tutors should teach and follow-up on students, using guidelines in clinical settings just as they would be teaching theory in school/colleges	25	71,4
Improve and maintain good collaboration/communication between college and hospital staff	22	62,9
Provision of adequate and up to-date equipment and supplies in the postnatal wards and in skills laboratory	20	57,1
Update tutors, preceptors, mentors, and clinical staff	20	57,1
Ensure a conducive learning and teaching environment, by involving each other, effective feedback to students, encourage self-directed learning, and support	19	54,3
Monitor and evaluate students' clinical learning throughout the training and keep all records.	17	48,6

4.5.10 SECTION E: LEGAL REQUIREMENTS FOR CLINICAL PRACTICE (ITEM 21)

This part of the study required the respondents to describe the legal requirements by the institution to provide clinical learning and teaching experiences. All the respondents (N=35) answered the questions.

4.5.10.1   *Item 21.1: Records that should be kept on students' accompaniment*

Of the respondents, 37,1% (n=13) reported that they would keep records for the statutory body concerned with training of midwives in Tanzania; 77,7% (n=27) would keep records for the college of the clinical hours a student spent in their midwifery training; 77,1 % (n=27) reported that students should also keep their own records, and

88,6% (n=31) indicated that the midwifery register was an important record (see table 4.26).

Table 4.26   Records that should be kept on students' clinical accompaniment (N=35)

Records		Yes	No	Don't know	Total
Statutory body records	Frequency	13	4	18	35
	%	37,1	11,4	51,4	100,0
College records of clinical hours	Frequency	27	-	8	35
	%	77,1	-	22,9	100,0
Students' own records	Frequency	27	-	8	35
	%	77,1		22,9	100,0
Midwifery register	Frequency	31	-	4	35
	%	88,6	-	11,4	100,0
Other	Frequency	2	-	33	35
	%	5,7	-	94,3	100,0

4.5.10.2   Item 21.2: Ways of ensuring that students are aware of their legal responsibilities regarding their clinical practice

All the respondents (N=35) answered this open-ended question. The question was analysed and categorised by the researcher by hand.

Table 4.27 indicates the information indicated by the respondents on students' awareness of their legal responsibilities with regard to their clinical practice.

Table 4.27   Ways to ensure that students are aware of their legal responsibilities regarding their clinical practice (N=35)

	Frequency	%
Legal policies to be part of their learning theoretically and practically and providing them with legal guidelines to review	32	91,4
Proper facilitation and guidance of students in the clinical settings by midwifery tutors, preceptors and ward supervisors	30	85,7
Assessing students continuously and in final examinations	26	74,3
Prohibiting students from dealing directly and alone with dangerous drugs or certain obstetric procedures like vacuum extraction	16	45,7
Role modelling by qualified staff for students to learn good behaviour	12	34,3

Table 4.27 shows that of the respondents, 91,4% (n=32) supported the training and provision of guidelines to students:

- Proper facilitation and guidance to students in the clinical settings by midwifery tutors, preceptors and ward supervisors (85,7%; n=30)

- Assessing students continuously and in final examinations (74,3%; n=26)

- Not allowing students to deal directly and alone with dangerous drugs or certain procedures like vacuum extraction (45,7%; n=16)

- Role modelling by qualified staff for students to learn good behaviour (34,3%; n=12).

4.7   CONCLUSION

This chapter discussed the data analysis and interpretation, with the use of graphs, frequency tables and descriptions.

Chapter 5 concludes the study, discusses its limitations and makes recommendations for midwifery education and further research.

CHAPTER 5

Findings, limitations and recommendations

5.1 INTRODUCTION

The purpose of the study was to describe the factors that contribute to the decline in clinical teaching of midwifery students in the postnatal wards during their clinical learning experience. This knowledge should assist in increasing clinical teaching and promoting clinical facilitation for midwifery students.

This chapter discusses the findings and limitations of the study and makes recommendations for practice and for further research.

5.2 FINDINGS

5.2.1 Respondents' age (item 1)

The age distribution revealed that 54,2% of respondents were aged between 31 and 45. In this age group many nurses and midwives have completed further education in nursing education after their initial nurse training and gained some clinical experience before embarking on upgrading their academic and professional careers. It is generally accepted that the nurse educator should be involved in both theoretical and clinical teaching (Billings & Halstead 2005:326).

5.2.2 Respondents' academic and professional qualifications, current occupation, years of teaching and educational system used at the nursing college (items 2, 3, 4, 5, 6, 7, 8 and 9)

The study found that of the respondents, 54,3% had a Diploma in General Nursing and Midwifery; 25,7% had an Advanced Diploma in Nursing Education and 11,4% had a Diploma in Nursing Education. The respondents currently teaching the student midwives in the clinical setting were ward supervisors (42,9%) and mentors (42,9%), and nurse educators (8,6%) from the nursing college (see figure 4.2).

Internationally it is accepted that midwifery training should be community-based. Thus, tutors and all health care practitioners involved in the teaching of student midwives should have comprehensive professional qualifications. The data revealed that of the respondents, 75,8% possessed the Diploma in Nursing; 12,1% had a BSc in Nursing; 82,9% were trained midwives, but none of the respondents possessed the professional qualification in Community Health and Psychiatric Nursing (see table 4.2). According to Billings and Halstead (2005:328-329), tutors and preceptors involved in clinical teaching should not only possess formal academic and professional qualifications, but specialized knowledge and expert clinical experience as well so that they can make a positive contribution to their students' intellectual and personal development.

With regard to the respondents' years of experience in teaching midwifery in the nursing college, 26,7% had been teaching for 6 years or more and 23,3% had been teaching for 2 years (see table 4.3).

For training midwives in Tanzania, 45,7% of the respondents indicated that the block system was used while only 5,7% indicated the day system.

5.2.3 Teaching in the clinical field (items 10 and 11)

In this section the study explored the time allocated for midwifery practice with the focus on clinical practice in the postnatal ward.

5.2.3.1 *Time allocated for midwifery practice*

The study found two main variations with regard to time spent in practice by the midwifery students. Of the respondents, 57,1% indicated that midwifery students practised for 2 weeks per year, while 54,3% indicated 1 hour per week, which meant an equivalent of 6 days (one week) each with 7 hours if they worked for 42 weeks in a year. Although the tutors scheduled clinical experiences to promote learning, there was ongoing dialogue about the best way to schedule experiences, the length of the experience, the timing of the experience in relation to didactic course assignment, and students' needs (Billings & Halstead 2005:330). Statutory bodies, who prescribe the minimum requirements for the midwifery training theory and clinical, provide the number of hours in which the midwife should complete the prescribed outcomes for their practice. Therefore, if all the integrated diploma nursing/midwifery schools used the same curriculum, then there was a problem in the implementation process.

5.2.3.2 Involvement in clinical accompaniment (item 12)

Item 12 addressed the accompaniment of the student midwives. The results revealed that all the respondents (100,0%) accompanied midwifery students in the clinical settings for less than a day per week. This finding is contrary to Cahill's (1997:14) emphasis that tutors should spend at least one day per week with students in the clinical setting.

The study found that 14,3% of the respondents spent less than a day per week in accompanying student midwives in the clinical settings while 65,7% accompanied students in the clinical settings for 1 to 5 hours per week.

Other staff involved in student midwives' clinical teaching consisted of ward sisters (74,3%) and clinical instructors (65,7%). As only three respondents were identified as tutors teaching student midwives, the data revealed was positive that the ward sister was involved in the clinical teaching of students.

In items 12.5 and 12.6, the study explored the preparation of the respondents for their roles in the accompaniment of student midwives as well as the way they were prepared. The data revealed that of the respondents, 82,9% were prepared for their roles of accompanying students in the clinical settings by getting the information regarding student's practical requirements; 65,7% got information regarding the students' practical requirements. Hinchliff (2005:148) emphasises that for tutors to render competent teaching, they should receive all the information with regard to the outcomes and requirements of the midwifery training.

With regard to planning activities for clinical accompaniment, the results indicated that 62,9% of the respondents identified the activities in the planning of clinical teaching, which included checking and distribution of the clinical experiences for the midwives; involvement of the student midwives and clinical staff in the preparation of a realistic clinical education plan (71,4%); time allocated for clinical supervision (82,9%); planning for student placement (85,7%); identification of the standards for the guidelines for clinical accompaniment (77,1%) and the identification of the records to be maintained (74,3%).

Furthermore, 40,0% of the respondents' only planning activity was the provision of a written outline of clinical education to all the preceptors/mentors/ward supervisors. For effective clinical teaching to take place, all the teaching staff involved in the teaching of

the student midwives should receive written guidelines from the nursing college (Hinchliff 2005:149).

5.2.3.3 Simulation Laboratory (item 13)

The results of the study showed that 80% of institutions did have a skills laboratory/demonstration room. According to Billings and Halstead (2005:531), simulations help to create a safe environment for student learning and promote standardised assessments. 20,0% of the respondents indicated that there was no skills laboratory, consequently the above could not be implemented.

In item 13.3 the respondents were required to identify the resources needed in the simulation laboratory for postnatal practice. The study found that of the respondents, 85,7% identified all the apparatus needed; 82,9% identified personal protective equipment and adequate space for counselling of patients and space for physical examinations of patients; 80% reported equipment for perineal care and suture removal, and 77,1% correctly identified the equipment and resources for baby care (see table 14.4).

5.2.3.4 Midwifery tutors as role models in clinical accompaniment (item 14)

The results showed that of the respondents, 57,1% indicated that midwifery tutors were not the main persons who acted as role models in clinical accompaniment. With respect to orientation of students in the clinical setting, midwifery tutors were rated lowest compared to all other clinical facilitators. This was contrary to the tutors' clinical teaching roles. The contradiction was revealed by the fact that "tutors supporting and leading all clinical teaching activities were rated highest as one of the ways of ensuring that student midwives meet their clinical learning needs in the postnatal ward during their practice". Tutors appeared not to be taking their full responsibilities in clinical accompaniment of midwifery students in clinical settings.

5.2.3.5 Preparation and assessment of students during clinical practice (item 15)

Of the respondents, 85,7% indicated midwifery register note books as one of the strategies to prepare student midwives for the clinical practice; 71,4% indicated giving adequate knowledge to the student midwives, and 51,5% indicated demonstration as one of the strategies to prepare students for the clinical practice. The researcher thus

concluded that emphasis was put on the theoretical and not the clinical preparation of student practica.

5.2.3.6 Formative evaluation of student midwives in postnatal wards (item 16)

Of the respondents, 60,0% revealed that they required meetings with clinical staff on the ward; 42,9% expected well-done assignments as assessments as well as a pass in the semester examination; 85,7% indicated continuous evaluation and final practical assessment of students; 88,7% gave feedback mainly at the end of semester and 57,1% assessed the students after the demonstration or role-play. Continuous assessment should also always be at the end of the demonstration and role-play. The majority of the respondents emphasised feedback at the end of the semester (see figure 4.5). Immediate and positive feedback is the most positive feedback to encourage students to develop as midwives (Mellish et al 2000:72).

5.2.3.7 Teaching strategies used during clinical accompaniment (item 17)

The data revealed that of the respondents, 94,3% and 85,7%, respectively, used demonstration and ward rounds. Case studies, problem solving, nursing rounds and situational teaching were also indicated as important teaching strategies by more than half of the respondents. Only 20,0% of the respondents indicated clinical judgment as a clinical teaching strategy. This raises concern because it should have been regarded as a much more important strategy, as it used for the basis for reflection later (Quinn 2001:435).

5.2.3.8 Conducive clinical environment (item 18)

The study found that of the respondents, 94,3% indicated that a conducive learning environment was an adequate physical environment where learning could take place; 88,6% identified adequate resources. With regard to the members of the teaching-learning situation the following were conducive to a learning environment: a humanistic approach and teamwork (71,4%); effective management style (60,0%); learner support (82,9%) and the necessity for a clinical laboratory (82,9%).

5.2.3.9 Clinical supervision (item 19)

The majority of the respondents acknowledged the importance of the postnatal ward supervisor in providing support (technical skills, evaluation, guidance to independent

functions) to the midwifery tutor and the student midwives during their clinical practice. The data also revealed that not much emphasis was placed on the student midwife as a member of the multidisciplinary team.

Of the respondents, 80,0% understood clearly what the role of the preceptor should be (see table 4.21).

Of the respondents, 82,9% identified the heavy workload of the tutors due to staff shortages as not conducive to a learning environment (see figure 4.8). Regarding strategies to improve the learning environment, 91,4% indicated employing more nurses and other staff; 82,9% proposed assigning more preceptors and interested midwives in the postnatal ward to accompany student midwives; and 80% emphasised improving equipment and supplies in the postnatal ward and skills laboratory.

5.2.3.10 Student midwives (item 20)

The study found that of the respondents, 94,3% acknowledged active participation in clinical practice as important, and 88,6% emphasised maintaining a good relationship with the postnatal staff.

From the data it was evident that the respondents were able to identify the roles that student midwives should have when working in the postnatal ward correctly (see table 4.23).

It was concluded that the respondents defined self-directed learning as learning individually and tutors were only consulted when necessary. The respondents also considered independent learning and learning without being forced and using learning creatively important (see table 4.24).

The study shows that 80,0% of the respondents indicated the evaluation of both the theoretical and practical examinations as the main way of detecting effectiveness of the clinical learning experiences. Of the respondents, over 80% identified using of qualified preceptors/mentors, employing adequate qualified staff, including tutors, to follow up students in the clinical setting by using guidelines, and maintaining good collaborative/ communication between college and hospital staff as strategies to improve clinical accompaniment (see figure 4.9).

5.3 LEGAL REQUIREMENTS FOR CLINICAL PRACTICE (ITEMS 21 AND 22)

The findings indicate that 51,4% of the respondents did not know about the statutory body records which should be kept regarding students' clinical accompaniment and 11,4% said it was not necessary to keep record for the statutory body. This meant that the respondents showed a lack of knowledge on legal record keeping. The respondents identified other records kept for training midwives as important (see table 4.26).

Of the respondents, 91,1% regarded training and provision of guidelines as the most important way of ensuring awareness of legal responsibilities; 85,7% indicated proper facilitation and guidance of students, and 73,3% emphasised continuous and final examination as a way of making students aware of their legal responsibly with regard to their training.

5.4 LIMITATION OF THE STUDY

Because of the limited scope of this study, a small sample of 35 respondents was used. Therefore, the findings cannot be generalised to the population.

5.5 RECOMMENDATIONS

Based on the findings, the researcher makes the following recommendations for practice to enhancing clinical teaching and for further research.

5.5.1 Professional and academic qualifications

There is a dire need for well-qualified and clinically competent midwifery tutors and preceptors. Clinical teaching should involve the careful design of an environment in which students have opportunities to foster mutual respect and support for each other while achieving identified learning outcomes. Tutors and preceptors who teach in the clinical setting are the crucial link to successful experiences for students.

Effective clinical teachers should be clinically competent; know how to teach, have collegial relationships with students, and be friendly, supportive and patient. It is essential to be knowledgeable and able to share the knowledge with students in clinical settings. Such knowledge includes an understanding of the theories and concepts related to the practice of midwifery as well as an ability to convey the knowledge in an understandable manner. Attention to three discrete teaching domains – instructional,

evaluative, and interpersonal – will facilitate the acquisition of the teaching skills needed to foster success in clinical settings.

Billings and Halstead (2005:331) stress that competence in the clinical practice of midwifery is being necessary for effective clinical teaching.

To prepare the tutors and preceptors for their role in clinical teaching, an introductory course to orient clinicians making the transition from role expert (teaching at the nursing college) to clinical teacher in the postnatal ward, should be developed and implemented.

Tutors and preceptors should be further developed both professionally and academically to improve their capacities in facilitation of clinical teaching/ accompaniment of midwifery students in clinical settings. The clinical staff should be up-dated on knowledge and skills to empower them in the facilitation of clinical accompaniment. Newly qualified tutors and staff in clinical settings should be employed to ensure continuity and a good standard of clinical accompaniment of midwifery students during their practice.

5.5.2 Nursing education

The researcher recommends the implementation of the integrated diploma curriculum in Tanzania where different models are used for theory and for practice. This is recommended to ensure a core-training curriculum in Tanzania. This curriculum should provide for ample practica time for the students so that midwifery tutors could implement it carefully to avoid inappropriate use of practical time. An orientation session should be planned as part of the curriculum development or curriculum review. The implementation of the curriculum should be discussed or reviewed in a workshop for the tutors and preceptors.

The nursing school management and authority should undertake supportive supervision locally and an external moderator employed.

Provision should be made in the macro planning of the nursing college for tutors to further their professional and academic careers. This could include workshops, in-

service training sessions and formal education where students could follow courses at a university or other tertiary institution.

5.5.3 Recommendations on factors that influence clinical teaching

The tutors at the nursing college as well as the clinical staff in the hospital and clinics where the students undergo their clinical experiences should prepare clinical education guidelines for midwifery students. In some instances, student midwives should be included in the team when these guidelines are being prepared. The guidelines should be based on the legal requirements of the Health Act in Tanzania, the statutory body as well as the training institutions. Information about clinical accompaniment should cover expected learning outcomes, clinical hours for students, responsibilities of tutors, preceptors, students, ward/shift supervisors' roles and for other involved facilitators during clinical accompaniment; requirements for students including records to be maintained, formative evaluations and final assessments. Furthermore, strategies and guidelines for formative and summative evaluation should be included. Before any clinical teaching is undertaken the staff involved in the teaching should receive the guidelines and undergo an orientation programme.

One of the requirements needed at a nursing or midwifery training institution is the establishment of a skills laboratory/simulation laboratory. Computer simulations could be installed. These programmes teach learners about a wide variety of procedures in midwifery nursing schools to allow learners to individualize decision-making, develop critical thinking skills and create plans for patient care. Furthermore, it is recommended that students first be taught to become competent in the midwifery skills necessary to render safe competent care to the patients in a simulation laboratory before going to the wards.

The following recommendations are made to improve clinical teaching:

- Identify qualified/trained preceptors for clinical facilitation of students during their clinical learning experiences.

- Employ adequately qualified tutors, midwives and clinical instructors in the teaching hospitals.

- Midwifery tutors should teach and follow up students using the set guidelines in clinical settings in the same way as when teaching theory in the nursing college/schools. Gerrish 1994 (in Quinn 2001:186) emphasises that practice placement requires a commitment of tutors for effective student learning in clinical areas.

- The nursing school and hospital authorities should improve and maintain good collaboration/communication between the tutors at the nursing college and the hospital staff involved with clinical teaching of the students.

- Provide adequate equipment and supplies in the postnatal wards to facilitate competent teaching.

- Update the knowledge and skills of tutors, preceptors, mentors, and clinical staff both in advanced midwifery and professional legal aspects.

- Ensure that there is a conducive learning and teaching environment, by involving all the relevant team members of the health care practitioners involved in clinical teaching: for example, effective feedback to students, self-directed learning and support.

- Monitor and evaluate students' clinical learning throughout the training and keep all records as required.

5.6 RECOMENDATIONS FOR FURTHER RESEARCH

The researcher recommends that further research be conducted on the following areas:

- Investigate the quality of clinical midwifery education in the integrated diploma in nursing/midwifery schools in Tanzania.

- Determine the educational/professional learning requirements of midwifery tutors in the nursing schools in Tanzania.

- Determine the students' assessment procedures for the diploma in nursing/midwifery schools in Tanzania.

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- Evaluate the midwifery competencies of the neophyte midwifery graduates with regard to postnatal care.

5.7   CONCLUSION

This chapter discussed the conclusions and limitation of the study and made recommendations arising from the findings for practice and further research.

The study attempted to identify the factors that influence clinical teaching and accompaniment of student midwives in the postnatal wards. The study found that tutors' and preceptors' educational and academic qualifications were low, and midwifery tutors did not act as role models in clinical accompaniment. The study identified several barriers to clinical accompaniment, such as heavy workload due to staff shortages in the hospital, inadequate or lack of equipment and necessary supplies, overcrowding of postnatal mothers and newborns, poor communication between college and clinical staff, poor planning and readiness for clinical accompaniment of students and students not being prepared and guided towards self-directed learning.

In conclusion, numerous factors were identified that influenced the decline in clinical teaching and clinical accompaniment of student midwives in the postnatal wards. The findings and recommendations of this study should benefit policy makers, nursing practice and education, and the midwifery students, and, ultimately and perhaps most importantly, the mothers and babies of Tanzania.

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PO Box 77615
DAR ES SALAAM

17 May 2006

The Director
Muhimbili National Hospital
PO Box 65000
DAR ES SALAAM

Dear Sir

REQUEST TO CONDUCT RESEARCH IN THE HOSPITAL

This letter serves to request your permission to conduct research into clinical accompaniment of student midwives in selected clinical settings in Tanzania.

I am presently registered with the University of South Africa and pursuing a Master's degree in Health Studies with specialisation in Advanced Midwifery by distance learning. This research is done to fulfil the requirements of the degree.

All clinical educators involved in the training of student midwives will receive a questionnaire to complete.

The researcher assures the management that ethical issues shall by all means be adhered to through the execution of the research.

I hope that my request shall meet with your favourable consideration.

Yours faithfully

Mrs Eliaremisa SN Ayo
NURSING OFFICER MOH

PO Box 77615
DAR ES SALAAM

1 June 2006

Dear Participant

The aim of the study is to explore the factors that may influence clinical accompaniment of midwifery students in the postnatal wards during their clinical practice.

The results of the study should assist nurse tutors to be actively involved in the clinical accompaniment of midwifery students.

I would appreciate it if you could take part in my research project and be an informant. The data will be gathered from you by means of a questionnaire.

Thank you for your willingness to be a participant.

Yours faithfully

Mrs ESN Ayo
RESEARCHER

A G R E E M E N T

I, ... on this .... day of .... 2006 hereby consent to

- complete the questionnaire developed by Mrs ESN Ayo on the topic "Factors which may influence clinical accompaniment of midwifery students in the postnatal wards in Tanzania"

- the use of data derived from these questionnaires by the researcher in the research report as she deems appropriate

I also understand that:

- I am free to terminate my involvement or to recall my consent to participate in this research at any time I feel like it

- information given up to the point of my termination of participation could, however, still be used by the researcher

- confidentiality will be maintained by the researcher and that the identity will not be linked to information

- no reimbursement will be made by the researcher for information given or participation in this project

- I may refrain from answering questions should I feel these are an invasion of my privacy

- by signing this agreement I undertake to give honest answers to reasonable questions and not to mislead the researcher

- I will be given the original copy of this agreement on signing it

I hereby acknowledge that the researcher has

- discussed with me in detail the purpose of this research project

- informed me about the contents of this agreement

- pointed out the implication of signing this agreement

In co-signing this agreement, the researcher has undertaken to

- maintain confidentiality and privacy regarding the participant's identity and information given by the participant

- arrange in advance a suitable time and place for the completion of the questionnaire to take place

- safeguard the duplicate of this agreement

INFORMANT: ....   **RESEARCHER: ....**

DATE: ....   **DATE: ....**

<div align="center">

QUESTIONNAIRE
FACTORS THAT INFLUENCE CLINICAL ACCOMPANIMENT
OF MIDWIFERY STUDENTS IN A SELECTED
CLINICAL AREA IN TANZANIA

</div>

1	2	3

NUMBER OF QUESTIONNAIRE

1   ETHICAL CONSIDERATION

Please do not attach your name to the document.

2   INSTRUCTIONS

3.1   Please answer all the questions.
3.2   Answer the questions by providing an "X" in the box corresponding to the chosen alternative.
3.3   Please answer all questions as honestly, frankly and objectively as possible.
3.4   Answer according to your own personal opinion and experience.
3.5   Please return the questionnaire by 2006

Answer the questions by placing an "X" in the box corresponding to the alternative applicable to you or write down your response in the space provided.

FOR OFFICE USE ONLY

SECTION A: BIOGRAPHICAL AND EDUCATIONAL DATA

1	**What is your age?**		
		ANSWER	
1.1	21-25 years or younger	1	
1.2	26-30 years	2	
1.3	31-35 years	3	
1.4	36-40 years	4	
1.5	41-45 years	5	
1.6	46-50 years	6	
1.7	51-55 years	7	
1.8	56-60 years or older	8	4
2	**What is your highest professional qualification?**		
		ANSWER	
2.1	Diploma in General Nursing and Midwifery	1	
2.2	Advanced Diploma in Nursing Education	2	

2.3	Diploma in Nursing Education	3		
2.4	Other (please specify)	4		5

3 What is your highest academic qualification?

		ANSWER	
3.1	Diploma in Nursing	1	
3.2	BSc in Nursing	2	
3.3	Master's degree in Nursing	3	
3.4	Other (please specify)	4	6

4 State your professional qualifications?

		YES	NO	
4.1	General Nurse	1	2	7
4.2	Midwife	1	2	8
4.3	Psychiatric Nurse	1	2	9
4.4	Community Health Nurse	1	2	10
4.5	Nurse Educator	1	2	11
4.6	Nurse Manager	1	2	12
4.7	Other (please specify)	1	2	13

5 State your current occupation.

		ANSWER	
5.1	Ward Supervisor		
5.2	Clinical Instructor	1	
5.3	Preceptor	2	
5.4	Mentor	3	
5.5	Nurse Educator	4	
5.6	Nurse Manager	5	
		6	14

SECTION B: TEACHING INFORMATION: THEORY

6 How many years have you been teaching midwifery at the nursing college?

		ANSWER	
6.1	1 year or less	1	
6.2	2 years	2	
6.3	3 years	3	
6.4	4 years	4	
6.5	5 years	5	
6.6	6 years or more	6	
6.7	Other (please specify)	7	15

7 Which educational system does your college follow?

		ANSWER	
7.1	Block system	1	
7.2	Day system	2	
7.3	Other (please specify)	3	16

8 If the block system is used, how many?

		ANSWER	
8.1	2 blocks per year x 2 weeks per block	1	
8.2	2 blocks per year x 4 weeks per block	2	
8.3	Other (please specify)	3	17

9	**If the day system is followed, state:**	NUMBER	ANSWER		
9.1	Day/s per week		1		18
9.2	Number of weeks per year		2		19
9.3	Other (please state)		3		20

SECTION C: TEACHING INFORMATION (CLINICAL)

10	**How many weeks/hours are allocated for midwifery practice?**	NUMBER	ANSWER		
10.1	Hours per week		1		21
10.2	Weeks per year		2		22
10.3	Other (please state)		3		23

11	**How many hours/weeks are allocated for postnatal clinical experience per year for the students?**	NUMBER	ANSWER		
10.1	Hours per week		1		24
10.2	Weeks per year		2		25
10.3	Other (please state)		3		26

SECTION D: TEACHING INFORMATION (CLINICAL ACCOMPANIMENT)

12	**Accompaniment of your students**				
12.1	**Are you involved in the accompaniment of your students in the clinical field?**	NO	YES		
		1	2		27

12.2	**If yes, please indicate how often the accompaniment is done.**	ANSWER	
12.2.1	1-5 hours per week	1	
12.2.2	6-10 hours per week	2	
12.2.3	Other (please specify)	3	28

12.3	**If no, please specify the reason.**	
	....	29

12.4	**Indicate other staff involved in the accompaniment of the student.**	YES	NO	
12.4.1	Clinical facilitator	1	2	30
12.4.2	Ward sister	1	2	31
12.4.3	Ward mentor	1	2	32
12.4.4	Clinical instructor	1	2	33
12.4.5	Other (please specify)	1	2	34

12.5   Have you been prepared for your role as clinical accompaniment of students?

	YES	NO		
	1	2		35

12.6   If <u>yes</u>, in what way were you prepared for student accompaniment?

	YES	NO	
12.6.1 Meetings with college and ward staff	1	2	36
12.6.2 Information received about the students' practica requirements	1	2	37
12.6.3 Other (please specify)	1	2	38

12.7   What are your activities in planning for clinical teaching and learning?

	YES	NO	
12.7.1 Checking the distribution of experienced/competent midwives in the three shifts	1	2	39
12.7.2 Involvement of student midwives, clinical staff in preparing a realistic clinical education plan	1	2	40
12.7.3 Time allocation for clinical supervision	1	2	41
12.7.4 Planning for students placement	1	2	42
12.7.5 Setting outcomes for students' learning	1	2	43
12.7.6 Identifying standard guidelines for clinical accompaniment	1	2	44
12.7.7 Identifying records to be maintained	1	2	45
12.7.8 Providing a written outline of clinical education to all preceptors/mentors/clinical instructors/unit supervisors	1	2	46
12.7.9 Other (please specify)	1	2	47

13   Skills laboratory

13.1   Does your institution have a skills laboratory?

	YES	NO		
	1	2		48

13.2   If <u>yes</u>, please answer the following questions:

13.3   What resources need to be prepared in the simulation laboratory for postnatal practices?

	YES	NO	
13.3.1 Apparatus for checking vital signs, weighing scale, tape measure	1	2	49
13.3.2 Personal protective equipment and adequate space for individual counselling of clients, for carrying out client's physical examination	1	2	50
13.3.3 Perineal care including repair, dressing and suture removal	1	2	51
13.3.4 Provision for baby care including immunisations	1	2	52
13.3.5 Resuscitation equipment, analgesics, anti-anaemia, anti-malarial, and ant-diabetic agents	1	2	53
13.3.6 Other (please specify)	1	2	54

13.4 Which skills do you demonstrate to student midwives in the skills laboratory before actual practice to patients/clients in the clinical setting?

	YES	NO	
13.4.1 Physical assessment of the postnatal woman	1	2	55
13.4.2 Assessment of the newborn baby	1	2	56
13.4.3 Care of the cords	1	2	57
13.4.4 Care of the breast and breastfeeding	1	2	58
13.4.5 Care of women with inverted nipples, engorged breasts/ infection	1	2	59
13.4.6 Care for genitals including infected episiotomies/ tears/ incontinence/prolapsed uterus/rectum	1	2	60
13.4.7 Counselling for family planning	1	2	61
13.4.8 Monitoring of growth of the baby	1	2	62
13.4.9 Other (please specify)	1	2	63

14 Roles of clinical facilitators

14.1 What are the roles of the clinical facilitator during clinical accompaniment?

	YES	NO	
14.1.1 Midwifery tutors, professional midwives involved in clinical accompaniment interacts with student midwives in clinical settings	1	2	64
14.1.2 Student midwives are assisted and supported so as make clinical learning easy, quick and comfortable	1	2	65
14.1.3 Facilitator participates in and enabling the action of student midwives in clinical practice	1	2	66
14.1.4 Student midwives are guided to meet their independent functions	1	2	67
14.1.5 Clarification of various approaches, encourage analysis and promote interpretation of conditions in clinical setting	1	2	68
14.1.6 Student midwives are informed and advised in relation to their course work and assessment	1	2	69
14.1.7 Students are ascribed with appropriate independent and autonomy	1	2	70
14.1.8 Other (please specify)	1	2	71

	YES	NO	
14.2 Midwifery tutors as role models are the main persons concerned with clinical accompaniment of student midwives in clinical settings.	1	2	72

14.3 Who orientates students to new clinical settings?

	YES	NO	
14.3.1 Ward sister in-charge	1	2	73
14.3.2 Midwife in-charge of the shift	1	2	74
14.3.3 Midwifery tutor	1	2	75
14.3.4 Clinical instructor/preceptor/mentor	1	2	76
14.3.5 Other (please specify)	1	2	77

		YES	**NO**		
14.4	**Do you accompany students in the clinical teaching?**	1	2		78

14.5	**If <u>yes</u>, specify the time you spend to accompany students in the postnatal ward.**		
		ANSWER	
14.5.1 Less than one hour every day		1	
14.5.2 More than one hour every day		2	
14.5.3 Once a week		3	
14.5.4 Forth nightly		4	
14.5.5 Once a month		5	
14.5.6 Once per semester		6	
14.5.7 Annually		7	
14.5.8 Other (please specify)		8	79

14.6   If you spend no time with student accompaniment, please state your reasons.

....

....

14.7   How do you ensure that student midwives meet their clinical learning needs in the postnatal ward during their practice?

	YES	**NO**	
14.7.1 By assigning the clinical teaching tasks to ward staff	1	2	80
14.7.2 By encouraging them to participate in planning for clinical practice	1	2	81
14.7.3 By supporting and leading all clinical teaching activities	1	2	82
14.7.4 By using mentors in clinical accompaniment of students	1	2	83
14.7.5 By providing them with a lot of theory before practice	1	2	84
14.7.6 Act as role model to students	1	2	85
14.7.7 Other (please specify)	1		86

15   Student preparation for clinical practice.

15.1   Please explain the process in preparing students for their clinical experiences in the postnatal ward.

....

....

....

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16   Formative assessment of students in postnatal wards.

16.1   How do you ensure the progress of students in the postnatal ward?

	YES	NO		
16.1.1 Meeting with clinical staff	1	2		87
16.1.2 Weekly reports	1	2		88
16.1.3 Monthly reports	1	2		89
16.1.4 Other (please specify)	1	2		90

16.2   Please state the relevant policies regarding formative evaluation of the students.

....

....

16.3   Which of the following methods do you use for evaluating midwifery students' progress during clinical accompaniment?

	YES	NO		
	1	2		
16.3.1 Continuous evaluation	1	2		91
16.3.2 At the end of every semester	1	2		92
16.3.3 End of demonstration/simulation/role play	1	2		93
16.3.4 Workbooks	1	2		94
16.3.5 Final practical assessment	1	2		95
16.3.6 Written field reports from the ward supervisors	1	2		96
16.3.7 Other (please specify)	1	2		97

16.4   When do you give feedback to student midwives with regard to their clinical learning?

	YES	NO		
16.4.1 End of semester	1	2		98
16.4.2 End of the year	1	2		99
16.4.3 End of the course	1	2		100
16.4.4 When they request	1	2		101
16.4.5 Other (please specify)	1	2		102

16.5   How do you give feedback to students about their clinical learning?

	YES	NO		
16.5.1 Individually in a private place	1	2		103
16.5.2 In a group of fellow students	1	2		104
16.5.3 On the spot when attending a client	1	2		105
16.5.4 In a classroom with preceptors/clinical instructors	1	2		106
16.5.5 In the presence of the ward supervisor	1	2		107
16.5.6 Other (please specify)	1	2		108

17   Teaching strategies used during clinical accompaniment.

17.1   Which teaching strategies do you use during clinical teaching?

	YES	NO	
17.1.1 Case study/presentation	1	2	109
17.1.2 Problem-solving	1	2	110
17.1.3 Demonstration	1	2	111
17.1.4 Clinical judgement	1	2	112
17.1.5 Nursing rounds	1	2	113
17.1.6 Ward rounds	1	2	114
17.1.7 Clinical meeting	1	2	115
17.1.8 Situational teaching	1	2	116
17.1.9 Other (please specify)	1	2	117

18   Conducive clinical learning environment

18.1   A conducive clinical learning environment for student midwives includes the following:

	YES	NO	
18.1.1 Adequate physical environment to deliver quality care and facilitate development of clinical competencies	1	2	118
18.1.2 Provide adequate and varied teaching and learning opportunities	1	2	119
18.1.3 There are adequate resources as space, equipment and other requirements which enhance the teaching and learning process	1	2	120
18.1.4 Appropriate humanistic approach	1	2	121
18.1.5 A teamwork spirit as fostered	1	2	122
18.1.6 Management styles are effective and flexible in providing good quality care	1	2	123
18.1.7 Teaching and learning support are provided to midwifery students such that they became responsible for their own learning, critical thinking and judgement	1	2	124
18.1.8 Provide clinical laboratory	1	2	125
18.1.9 Other (please specify)	1	2	126

19   Clinical supervision

19.1   What are the responsibilities of the postnatal ward supervisor in accompanying students during their postnatal practica?

	YES	NO	
19.1.1 Providing support to midwifery tutor and student midwives	1	2	127
19.1.2 Providing guidance to students' independent functions	1	2	128
19.1.3 Providing technical skills based on knowledge and practice	1	2	129
19.1.4 Assign students to reduce the workload to staff	1	2	130
19.1.5 Plan for students' clinical rotation	1	2	131
19.1.6 Evaluating students' clinical performance	1	2	132
19.1.7 Other (please specify)	1		133

19.2   What are the roles of the preceptor/clinical instructors/mentor?

	YES	NO		
19.2.1 Acts as resource persons for the student midwives	1	2		134
19.2.2 To facilitate learning of technical skills to student midwives in the clinical setting	1	2		135
19.2.3 Participate in planning and preparation for clinical teaching and learning	1	2		136
19.2.4 They are role models, energisers, and visionaries for student midwives	1	2		137
19.2.5 Support students in developing communication skills	1	2		138
19.2.6 Provide guidance to student midwives in developing abilities for managing the postnatal ward/unit and personnel	1	2		139
19.2.7 Facilitate the internalisation of professional ethics, standards and behavioural patterns to student midwives	1	2		140
19.2.8 Other (please specify)	1	2		141

19.3   What are the barriers that you meet during clinical accompaniment of midwifery students in the postnatal ward?

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19.4   How should you improve and ensure that there is a conducive learning environment for student midwives during clinical accompaniment?

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20   Student midwife

20.1   What are the roles of student midwives during their clinical learning experiences?

	YES	NO		
20.1.1 Perform learning diagnosis	1	2		142
20.1.2 Active participation in clinical assignments and practices	1	2		143
20.1.3 Self-assessment of clinical performance	1	2		144
20.1.4 Utilise learning styles that are critical or reflective	1	2		145
20.1.5 Being responsible but not accountable	1	2		146
20.1.6 Engage in critical and creative thinking, enquiry, analysis, independent decision-making, self-awareness and ability to reflect upon professional practice	1	2		147
20.1.7 Set a good clinical learning environment by creating and maintaining good interpersonal relationship with postnatal staff	1	2		148
20.1.8 Other (please specify)	1	2		149

20.2 What do you understand by self-directed learning?

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20.3 How would you detect whether the midwifery education in which you are facilitating was effective?

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20.4 Please give your suggestions on how to improve the clinical accompaniment to midwifery students in the postnatal ward?

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SECTION E: LEGAL REQUIREMENTS

21   Legal requirements for clinical practice

21.1   Which records should be kept regarding student accompaniment?

	YES	NO	
21.1.1 Statutory body records	1	2	150
21.1.2 College records of clinical hours	1	2	151
21.1.3 Students own records	1	2	152
21.1.4 Midwifery register	1	2	153
21.1.5 Other (please specify)	1	2	154

22   How do you ensure that students are aware of their legal responsibilities regarding their clinical practice?

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Thank you for your assistance in completing this questionnaire