

**STUDENT MIDWIVES' EXPERIENCES REGARDING COMPLETION
OF MIDWIFERY REGISTER AT A NURSING COLLEGE IN THE
EASTERN CAPE**

by

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the degree of

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**UNIVERSITY OF SOUTH AFRICA
SUPERVISOR: DR SH KHUNOU**

15 DECEMBER 2021

DEDICATION

I dedicate this study to my late grandparents, Fikile, Bethiwe Dondolo, my late parents-in-law, Masinda and Nomvo Sogobile.

Gone but not forgotten.

DECLARATION

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I affirm that the above dissertation is my own work, all the sources that I have quoted have been acknowledged by means of thorough references. This work was not submitted previously, for examination at Unisa or at any other institution.



15 December 2021

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.....

SIGNATURE

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W.N.T. Sogobile

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ABSTRACT

The purpose of this study was to explore and describe experiences of student midwives regarding completion of midwifery register at a nursing college in the Eastern Cape. A qualitative, explorative, descriptive and contextual design was employed. Ten participants were encompassed, and a non-probability sampling technique was used. Data collection involved unstructured face-to-face interviews. Interview recordings were transcribed verbatim, and data analysis followed Tesch's eight-step method. Findings revealed enormous trials such as lack of resources, deficiency of support by midwives and lecturers. The following themes regarding completion of midwifery register emerged from data analysis; positive experiences, personal experiences, challenges experienced, deterrent factors and finally impact of non-completion of midwifery register. Recommendations were done centred on research findings for midwifery academics, clinical midwife practitioners, student midwives, nursing institutions, and lastly, further research.

Key concepts: Clinical placement; Completion; Experience; Midwifery register; Nursing college; Student midwife

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ABBREVIATIONS

CLE	Clinical learning environment
COVID-19	Corona Virus Pandemic 2019
Dr	Doctor
EC	Eastern Cape
ECDoH	Eastern Cape Department of Health
EMS	Emergency Medical Services
ESMOE	Essential Steps in the Management of Obstetric Emergencies
ICM	International Confederation of Midwives
MOU	Midwife Obstetric Unit
NCCEM	National Committee on Confidential Enquiries into Maternal Deaths
NEI	Nursing Education Institution
NHI	National Health Insurance
NMC	Nursing and Midwifery Council
NMCN	Nursing and Midwifery Council of Nigeria
OSCE	Objective Structured Clinical Examination
PPE	Personal Protective Equipment
PV	Per vagina
SANC	South African Nursing Council
SDG	Sustainable Development Goals
UNICEF	United Nations of International Children's' Emergency Fund
UNISA	University of South Africa
WHO	World Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

International Confederation for Midwives (ICM) refers to a midwife as someone who was successfully trained to be proficient with skills needed to deal with pregnancy, childbirth, and the immediate post-natal phase (ICM 2018). Midwifery, therefore, has become a scientific profession and as such it requires formal training. Midwifery curriculum is divided into a theory and practical component as stipulated by the South African Nursing Council (SANC), R425 (SANC 1985). Theory facilitation precedes clinical allocation, where they are expected to perform midwifery procedures. Mastering both theory and practical components, therefore, becomes a crucial factor regarding safe midwifery practice. During clinical allocation, students have responsibility of completing a midwifery register starting from third year. Furthermore, number of hours spent in clinical areas is a SANC prescript. The student, therefore, has a SANC stipulated time frame in which to complete and record pre-determined midwifery procedures under supervision of qualified midwives.

Student midwives commence module of midwifery nursing science from their third year of training. They must complete a minimum of 40% theory hours as well as 60% of clinical experiential learning hours (South Africa 2020). The midwifery curriculum is made up of 30% theory and 70% clinical experiential learning (Malwela, Maputle & Lebeso 2016:969). Furthermore, the SANC prescribes 1000 clinical hours that student should accumulate to be competent. In this regard, Magobolo and Dube (2019:2) stipulate that student should complete pre-determined midwifery procedures within a specified time. Midwifery skills must be performed, and correctly recorded in midwifery register (South Africa 2020). By end of fourth year, student midwives are expected to have successfully completed 90% of midwifery cases and remaining 10% by January following year. The student will then be regarded as having met all midwifery clinical requirements. Failure to meet all necessary SANC

requirements within this period means that the student will not commence community service (South Africa 2020:16).

Documentation is the proof of recording that midwife do to confirm the provision of midwifery care (Juwita, Ahmad, Syarif & Mappaware 2019:149). Dike, Onesoga, and Njoku (2015: 1404) state that midwifery records refer to all records used by a student and midwife concerning midwifery care. Additionally, to prevent medico-legal hazards a midwife and student midwives, shall keep precise records of events from pregnancy to puerperium according to R2488 (SANC 1990). Student midwives must document nursing care provided both in the patient's clinical file as well as midwifery register.

Research has shown that midwifery register documentation and completion can be a daunting task, especially if midwifery student is not ably supported by registered clinical midwives (Pama 2017:25; Magobolo & Dube 2019:1). Additionally, Vuso (2017:135) affirms this, as the results reflect that midwifery students were prevented from completing their midwifery register due to shortage of staff. One wonders if many such factors can be regarded as impediments to completion of midwifery register. For this study, the researcher aims to advance insight into experiences of student midwives regarding completion of midwifery register, to establish if indeed, this phenomenon exists.

1.2 BACKGROUND TO THE STUDY

The student midwife needs adequate support and supervision from lecturers and clinicians so that completion of the register becomes an amiable experience (Setumo 2013:23). Empirical evidence has shown that sometimes, the exact opposite occurs during placement of students in the clinical learning environment (CLE). Pama (2017:25) has shown that completion of a register can be challenging especially if there is inadequate support by midwives. Furthermore, Vuso (2017:135) discovered that midwifery students were prevented from completing midwifery register due to shortage of staff. Students need continuous support during clinical placement to enhance integration of theory into practice. Additionally, Meyer (2012:90) found that student midwives were not even orientated in the correct way of filling in the register

and found it to be a complicated document. The study findings demonstrate that completion of register can be quite a challenging obligation and that many factors inhibit its completion.

The results of a study conducted on hindrances to ideal midwifery experiential learning environment in maternity units concluded that, learning situations were not ideal due to lack of resources and insufficient support from midwives (Thopola & Lekhuleni 2015:981). In this regard, registered midwives declined to counter sign for student midwives' post-performance of midwifery procedures (Thopola & Lekhuleni 2015: 981). This refusal by midwives resulted in poor checking and countersigning of maternity case records, thus leading to unsuccessful completion of midwifery register. The statements suggest that student midwife sometimes faces many challenges concerning experiential learning during clinical placement.

Mentoring and coaching is crucial for a smooth clinical learning experience. The reality is that mentoring and availability of opportunities to practise are sadly lacking. Moore (2015:432) found that students were inadequately mentored due to busy work schedules of registered clinical midwives who prioritized needs of women in their care. In South Africa, Meyer (2012:70) found that midwifery students were left alone for an alarming 80% of the time. Regarding opportunities for practising midwifery skills, in South Africa, Vuso (2017:86) found that midwifery students were concerned about increased intake, which greatly contributes to overloaded maternity units. This suggests that high student volumes jeopardise opportunities in the clinical field. Therefore, findings suggest huge number of students has led to inadequate mentoring of students and failure to meet learning outcome, namely, completion of midwifery register.

Midwives have a duty to supervise student midwives during clinical placement for skills attainment (Bweupe, Ngoma & Sianchapa 2018:374). Supervising a student entail being equipped with specific practical, educational, and counselling skills. Ultimately, Bruce, Klopper and Mellish (2011:256) state that midwives also have a duty to teach, mentor and supervise midwifery students during their allocation so that they can provide quality care to ensure patient safety. Rikhotso, Williams, and De Wet (2014:1165) discovered that midwives feel that the caring process for students is an extra workload. Paradoxically, in the United Kingdom, Olander, Rayment, Bryar

and Brook (2018:50) revealed that utmost mentors planned students' time in advance to facilitate an inspiring learning experience.

The findings of the two studies are quite stark and suggest that midwife supervisors in South Africa do not uphold their teaching and mentoring duty. Empirical evidence suggests that barriers to teaching and supporting student midwives can be attributed to registered midwives as well as student midwives. Malwela et al (2016:997) found failure to teach student midwives as being due to a shortage of staff. Vuso (2017:62) revealed that student midwives' commitment to their studies was poor and they would rather engage in inappropriate behaviour during learning time. These findings are very disconcerting as student midwives need a lot of guidance during clinical placement. To this effect, Thopola and Lekhuleni (2015: 984) concluded that student midwives need guidance and mentoring in midwifery units to master the SANC required practical skills. Unfortunately, this is not always the case. Instead, student midwives are often left confused and misguided when placed in midwifery clinical field.

Students expect that the correct method to perform procedures should be demonstrated and taught to them by the lecturer and similarly applied by the clinical midwife. Regarding this matter, incongruences were found by Longworth (2013:837), where students were frustrated by inconsistencies in practice and what was taught in the classroom. In South Africa, Muthathi, Thurling and Armstrong (2017:214) also concluded that there is a necessity to enhance clinical practices amongst nursing education institutions and clinical education settings.

A shortage of midwives is not exclusive to South Africa. Empirical evidence has shown that there is a global shortage of midwives (Matlala 2017:14). The assertion is that shortage of midwives impacted negatively on student supervision, mentoring and teaching. Kobe, Downing, and Poggenpoel (2020:2033) assert that shortage of midwives has affected the nurse-patient ratio with less or no caring for the patient. In 2019, SANC eRegister (SANC 2018 & 2019), the number of qualified midwives stood at 59673, where populace of South Africa revealed over 58.78 million people. This also indicates a shortage of midwives to serve the South African citizenship. Moreover, for the last five years, the annual average number of student midwives that qualify from nursing college in the Eastern Cape Province is approximately 375.

This number is extremely inadequate to cater for the population of the Eastern Cape. It is therefore vital that student midwives complete the register timeously so that more qualified midwives can be available to accommodate for the health care requirements of the population.

1.3 PROBLEM STATEMENT

Kumar (2019:80) explains that any question that one wants answers for and any postulation or declaration that warrants challenge or enquiry can become a research problem.

The researcher has noted with great concern that student midwives experience challenges during completion of midwifery register. The incomplete register is noted periodically when students return from clinical allocation, and upon imminent exit from the course. In most instances, procedures are incomplete or not documented in midwifery register. Crucially, an incomplete midwifery register suggests a theory and practice gap which detrimentally affects a safe midwifery practice, as well as completion of training. The student midwife is then left with no option but to extend training period, and commencement of community service will therefore be delayed. The delay does not only affect the student but has financial implications for both student and the Department of Health. Ultimately, political demands regarding the output of qualified midwives to meet the health care demands of the population will not be met. The shortage of midwives will therefore persist.

A modest amount of information has been empirically documented regarding completion of midwifery register. The researcher's experience is that, over the years, many students have been held back due to incomplete midwifery registers. This backdrop formed the genesis of the researcher's decision to explore the experiences of student midwives concerning completion of midwifery register at a nursing college in the Eastern Cape.

1.4 PURPOSE OF THE STUDY

Gray, Grove and Sutherland (2017:78) define the purpose of research as a clear brief account of the investigator's precise focus or intention.

The purpose of this qualitative study was to explore and describe experiences of student midwives regarding completion of midwifery register at a nursing college in the Eastern Cape.

1.5 RESEARCH OBJECTIVES

Research objectives, according to LoBiondo-Wood and Haber (2018:32), simplistically denote to what the researcher hopes to accomplish with the research.

The research objective for the study was:

- To explore and describe the experiences of student midwives regarding completion of midwifery register.

1.6 RESEARCH QUESTIONS

Polit and Beck (2017:81) refer to research enquiries for qualitative research as those that state the phenomenon pertinent and population of attention.

The study was steered by the following question:

- What were the experiences of student midwives regarding completion of midwifery register?

1.7 SIGNIFICANCE OF THE STUDY

Grove, Burns and Gray (2013:74) state that concerning significance, researchers must demonstrate that the planned study has clinical or theoretical bearing and that the study will make an influence on scientific knowledge or clinical practice. Furthermore, a database for other researchers and worldwide community will be made available. Additionally, policymakers will be more informed regarding completion of midwifery register so that further challenges can be avoided. Finally, the East Cape Department of Health will gain insight into midwifery register completion to adapt and review it so that it becomes more student friendly.

Benefits of the study for student midwives and the nursing education institution.

The study will;

- Provide insight re positive and negative aspects of filling in midwifery register.
- Provide awareness regarding challenges experienced when filling in the register in order to mitigate negative experiences.
- Create awareness of the importance of a sound clinical laboratory experience.
- Make midwifery lecturers aware of the importance of clinical accompaniment and regular follow-up on clinical progress of student midwives. This will avert delays in completion of midwifery register.
- Facilitate timeous completion of midwifery register to avoid re-allocation of student midwives to the already over-burdened maternity units.

1.8 DEFINITION OF TERMS

Creswell (2014:74) explains that the researcher is obligated to define terms that go beyond common language to enable individuals outside the field of study to understand them. The following terms are of special significance to the study:

1.8.1 Completion

The Oxford Advanced Learner's Dictionary describes completion as an act or process of finishing (2005:296 Sv "completion"). In this study, completion pertains to filling in of midwifery register by student midwives during clinical placement.

1.8.2 Experience

Experience encapsulate knowledge coupled with skills of understanding what is learned from doing, seeing or observing, touching or feeling over some period (Roth & Jornet 2014:107). In context of this study, experience refers to practical learning that midwifery students encounter whilst performing midwifery procedures to complete the midwifery register.

1.8.3 Clinical placement

Clinical placement is described in the Nursing Act (South Africa, 2005), as periods expended by a learner in clinical practice setting and other experiential learning places to ensure that the purpose of the programme is accomplished. In this study, maternity units such as MOUs (Midwife Obstetric Units) for low-risk deliveries and

labour wards for high-risk deliveries are places where students are allocated during training for clinical exposure and completion of midwifery register under supervision.

1.8.4 Midwifery register

A midwifery register is a document that guides a student through observations and activities that should be done in the wards (Bruce, Klopper & Mellish 2011:220).

In relation to this study, midwifery register is the SANC-directed document that the student utilises to record all midwifery procedures performed during clinical allocation.

1.8.5 Nursing College

Nursing College is a tertiary educational organisation that bargains professional nursing education at the basic and post-basic levels, where nursing education has been approved according to Regulation R425 (SANC 1985). The college understudy is a public nursing college in Eastern Cape, and it is funded by Eastern Cape Department of Health. It is one of five main campuses in Eastern Cape and is recognised by the SANC.

1.8.6 Student midwife

According to the Nursing Act (Act no 33 of 2005), a student midwife is a nursing student registered with the SANC and is undertaking education and training at an accepted nursing college and has fulfilled prescribed conditions. In this study, a student midwife is a learner who has enrolled for the 4-year diploma course and is in fourth level of study.

1.9 THEORETICAL FOUNDATIONS OF THE STUDY

Creswell (2014:83) explains that qualitative studies are often used to develop a theory as opposed to the request of frameworks as departing point that emphasises the study.

1.9.1 Meta theoretical assumptions

Collins and Stockton in Makua (2021: 9) refer to meta-theories as those assumptions that are considered true because they are built on logical reasoning and judgement without the necessary validation. The following theoretical assumptions constituted the foundation of this study.

1.9.2 Philosophical

Philosophy refers to a world view and denotes one's assumptions, values, and philosophies about nature of authenticity, knowledge, and methods of obtaining awareness (Brink et al 2018:20). The study adopted the constructivism assumption which entails collaboration between participants and the researcher in order to understand participant's perspective (Botma, Greef, Mulaudzi & Wright 2016: 42). The study involved informal interviews so that direct collaboration between the participants and the researcher was assured

1.9.3 Methodological

The methodological assumption should focus on how the researcher should obtain knowledge according to Polit and Beck (2017: 9). In other words, "the how" of doing things. The researcher intended to understand experiences of student midwives, by obtaining participants' account regarding completion of midwifery register.

1.9.4 Ontological

Guba (1990) in Brink et al (2018:19), describe an ontological assumption or foundation as one that is concerned with reality. This means that ontology is concerned about the nature and existence of the phenomena. In the context of this study, the researcher aimed to explore and describe reality of the experiences of student midwives regarding completion of midwifery register. By so doing, the actual lived experiences of the student midwives could be determined.

1.9.5 Epistemological

Polit and Beck (2017:9) believe that epistemology is concerned with a connection between researcher, participants and the phenomenon being studied. The epistemological assumption, in the context of this study, engrossed on the truthful

and valid experiences of student midwives regarding completion of midwifery register. To achieve this, the researcher strove to maintain a solid and genuine relationship with student midwives.

1.10 RESEARCH DESIGN AND RESEARCH METHODOLOGY

Research design is defined by Blaikie in de Vos, Strydom, Fouche and Delport (2011:142) as an integrated declaration and justification for the more procedural decisions involved in planning a research project. The study adopted a qualitative, explorative, descriptive, and contextual design. Kumar (2014:14) states that qualitative studies aim to explore multiplicity rather than to measure and it accentuates description of feelings and experiences rather than their dimension. The study, therefore, chose the design to explore and describe the experiences of student midwives concerning completion of midwifery register. Furthermore, research design was also based on philosophical, ontological, epistemological, and methodological foundations. Chapter 3 further expatiates on the research design and methodology

1.11 TRUSTWORTHINESS

Trustworthiness ensures accuracy of data assembly and analysis and that findings are a precise replication of what the participants want to articulate (Vuso 2017:16). Brink et al (2018:157) refer to qualitative validity as the employment of procedures to ensure the accuracy of findings. The researcher used Lincoln and Guba's model of trustworthiness as a guide to sustain trustworthiness of the study (de Vos et al 2011:419). The following trustworthiness measures were employed to guarantee accuracy of study findings, namely, credibility, dependability, transferability and confirmability. These methods are discussed in detail in Chapter 3.

1.12 ETHICAL CONSIDERATIONS

Muller (2014:59) describes ethics as a highly focused field of study that contracts with the dynamics of what is right or inappropriate in human actions.

The study embraced ethical principles as advocated by the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research namely, respect for persons, beneficence, and justice (Gray et al 2017:161).

Annexures presenting written permission were sought from the Ethics Committee of the University of South Africa (UNISA), Ethics Committee of the Eastern Cape Department of Health, College Head, and principal of specific nursing campus as well as from maternity hospital involved. An information leaflet was provided and written informed consent were obtained from research participants. Ethical issues will be discussed in Chapter 3.

1.13 SCOPE AND LIMITATIONS OF THE STUDY

Burns and Grove (2011:361), describes a scope of a study as broad if it has a broad study purpose and if a large sample is used. The statement emphasises research aim and sample size. In this study, a large sample and a broad aim were employed. Based on this, the scope can be classified as broad. The results of this study may not be generalised to all student midwife experiences, as findings pertain only to one nursing campus in the Eastern Cape.

1.14 OUTLINE OF THE DISSERTATION

This study is made up of five chapters, namely:

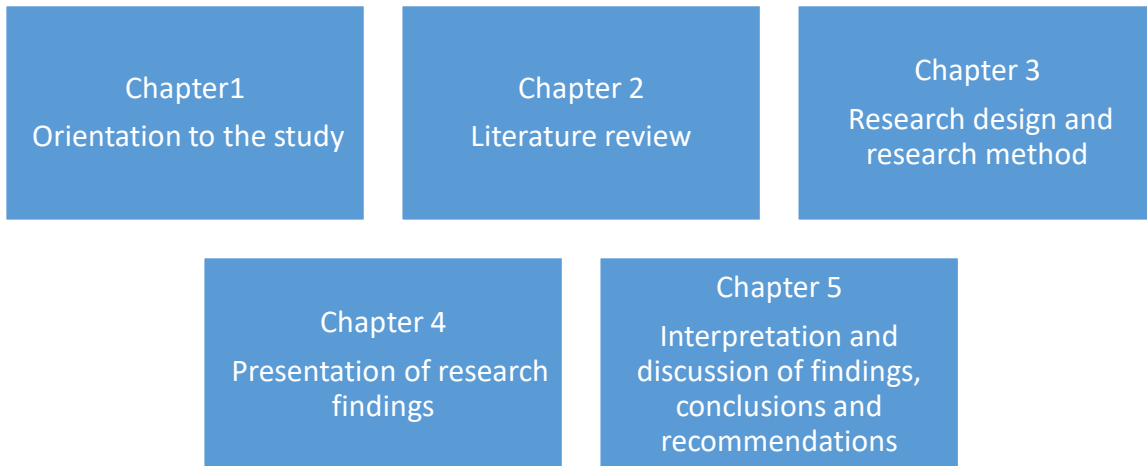


Figure 1.1 Outline of the dissertation

1.15 SUMMARY

Chapter 1 introduced the reader to the topic, namely, “Student midwives’ experiences regarding completion of midwifery register at a nursing college in Eastern Cape”. The introduction, background, problem statement, aims and objectives, as well as research questions, are also included. Applied foundations, design, methods, and ethical considerations, scope and limitations, make up the latter part. Chapter 2 presents literature pertinent to the study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 1 presented orientation to the study, introduction and background, problem statement, aims and objectives as well as research questions, applied foundations, research design and research methods, ethical considerations, scope and limitations of the study and structure of the dissertation. Chapter 2 discusses literature review relevant to the study. The focus is on topics related to completion of midwifery register by student midwives during clinical placement in clinical learning environment.

2.2 PURPOSE OF LITERATURE REVIEW

Literature review is conducted to determine current and valuable information about a particular phenomenon and to recognise any knowledge differences that exist (Gray, Grove & Sutherland 2017:48). Additionally, Polit and Beck (2017:733) refer to literature review as a critical outline of existing familiarity on the chosen topic, often planned to fit the research problem. Literature review relating to this study focused on the most current and important information relating to the research problem, which is completion of midwifery register. Indeed, the literature review enabled an elicitation of gaps that exist concerning completion of midwifery register.

2.3 LITERATURE REVIEW STRATEGY

The review commenced 2019, when researcher's interest in conducting the study was at its highest. By and large, it entailed the following consultations.

- Electronic searches from Google scholar on related topics.
- Previous Master's and Ph.D. studies with similar topics.
- Usage of Unisa library.
- Medical library from a tertiary maternity hospital in the Eastern Cape.
- Nursing college library.

- Local and National newspaper articles related to the study topic.
- White papers and directives related to the study topic.
- Sabinet.
- EBSCO Host nursing and media reports, departmental citations, and legislative frameworks relevant to midwifery register.

de Vos et al (2011:238) aptly state that researchers must trace all available literature that is broadly and specifically relevant to their topic. In this study, literature review was concentrated on the key concepts relating to completion of midwifery register as well as data related to associated concepts.

2.4 MEANING OF MIDWIFERY

Sellers (2013:12) defines midwifery as a sub-section of a collective nursing profession and is regarded as a distinctive entity by the International Confederation of Midwives (ICM). Furthermore, Sellers (2013:13) explains that the ICM, of which South Africa is a member, expresses a midwife as a person who successfully accomplished a midwifery education program that is accepted in the country. Midwifery denotes a caring occupation accomplished by registered persons which supports and assists the mother-baby pair to achieve and maintain optimum health from pregnancy to puerperium (South Africa 2006:6).

2.4.1 Midwifery as a science

Meyer (2012:19) states that midwifery is referred to as a science, meaning that it consists of, and requires the organised application of knowledge. Burns, Grove and Sutherland (2017:39) assert that science is a comprehensible body of knowledge composed of research findings and examined theories for a specific discipline. The purpose of science is to describe and understand the actual and practical world so that new knowledge or expansion of existing knowledge can be achieved. The study sought to pursue a scientific process to gain insight, new knowledge, and augmentation of existing knowledge concerning completion of midwifery register.

2.4.2 Midwifery as an art

Marder (2019:1) refers to an art as a skill or craft. The art utilised in the performance of skills, allows midwives to recognize needs and to promote self-confidence of women in their care. Furthermore, skills application is what succeeds midwifery to be classified as an art (Meyer 2012:20). In this study, midwifery as an art is recognised by specific skills that are performed and documented in midwifery register.

2.5 THE STUDENT MIDWIFE

According to the Nursing Act (2005:27), a midwifery student is a nursing student registered with SANC, who is undertaking education and training at an accredited nursing school and who has conformed to prescribed conditions. In this study, a midwifery student is a learner who has registered for R425 diploma course, which is the basic nursing education and training leading to registration as a nurse (general, psychiatric, and community) and midwife, (SANC 1985). According to SANC (2020), the number of fourth-year students registered with SANC was 9280 females and 2930 males.

2.5.1 Role of the student midwife

The East Cape Department of Health (2020:17) explains the role of student midwife as follows;

- Must be registered for the current academic year - means that the student midwife must have registered for fourth year of study after successfully completing the third year.
- Having personal professional indemnity - means that the student must be a paid-up member of a registered health care workers' union so that he/she can be professionally represented in the case of malpractice allegations. An example of such a union is the Democratic Nurses Union of South Africa (Denosa).
- Avoid absenteeism when placed in the CLE - means that the student must have attended 85% of theory and clinical placement attendance.

- Obtain year marks to enter for examinations - means that the student must obtain at least 40% in theory evaluations and 50% in practical.
- Being aware of personal progress and knowing when to seek assistance – means that the lecturer should make the student aware of poor progress so that the student can request assistance.
- Being available for assessment and remedial teaching – means students must be encouraged to present themselves for the remedial program when necessary.
- Taking full responsibility for the achievement of learning outcomes – means that the lecturer must impress it upon students that ultimately the choice and responsibility to be successful depends on them.

2.6 MIDWIFERY TRAINING

2.6.1 Midwifery Training Internationally

2.6.1.1 *United Kingdom*

The Nursing and Midwifery Council (NMC) in United Kingdom, reviewed pre-registration midwifery education in 2006 (Mayes 2013:38). This resulted in the commencement of a degree program as recommended by the council in 2007. Clinical training involved antenatal, intrapartum, and postnatal care. Pre-registration standards for midwifery education were updated in 2009 with programs duration set at 3 years and 18 months for registered nurses. The NMC competencies were divided into four domains, namely:

Effective midwifery practice - this involves vital skills which include communication between the woman and midwife, management of normal labour and birth, initiation and continuance of breastfeeding and medicines management.

Skilled and ethical preparation - means that declaration of good health and good character must be made by the Lead Midwives for Education (LME) on the completion of program.

Individual development of the midwife - means that the midwife must be developed to such an extent that he/she is capable of being a safe practitioner.

Achieving quality care through evaluation and research - involves auditing and monitoring of compliance by local authorities and supervisors of midwives.

2.6.1.2 Norway

Lukasse, Lilleengen and Fylkesnes (2017:80) explain history of midwifery teaching in Norway as follows;

- Midwifery teaching became a specialty in nursing in 1952.
- Only qualified nurses were admitted to the course and was offered at a hospital-based institution.
- The length of midwifery training was 18 months.
- Later, in 1980, midwifery education moved from hospital to school-based program.
- The course took two years for midwives to become authorised personnel.
- In 2004, new legislation determined that midwifery education would be a two-year full-time education programme.
- A midwifery curriculum was developed, and the course was done at nursing education institutions.
- The 50% theory and 50% practice became included in two academic years respectively.

2.6.2 Midwifery training Sub-Saharan Africa

The following section discusses midwifery training in different Sub-Saharan countries

2.6.2.1 Democratic Republic of Congo (DRC)

Bogren, Ndela, Toko and Berg (2020:6) state that since the didactic reorganisation in 2013, a three-year midwifery programme was introduced at a high-ranking educational level which is in line with international norms and standards. Successful candidates who completed were registered and recognised as A1-level midwives. Currently, there are two official educational programmes for developing a midwife in the DRC. The first programme is a three-year direct entry programme, and the minimum entrance requirement is the secondary school education. The second

programme comprises a 12-month in-service for nurses educated within a three-year curriculum at a higher academic level. Both courses are offered at higher education level namely, university or nursing education institution. Curricula for each of the two educational programmes comprises of 60% theory and 40% clinical practice. On completion of the direct–entry program students receive a diploma and those completing 12-month in-service education program receive a certificate.

2.6.2.2 Tanzania

Musoke (2020:27), states that Tanzania started formal midwifery training courses which were hospital-based in 1949. Midwifery lecturers taught students in the classroom and accompanied them in clinical settings. In 1952, clinical instructors were introduced to ease the workload on midwifery lectures. Currently, the R425 integrated diploma course is offered at 14 nursing education institutions. Midwifery students are required to accumulate 500 hours of theory and 1500 hours of clinical practice. Midwifery lectures are mandated by the curriculum to demonstrate required competencies to ensure integration of theory into practice.

2.6.2.3 Zambia

Miyanda (2015:1) revealed that, a shortage of trained of midwives have been noted in Zambia. In 2008, to curb scarcity of midwives, Zambian minister of health introduced the direct entry to midwifery programme whereby prior education was not required. The curriculum comprises of the first six months of general nursing and 12 months where students are taught midwifery content. Students are allocated to clinical sites where they are mentored and supervised for experiential learning by trained supervisors in the last six months of training.

2.6.3 South Africa

Meyer (2012:24), states that in South Africa, midwifery was introduced at a post-basic level in 1922. To be admitted to midwifery training, a candidate must have successfully accomplished a three-year course in general nursing. The duration of the course was 12 months. Later, in 1977, the SANC introduced a two-year midwifery programme which has since been eliminated. Then in 1994, the political shift in the post-apartheid era had a major impact on midwifery education.

Education and training were transformed so that only certain individuals and students could pursue and complete SANC-approved midwifery programmes with associated practical components to be admitted to the SANC register for midwives. The following midwifery programs, together with legislative frameworks, form the pillar of midwifery training in South Africa.

The following SANC regulations are responsible for midwifery courses in South Africa;

- **Regulation R254 (SANC 1975)** is a one-year midwifery course that can be taken by a registered nurse who has successfully accomplished a three-year diploma in General Nursing Science. The last intake for the program was in 2019 and is in the process of being phased out.
- **Regulation R212 (SANC 1993)** is a one-year diploma midwifery course that can only be taken by a nurse who has successfully completed a three-year Diploma in General Nursing Science, a one-year diploma in Midwifery Nursing Science, and should have three years of experience working in maternity wards. The course is called Advanced Diploma in Midwifery and Neonatology (ADM) course. This course is currently in the process of phasing out with 2020 as the last intake.
- **Regulation R425 (SANC 1985)** is a four-year diploma programme that leads to registration as a Nurse in (General, Psychiatry, Community) and midwife. The last intake was in 2020 as the course is to be discontinued.

2.6.3.1 The future

Sellers (2018:19) states that new nursing education courses will be offered from 2024 through a three-year bachelor's degree in the higher education band Level 8. Contrarily, as early as 2019, the South African Nursing Council implemented a long-awaited Bachelor of nursing programme which is R174 (SANC 2013) and approved that several public and private institutions would offer these programmes, pending institutions' accreditation (SANC 2013).

Midwifery has been unified into the programme which will be offered at degree level and successful candidates will exit as registered nurse-midwives. The Advanced Diploma in Midwifery will be offered over two years, R1497 (SANC 2019).

The online accreditation system is already up and running with regards to progress in the implementation of the new nursing qualifications, which include new nursing education standards, curriculum guidelines, and scope of practice of the envisioned new nursing cadres. Indeed, currently, some nursing colleges and universities have been accredited by SANC to offer the new qualification courses and are doing so since 2020. In South Africa, this proposition was only recommended in 2013 when a new framework for Nursing Qualifications was established (Blaauw et al 2014:1).

As mentioned previously, motivation of this study is the R425 diploma which, when successfully completed, validates that the student can be registered as a general nurse, community nurse, psychiatric nurse, and midwife with SANC. Roets, Botma and Grobler (2016:428) state that diploma and degree programs contain the same content, degree programmes provide students with a more detailed study of the physical and social sciences, nursing research, leadership, and management, as well as community and public health nursing. In addition, there is no difference between degree-qualified and diploma-qualified nurses. Both qualifications run over 4 years and midwives register with SANC as a nurse with General, Community, Psychiatry, and Midwife. Roets et al (2016:427) revealed that between the two groups there is also no salary nor rank difference.

2.6.4 Theoretical midwifery training

Four-year diploma students commence midwifery training from third year and complete training in the fourth year. Degree students commence midwifery modules in the fourth year of study. Midwifery lecturers initiate training by lecturing and facilitation of midwifery theory content in the classroom through a block system. Bruce, Klopper and Mellish (2011: 287) inform that a block system separates curriculum into chunks to cover theory content. In the case of midwifery, the programme is primarily approved by SANC, which is the supreme quality control body of all nursing and midwifery training. The study guide stipulates that the theory must be covered over two academic years (South Africa 2020:27). A total of 48 credits is awarded for the two years of training. Credits are determined as follows. One credit equates to 10 notional hours therefore 48 credits multiply by 10 notional hours equals 480 notional hours.

Student midwives are taught theory in the classroom as a background to a practical module and thereafter they are allocated to various maternity units for practice. Aragaw, Sinishaw, Daba and Mekie (2019:205) aptly state that meaningful relationship of theory and practice takes place during clinical placement. The student therefore must have background information that must be taught in a classroom setting to be integrated into practical performances.

2.6.4.1 Midwifery theory content

The midwifery theory content is detailed in the SANC-approved curriculum for the four-year diploma course (South Africa 2015:18). A good midwifery educational experience can only enhance the confidence of the student midwife. A study by Vermeulen, Peersman, Wagemans, de Clercq, Gucciado, Laubach, Swinnen, Beeckman, Buyl and Fobelets (2016:6) revealed that student midwives felt there is a need for reliable education material, new technologies such as virtual reality and serious gaming that warrants further consideration. This is to assess how these progressions may contribute to preparing students for placement.

The statements suggest that a good and up-to-date midwifery classroom experience is essential to prepare midwifery student for clinical practice. Student midwives cover third and fourth-year theoretical content in a classroom setting. In total the number of hours to spend during third year is 170 hours and 420 hours for fourth year. The minimum SANC required theoretical course content is depicted in the table 2.1 below.

Table 2.1 Student theoretical content requirements

THIRD YEAR		FOURTH YEAR	
CONTENT	HOURS	CONTENT	HOURS
Anatomy and physiology	35	Abnormal pregnancy	80
Normal pregnancy	40	Abnormal labour	80
Normal labour	40	Abnormal puerperium	80
Normal puerperium	8	Abnormal neonate	45
Normal neonate	40	Contraception, Fertility	45
Revision and demonstrations	7	Management of midwifery unit	40
Total	170	Mothercraft	10
		Revision	40
		Total	420

Eastern Cape Department of Health (2019)

2.6.5 Clinical midwifery training and requirements

Midwifery programs differ from the usual educational program in that it incorporates a clinical component that carries either an equal or higher weighting than theoretical training. The clinical training component, therefore, forms a significant part of midwifery training. The Nursing and Midwifery Council (NMC) (2011), as stated by Gregory (2014:508), stresses the importance of a hands-on profession by asserting that midwifery is practical.

2.6.5.1 Simulation learning for student midwives

Simulation learning commences immediately after a theoretical learning experience in the classroom and continues throughout midwifery training experience. Learning consolidates or brings together theory and practice. The main drive of simulation learning experience is to prepare student midwife for clinical learning environment as well as for performance of skills. Learning takes place in a simulation laboratory. Muthathi et al (2017 88) state that a clinical laboratory is an educational facility in which a student can be taught and practice skills before using them in clinical settings. Additionally, Meyer (2012: 27) explains that a simulation laboratory is a classroom that resembles a hospital furnished with learning equipment. Midwifery lecturers demonstrate midwifery skills after which students are allowed to practise the skills until they are confident. A sound simulation experience enhances the student midwife's integration of theory into practice. Reyhan, Mete, Sayiner, and Celik (2018:239) found that students preferred simulation learning for the following reasons: 72.3 % felt it improves communication skills, 68.2% felt it improved their critical thinking; 85% their professional skills, and 80.9% their professional accountability.

2.6.5.2 Clinical skill requirements for student midwives

Ahmadi, Shahriari and Kohan (2018:64) state that clinical skills reinforce midwives' professional practice and consequently students should have an opportunity to learn, mature and master skills. To fulfil the practical part of training, SANC regulation R2488 (SANC 1990) has prescribed 16 midwifery skills (procedures) and one thousand clinical hours that student midwives should complete. Table 2.2 below depicts 16 SANC prescribed skills that must be completed to qualify as a midwife.

Table 2.2 List of practical skills for student midwives (R425).

THIRD YEAR SKILLS (Normal midwifery)	FOURTH YEAR SKILLS (Abnormal midwifery)
1. History taking from a pregnant woman for risk assessment	1. Management of mild gestational proteinuria hypertension
2. Physical examination and abdominal palpation	2. Plotting of abnormal gravidograph
3. Plotting a normal gravidograph (progress of pregnancy)	3. Management of a newborn under phototherapy for treatment of neonatal jaundice.
4. Examination of a newborn baby	4. Management of post-partum haemorrhage (pph)
5. Examination of a placenta	5. Resuscitation of a new-born
6. Examination of a woman during puerperium	6. Plotting of partogram during abnormal progress of labour
7. Partogram - plotting of progress of normal labour, witness vaginal deliveries	7. Deliver at least 15 new-born babies
8. Conduct pelvic assessments on a pregnant woman	8. Performance of an episiotomy

SANC (1990)

Experiential midwifery learning is diverse as it extends to four dissimilar areas namely: the antenatal, labour, puerperium and neonate. Additionally, skills performed from previously mentioned areas should be recorded in midwifery register within a specified time of 1000 hours. Recording of skills takes place during clinical allocation in the designated maternity units supervised by a registered midwife who endorses competency. The student midwife can only be endorsed by a midwifery lecturer upon successful completion of 16 skills and at least when 1000 clinical hours have been covered. For midwifery students to reach their objectives, Pama (2017:53) recommended that midwives should form a conducive and allow students to practice their skills according to their learning outcomes to enhance integration of theory into practice. Student midwives are therefore dependent on midwives for supervision in the absence of midwifery facilitator. Gaberson and Oerman in Muthathi, Thurling and Armstrong (2017:219) supports the above statement that nursing students rely on clinical facilitation and supervision by midwives. This will assist them to amplify period spent in clinical learning environments and perfect the art and skill of nursing.

2.6.6 Legislative framework for midwifery training

Nurse and midwifery training is regulated by the SANC. This is to ensure that quality patient care and training are provided. It is the regulatory body that prescribes skills

for education and training. To provide nursing and midwifery training in South Africa, a nursing college must apply and meet the criteria stipulated by the SANC. The SANC was established and enacted in the Nursing Act (Nursing Act 33, 2005:6). Furthermore, midwifery is controlled by the Protection Information of Information Act (South Africa 2013), and finally, the Constitution of the Republic of South Africa (South Africa 1996) which regulates disclosure of patient information and the right to quality care respectively. The following SANC Regulations form part of the legislative framework:

- **Regulation R425 (SANC 1985)**

This regulation is for training of nursing students who have registered for the four-year diploma in elementary nursing education and training, leading to registration as a nurse (general, psychiatric, community) and midwife. Student midwives are registered for the four-year diploma at a nursing college and their training is governed by this regulation.

- **Regulation R2488 (SANC 1990)**

This regulation is concerning to circumstances under which registered midwives and enrolled midwives may carry on their profession. The regulation entails; keeping of records; management of women during antenatal period, labour, and puerperium; keeping records of maternity cases attended including antenatal visits, labour, the mother, and child. The training of student midwives entails caring women during antenatal period until the period when the child is born. This regulation guides them on midwifery skills performed, recorded on midwifery register and endorsed by registered midwife.

- **Regulation R387 (SANC 1985)**

This regulation applies to laws over acts and omissions, including where the midwife neglects the patient wilfully or omit provision of care including treatment; fail to keep clear and precise records of progress of pregnancy, labour, and puerperium. During training students are guided by registered midwives on completion of maternity records and midwifery register.

- **Nursing Act (Nursing Act 33, 2005)**

Chapter 2 of this act referees to education, training, research, registration, and practice of midwives. The nursing act further stipulates that a person undergoing education or training in nursing must apply to the SANC to be registered as a student. This will ensure that student midwives comply with agreed conditions of the curriculum at a nursing education institution. The R425 students follow a specific programme for the period of 4 years.

- **Regulation R2598 (SANC 1984)**

This regulation is relating to Scope of Persons. Chapter 3 of this regulation relates to the scope of practice of a registered midwife. The scope of practice of a registered midwife shall entail; the diagnosis of a health need and implementation of midwifery regimen; the prevention of disease relating to pregnancy, labour, puerperium and monitoring health status of mother and child.

2.6.7 Midwifery skills and maternity records applicable to the midwifery register

The Regulation R2488 (SANC 1990) regulate the training of nursing students who have registered for the R425 diploma course in basic nursing education and training, leading to registration as a nurse (general, psychiatric, community) and midwife (SANC 1985). During midwifery training, student midwives follow a theoretical and practical component, and the practical component involves performance of skills which are then recorded in midwifery register and endorsed by registered midwife.

The midwifery register is a SANC prescribed document which entails the following procedures; palpation of 40 women during antenatal period; witnessing of 5 normal deliveries; health education to pregnant women on antenatal and postnatal exercises; conduction of 20 normal deliveries; performance of pelvic assessment on 5 women; performance of 20 vaginal examinations (pv); nurse 10 mothers in antenatal ward, 10 mothers in post caesarean section ward and 10 mothers in post vaginal delivery ward; nurse 15 sick babies; witness 5 abnormal deliveries; witness 1 episiotomy performed by a midwife; performance of 1 episiotomy and assist 3 women to breastfeed post-delivery. On completion of these midwifery skills the student

midwife then, has complied with the SANC requirements and may commence community service.

- **Maternity records applicable to patient care**

The Regulation R2488 (SANC 1990: s4) emphasises that a registered midwife shall keep clear records of the progress of pregnancy, labour and the puerperium including the emergency acts performed in connection with the mother and child. During clinical student midwives are required to accurately record, in detail, all skills performed on a patient, firstly, on the patients' maternity case record, secondly, on the labour ward admission register, and lastly, on the students' midwifery register, which is then checked and endorsed by a midwife. The maternity case record entails intervention details from the antenatal clinic visit up to post-delivery period. The following legal prescripts apply when recording in the midwifery register;

2.6.7.4 Caveats related to midwifery record keeping

Muller (2014:41) highlights the following problem areas that should be avoided regarding midwifery clinical record keeping;

- *Inadequate/incomplete documentation* - records should be completed if full after performance of midwifery skills.
- *Absence of documentation* - all skills should be documented, as absence of documentation means the skill was not performed.
- *All or part of the clinical record missing* - records should be kept under lock and key and no part of the maternity records should be detached.
- *Modification of records* - alteration of records is not allowed.
- *Fabrication of the clinical record* - the sequence of events should be recorded as they happen during patient care.

2.6.7.5 Importance of record-keeping

Muller (2014:41) highlights the following;

- Clinical record keeping is a professional responsibility and should be upheld if legal matters are to be avoided.
- Records provide evidence of care and are provided especially since the public becomes more aware of their rights including the Charter of Patients' rights.
- It provides a baseline assessment that forms a point of reference for future care.
- Specific health problems are identified and indicated as such so that all carers are alerted, and interventions can be planned.
- Accurate record-keeping provides opportunities for updating and continuity of care.

Mutshatshi, Mothiba, Mamogobo and Mbombi (2018:1931) revealed that nurses under employment of public hospitals experienced record keeping as a challenging activity due to lack of time to complete records. To compound matters SANC's analysis report, as cited by Mutshatshi et al (2018:1931), revealed that 769 nurses were found culpable of professional transgression due to their failure to record nursing interventions in nursing records. The study findings underscore how important it is for the student midwife to accurately complete the maternity records and the SANC prescribed midwifery register.

2.7 CHALLENGES FACED BY STUDENT MIDWIVES DURING COMPLETION OF MIDWIFERY REGISTER

The process of completing midwifery register within a specific timeframe is not always easily achieved. Results of the study conducted by Pama (2017:53) revealed that student midwives were having difficulties in completing the midwifery register due to overcrowded units by student midwives from different Nursing Education Institutions, few learning experiences, and no time allowed to fill in the register under supervision. Moreover, when students are allocated for shorter periods, they learn a variety of skills, but they do not get the opportunity to master them (Pama 2017:50). In addition, results of the study by Magobolo and Dube (2019:4) revealed that

student midwife attendance in clinical placements was hampered by absence due to personal matters such as physical illness, family accountabilities, and problems with transport to the clinical areas. Concerning the all-important concept of documentation, a study that was done in Ireland, by Bradshaw, Pettigrew and Fitzpatrick (2019:29) found that even experienced preceptors felt that documentation of the register was not user-friendly, let alone comprehensible by student midwife. The results therefore, suggest that students faced challenges concerning completion of midwifery register.

2.8 CLINICAL LEARNING ENVIRONMENT (CLE)

The student midwife is subjected to a block system model of teaching that covers the curriculum in its entirety over two years. Each block period is followed by a demonstration of skills in the midwifery clinical laboratory by the midwifery lecturer. A period of skill practising by the student midwives then follows under the supervision of the midwifery lecturer. The practise period enables the integration of theory and practice as well as the honing of skills on the part of the students. The student is then ready for a clinical placement period for performance of the SANC required midwifery skills. To cite just one example, a student is required to complete skills related to normal pregnancy after theoretical facilitation and demonstration of the subject. The pattern then continues systematically over two years until the whole curriculum is covered.

The clinical learning environment is an essential facet of clinical education of student midwives. According to SANC (SANC 2013) 58 (1), CLE is mandatory because nursing education institution can be accredited by the SANC if only there is an approved CLE. Bruce, Klopper and Mellish (2011:254) define clinical learning as the attainment of knowledge, skills, and values in a clinical practice setting and is also termed a clinical learning environment.

2.8.1 Essential strategies for effective clinical learning

Rikhotso et al (2014:1164) state that CLE, should have a conducive learning environment with good relationship between students and midwives. It is imperative, therefore, for the CLE to be encouraging to promote integration of knowledge and

practice gained so that learning outcomes can be achieved. With midwifery being a more hands-on profession, it especially requires that the CLE be favourable. Maaka (2017:14) asserts that the initial experience in a midwifery clinical setting can be traumatic, especially in labour wards. Therefore, the CLE should be as student friendly as possible so that required experiential learning takes place. The following strategies have been identified as invaluable to assist student midwives to achieve their clinical learning outcomes in the CLE;

2.8.1.1 Simulation learning

Simulation is described by the Oxford Advanced Learner's Dictionary (2005:1370) as a situation in which a particular set of situations is created theatrically to study or experience a real situation. In midwifery, this takes place in a clinical laboratory where dolls capable of animation are used to mimic pregnant women and new-born babies. To cite just one example, a birthing doll is used to demonstrate a woman giving birth. Muthathi, Thurling and Armstrong (2017: 215) state that a simulation laboratory is a setting in which a learner can be taught and practice clinical skills before application on live patients. A study by Carolan, Olah and Kruger (2013:6) found that students identified a need for greater skills training and were intensely focused on more time for practising their skills in clinical laboratory in preparation for practice. Students in the study also voiced a need for remedial sessions to enhance confidence development by including more skills practice during educational experience. Therefore, simulation laboratory experience before clinical placement was regarded as vital to skills acquisition. In addition, the students suggested that enough time be allowed for practise of their skills. Thus, in summary, the clinical laboratory experience moulds the student midwife to be prepared for clinical placement.

2.8.1.2 Accompaniment

Clinical accompaniment is a process where nurse educators support students during clinical placements to ensure that learning outcomes are achieved (SANC 2011:4). Bosch (2020:19) postulates that the importance of accompaniment is to be mentored or guided by a person in the nursing profession with advanced skills and knowledge in a particular discipline. The role of clinical accompaniment is performed by the

lecturer as well as the clinical preceptor. The Nursing Act (South Africa 2005) stipulates that nurse educators must spend at least 30 minutes per fortnight per student in clinical institutions to support and mentor students. Therefore, the achievement of learning outcomes is largely dependent on a good clinical accompaniment experience that includes regular checking of clinical progress and assessments. A study by Muthathi et al (2017:216) found that students alluded to deprived accompaniment by nurse educators as a hindering factor to clinical learning. Additionally, Maphuthi (2016:20) suggests that student midwife should be accompanied to facilitate learning opportunities during clinical placement.

2.8.1.3 Supervision

Clinical supervision is a progression involving a supervisor and supervisee or more professionals to support and assist in the growth of nursing students to become professionally mature (Mampunge & Seekoe 2014:58). Maphuti (2021:18) informs that the Department of Health (DOH) Domain 2.3 of the National Core Standards for Health Establishments in South Africa, emphasises that to ensure patient safety a supervision program for students should be in place to ensure skills attainment. Matlala (2017:20) states that midwifery supervision can be an immensely supportive structure, but unfortunately it was described that the midwives' experience of supervision is often punitive, which impacts negatively on their self-confidence and psychological health. Furthermore, a study by Phiri (2017:124) found that midwifery students credited their lack of learning to a lack of supervision. Additionally, Mbakaya et al (2020:6), found the sporadic supervisory support in the CLE as an inhibiting factor. The negative findings regarding lack of accompaniment described in the statements demonstrate that, poor accompaniment of students could cause failure to achieve learning outcomes.

2.8.2 Essential components for clinical learning

Van Rooyen and Jordan (2016:79) believe that a good educational setting portrays the following characteristics;

2.8.2.1 Adequate learning opportunities

Learning opportunities should be adequate for accomplishment of learning outcomes. The CLE should be free from physical or psychological harm, and for this to materialise there should be trust, mutual respect, and hopefulness between the registered nurse and the student. Additionally, the CLE should allow the student to be innovative if practice standards are not compromised. All cultural, gender and religious affiliations should unfailingly be respected, and no student should be rejected based on these phenomena. Learning opportunities should be ample so that the student midwife has easy access or is easily exposed to the SANC required skills. Unfortunately, this in South Africa is not easily attainable. Many students make it difficult for midwives to supervise and assist during clinical allocation. Moreover, when clinical facilities are congested with students, some students may not be able to accomplish their learning outcomes (Pama 2017:53). Consistently, Mathebula (2020:25) found that the cause of limited learning opportunities at the CLE was due to students experiencing competition with students from other health educational institutions.

A study conducted in Zambia revealed that the increasing student population, among other factors, makes it difficult for midwives to assist and monitor students and patients effectively (Bweupe, Ngoma & Sianchapa 2018:374). Additionally, Meyer (2012:64) corroborate the study findings when the participants stated that they fought among themselves to get procedures to fill in the register. Furthermore, midwifery students can have several sources of stress in labour wards. In Norway, Brunstad, Giska and Hjamhult (2016:137) state that midwifery students are required to be the focal birth attendant in at least 50 normal births; and it was found out that the main concern of midwifery students in labour wards was how to gain access to learning experiences. Additionally, in Malawi, Khapagawani (2015:209) revealed that students were instructed not to waste time on performing procedures like they were taught but to rather take shortcuts.

The challenge of gaining contact to the learning experience, therefore, has a disastrous impact on the completion of the midwifery register.

2.8.2.2 Staff commitment to teaching and learning

Staff should show commitment regarding teaching and learning for students to achieve outcomes and to enhance students' progress in the CLE. A poor relationship between the student and registered midwife can lead to frustration and demotivation on the part of the student. This, in turn, will harm the student's learning outcomes (Khapagawani & Useh 2013: 184). Students need adequate support during clinical placement to enhance integration of theory into practice. Setumo (2013:74) found that clinical staff was not supportive to students to promote achievement of learning outcomes. This had impacted register completion negatively.

2.8.2.3 Material resources

In a profession where lives of mother and baby child are at stake, it is unconscionable not to have necessary equipment needed to practice safe midwifery care. In South Africa, Mhlongo (2016:47) revealed that there is scarcity of equipment vital for patient care, if available, it is frequently not in good working order. Examples of essential equipment are blood pressure machines and umbilical cord scissors. Additionally, Thopola and Lekhuleni (2019: 5) found that due to the scarcity of essential equipment, learner midwives and midwifery practitioners used non-medical equipment, this caused a risk to pregnant mother and foetus. It can therefore not be stressed enough that material resources are vital and can save the life of both the mother and child. Mathebula (2020:33) discovered that even in developed countries such as New Zealand, CLE's were unsafe and health care was at a risk due to lack of clinical resources.

The above discussion suggests that although the CLE plays an important role in the development of student midwives, it is often a very unfavourable environment in which to achieve the prescribed learning outcomes. This is confirmed by Thopola and Lekhuleni (2016:894), who revealed that experiential learning environment was not conducive for achievement of learning goals. Ebert, Tierney and Jones (2015: 294) aptly states that the clinical environment can either facilitate or impede the student's ability to integrate theory into practice. The study mentioned above suggest that the CLE impeded the student midwives' progress.

2.9 MAIN ROLE PLAYERS IN THE EMPOWERMENT OF STUDENT MIDWIVES IN THE CLE

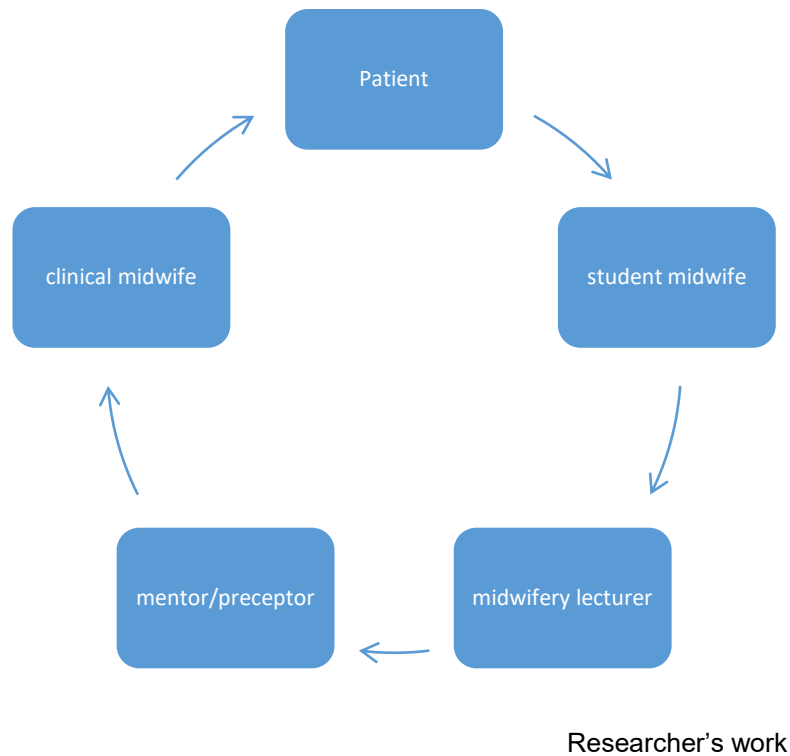


Figure 2.1 Role-players in the empowerment of student midwives

2.9.1 Patient

The patient is the most important role-player in the CLE. That means, no patient no need for a CLE. The Constitution of South Africa decrees that every single patient has a basic right to quality care (South Africa 1996). Additionally, the Department of Health in 2008 has adopted the Patient's Rights Charter as a means of realising patients' constitutional rights to quality health care (Booyens 2013:10). The Charter attempts to balance patients' rights with their responsibility to take care of their health and well-being.

Broadly speaking, according to Booyens (2013:10), patient's rights include the following;

Timeous access to all forms of health care, treatment, and rehabilitation, including special needs. This must be provided by polite, empathetic, and patient health care workers.

- This means that all pregnant women are seen as they report to antenatal service and no pregnant patient must be turned away. Treatment should be provided and commenced the same day, namely, treatment such as antiretroviral therapy to HIV (Human Immunodeficiency Virus) positive clients. Special needs, such as counselling services, should be provided when there is a need, especially to women who gave birth to stillborn babies or babies with abnormalities.

Ability to choose one's health care provider and health care institution:

- This means that patients have a right to utilise the institution of choice, therefore patients must not be turned away irrespective of geographical origin.

Provision of health care education in a language understood by the health care recipient:

- This means in all midwifery units; health education should be communicated using the patient's home language. This will enhance the level of understanding between the patient and the midwife. All health education posters and information pamphlets about, for example, exercise and diet, should be in the patient's mother tongue.

Referral for a second opinion:

- Pregnant women that are classified as low risk are managed at the low-risk clinic for antenatal care and give birth in MOUs, but as soon as complications arise, for example, poor progress of labour, they must be transferred to the high-risk clinic or labour wards for further management.

Right to complain about health care received:

- This means pregnant women have the right to complain about services rendered to them during a visit or a stay in hospital. Antenatal clinics and labour wards have suggestion boxes that are visible to patients. Anytime when the patient is not satisfied with the care rendered, they are allowed to

complain in writing via the suggestion boxes or even verbally through the person in charge of the unit.

2.9.2 Student midwife

Phiri (2017:43) states that nursing students in South Africa do not enjoy the supernumerary status that is in place in various parts of the world. Student status in South Africa is affected by different funding models, for example, the stipend or learnership model, and is expected to fulfil the 40-hour work per week. The student midwives involved in the study are funded by way of a bursary system. Additionally, midwifery training is designed for adult learners and as such, they should be self-directed, motivated, and accept full responsibility for their learning outcomes.

The East Cape Department of Health (2021:21) outlines the student midwife's role as follows:

- Be legitimately registered as a student midwife for the academic year.
- Be insured for culpable incidents.
- Be in possession of prescribed books.
- Be present in all learning areas.
- Obtain examination entrance year mark.
- Be aware of academic and clinical progress and seek help if required.
- Available for remedial teaching and assessments.
- Take full responsibility for academic learning outcomes.

2.9.3 Midwifery Lecturer

The lecturer is most certainly a very important cog in the clinical learning experience of the student midwife. The WHO (2014:8) outlines the lecturer competency domain in the CLE as follows; creating an effective and safe environment for clinical teaching of midwifery care and fostering individualised experiential learning. According to Borrageiro, in Mathebula (2020: 25), nurse educators are responsible for bridging the gap between the theoretical and practical aspect. In support, Maaka (2020:16) believes that midwifery lecturers strengthen the adaptation of student midwives to experiential learning. It is the lecturer who knows the student midwife on a more personal level and with whom the student midwife usually feels more comfortable. A

study done in South Africa by Senti and Seekoe (2014:83), revealed that students were accompanied by unacquainted lecturers who displayed undesirable attitudes towards them. The lecturer should adequately support the student midwife in the CLE. Additionally, Xaba (2014:29), found that lecturers who teach theory must accompany students in the CLE to bridge theory practise gap. Unfortunately, many studies reveal that lecturer support in the CLE was sadly lacking. Consistently, Muthathi et al (2017:2223), found that lack of accompaniment by midwifery lecturers contributed to inadequate experiential learning.

2.9.4 Mentor/Preceptor

A preceptor, sometimes also called a mentor, is a competent, confident, and experienced registered nurse who supports another nurse by giving quality nursing care through guidance and training (Booyens 2013:219). This means that the preceptor/mentor holds both a clinical function as well as an education function. Malwela et al (2016:969) state that mentors or preceptors provide guidance and support to students during clinical placement. To enhance successful outcomes and to ensure internalisation of clinical content and skills, student midwives need to have clinical command and guidance (Bosch 2017:22).

A study by Phiri (2017:35), found that there was strong evidence that midwifery students need positive role models in the form of mentors. However, Malwela et al (2016:997) found that staff shortage inhibited midwives to adequately accomplish mentoring of students. This impacted negatively on the students' competency as they were not properly supervised. It is apparent that mentoring of student midwives contributes to acquisition of skills and completion of the midwifery register. Agreeably, mentoring has been found to be beneficial to both mentee and mentor (Khunou 2018: 240). Integration of theory and practise and accurate completion of the midwifery register will be enhanced by adequate mentoring of student midwives.

The study findings demonstrate that although mentoring and preceptorship can be a positive experience for a midwife, it is sometimes neglected due to a variety of extraneous factors. This is to be lamented because the mentor/preceptors' role in guiding and supporting the student to achieve the learning outcomes is invaluable.

The ensuing discussion highlights some of the responsibilities and challenges experienced by mentors/preceptors.

2.9.5 Registered clinical midwife

Ultimately, it is SANC Regulation R2598 (SANC 1984) that proposes the scope of practice of a midwife. In essence, the role is twofold, meaning that the midwife has a responsibility towards both the patient and new-born as well as to the student midwife. The role of the registered midwife although mostly practical also entails educational aspects. These are *inter alia*.

2.9.5.1 Patient role

The midwife has various roles to play during management of patients in maternity units. The patient role of a midwife entails the following:

The midwife educate regarding promotion, maintenance, restoration, and support of health status of a mother and her child during antenatal, delivery, and puerperal stages (Human & Mogotlane 2017:142); the provision of effective patient advocacy that enables patients to attain the health care he/she needs (SANC 1984); educate mothers and family about patients' rights (Human & Mogotlane 2017:142) and education regarding prevention of disease concerning pregnancy, labour, and puerperium (SANC 1984).

2.9.5.2 Student role

To facilitate experiential learning during clinical placement the midwife has the following roles to play:

The midwife acts as a student mentor and role model (Bosch 2020:21); assists with student accompaniment to augment students' knowledge (Bosch 2020:21); teach students how to implement safe, competent, maternal, and childcare within a legal and ethical framework (Human & Mogotlane 2017:142) and assists with the creation of opportunities to obtain knowledge and skills (Bosch 2020:21).

It is the registered midwife who spends most of clinical allocation period with the student midwife. He or she is the main contributor in terms of education, supervision,

support, guidance, and honing of midwifery skills in the CLE. Setumo (2013:36) states that student midwives are assigned to clinical midwife for coaching and support during clinical placement to develop clinical learning experience. Bweupe et al (2018:374), poignantly states that the clinical supervision of a student by a registered professional is essential for skills acquisition. Most notably, Pama (2017:20), found that to ensure optimum learning student midwives need adequate support and supervision during their first three months. In addition, Meyer (2012:74) found that students were allocated on lengthy night duty shifts during their third year when registered midwives are few and there is no lecturer or mentor/preceptor to guide and support them. Furthermore, study findings by Pillay and Mtshali, in Setumo (2013:36), revealed that clinical supervision by registered midwives was viewed as taking more time of the midwife who is also responsible for busy ward routine. A study by Thopola and Lekhuleni (2016: 981) had a similar adverse finding, namely that students were regarded as part of the workforce, indicating they had to engage in duties not related to their learning outcomes.

Rikhotso, Williams and De Wet's (2014:1164) study findings revealed similar negativity on the part of students, in that they experienced insufficient support, lack of mentoring, isolation from clinical activities, and inhumane attitudes by clinical midwives. The findings suggest that the student midwives' experience in the CLE can be quite harrowing. Further negative findings regarding registered midwives were found by Malwela et al (2016:997), namely, that midwives had a negative attitude towards teaching students and even labelled the comprehensive four-year diploma students as lazy and irresponsible.

In contrast to above findings, Caka and Lekalakala-Mokgele (2013:611) discovered that when students were allocated to the CLE, registered midwives were always available to guide and supervise. A similar positive finding was revealed in Sweden by Bos (2014:14), namely that students were welcomed and orientated to the unit.

Based on the above discussion, although supervision of student midwife by registered midwife is invaluable, learning experience is sometimes beneficial while other times it is grossly unacceptable. In addition, the role-players' characters in the CLE are usually known but sometimes a particular role gets shifted. Muthathi et al (2017:2223) state that incongruences and expectations between the roles of the

lecturer, clinical preceptor, and clinical midwife sometimes exist, and this repeatedly results in the sub-optimal quality of clinical support for the student. When this occurs, the student becomes frustrated and angry. The CLE therefore would pose fewer challenges to student midwives if all role players performed their respective roles optimally.

2.10 COLLABORATION BETWEEN EDUCATIONAL AND CLINICAL INSTITUTIONS

2.10.1 Factors influencing midwifery students meeting midwifery requirements

Educational and clinical institutions need to have a strong collaborative relationship as this will facilitate students to meet all midwifery requirements. Ultimately, skills obtained will be successfully documented in midwifery register.

Empirical evidence has, over time, identified and suggested several inhibiting factors that prevent students from attaining midwifery requirements. The current devastating effects of the COVID-19 pandemic have exacerbated the already identified inhibitory factors. The following challenges influence the student's successful attainment of midwifery requirements:

2.10.1.1 *Partnership formation*

SANC (2013a:105) advocates that the partnership between the two institutions ought to be maintained through frequent communication and sharing of information. The partnership is to foster and enhance midwifery students to achieve midwifery requirements. Phiri (2017:72) postulates that clinical experiential learning in nursing education cannot be taken for granted or ignored because it forms the core business of nursing education. Moreover, it is an essential part of ALL nursing curricula. The nursing education institution and CLE are therefore co-dependent. Bruce et al (2011:260) state that the need for formal associations or partnerships between nursing education institutions and health services is important for the clinical education of midwives. Mathebula (2015:31) concurs with the aforementioned statement that nursing education institutions and clinical learning facilities should have collaborative meetings. Agreeably, Xaba (2014:15), informs one that the

comprehensive nature of midwife training needs participation of all members of the health team.

2.10.1.2 Timeous and regular communication

Xaba (2014:79), recommended a timeous co-operation among the nursing education institution and CLE for clinical learning to be effective. In a study regarding student absenteeism in the CLE, Magobolo and Dube (2019:5) recommended that there should be proper communication and regular meetings between midwives, lecturers, and students to identify student problems in the CLE. Similarly, Netshisaulu and Maputle (2018:1166), in a study regarding new graduate competence, recommended that to enhance competence, there should be collaboration between the nursing education institutions and the hospital management.

Unfortunately, relationship between the two institutions is not always favourable and student friendly. Over the years, certain factors such as dwindling financial resources and staff shortages, particularly in the professional nurse category, have strained the relationship. Additionally, Mathebula (2020:31) found that communication between the two institutions was sub-standard because the nursing education institution did not even supply the clinical facilities with student clinical objectives.

The study highlights that a good relationship between two institutions is paramount to achieving student learning outcomes. For this to materialise, there should be regular discussions about learner practical requirements, learner academic performances, learners' behaviour in clinical situations, challenges experienced by clinical staff concerning learners, and clinical attendance illness, and research updates. These discussions should be held at least on a quarterly basis.

2.11 LITIGATION AGAINST POOR MIDWIFERY PRACTICE

The midwifery register validates, in writing, the successful implementation of midwifery skill requirements and practices by student midwife. This is the reason why the register is kept for at least five years. Should anything adverse be discovered retrospectively and therefore be the focus of a legal investigation, midwifery register, student midwife, registered midwife, or midwifery lecturer may be implicated and

therefore summoned to appear in a court of law. This is the reason why all practitioners should have indemnity insurance.

The likelihood of a woman dying because of pregnancy-related causes is extreme in Sub-Saharan Africa (Matlala 2017:16). Even internationally, Magqadiyane (2020:1036) discovered that, maternal health litigations continue to become a global concern. A study carried out in Iran by Peyman, Nayeri, Bandboni and Moghadam (2017:135) informs that legal matters affecting midwives are detrimental in that midwives may feel resentful and anxious and this, in turn, may lead to anger and frustration. South Africa is not exempt from the ever-increasing litigations in the midwifery field. The country has unfortunately not met the 2015 time limit of the Millennium Development Goals (MDG's), specifically goal four and five, which are intended to reduce child mortality and improving maternal health (South Africa 2011:20). In this regard, Sellers (2018:22) points out that the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD) has implemented a remedial approach called essential steps in the management of obstetric emergencies (ESMOE) to reduce litigation in midwifery practice.

A dominant theme of the midwives' lack of competence as a leading cause of maternal untoward incidents was identified (Magqadiyane 2020:1036). The Eastern Cape DoH is executing a multi-pronged approach to help reduce medico-legal claims that have charged the province just over R1bn over the past few years. Regrettably, about 90% of the legal claims are stemming from the maternity section (<http://www.sanews.gov.za>). In this regard, Magqadiyane (2020: 1043) concluded that there should be an ongoing establishment of medical malpractice training courses for midwives.

The foregoing discussion makes it clear that increasing litigation, coupled with student and midwife fear of litigation, are two very disconcerting phenomena. Although attempts have been made to alleviate the situation, South Africa still lags far behind. The implementation of the Sustainable Development Goals (SDG's) with a deadline of achievement by 2030 will hopefully contribute in a meaningful way.

2.12 SUMMARY

Literature most pertinent to the study was presented in this chapter. Local and international studies were scrutinised regarding experiences of student midwives during clinical allocation. Global midwifery training, theoretical and practical requirements, main role players in the empowerment of the student midwives, collaboration between educational and clinical institutions and litigations against poor midwifery practice were discussed.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The previous chapter discussed literature review relevant to the experiences of student midwives regarding completion of midwifery register. Chapter 3 informs the reader about research design and research method to be undertaken. The chosen design and method include, inter alia, research design, research setting, sampling process, data collection instruments, process, and data analysis. Ultimately, the chosen design and method enabled accomplishment of aims and objectives of the study and answered research questions.

3.2 RESEARCH DESIGN

Kumar (2014:122) states that research design is the road map that one decides to follow during the research expedition to find answers to research questions. This enquiry truthfully answered the questions namely, what were the experiences of student midwives with regards to the completion of the midwifery register? The question of what challenges were faced during the above task was answered.

Furthermore, de Vos et al (2011:142) described a research design as a set of judgements regarding what topic must be studied amongst what population, using what methods, and for what purpose. The researcher's decisions were steered to select student midwives' completion of midwifery register to identify the challenges faced to mitigate it.

Research design is an active process that includes making decisions about every aspect of the research in a very grounded way concerning the research questions and the shifting context (Mason 2018:30). The researcher was involved in a prepared and hands-on manner using personal interaction with the study participants and ensured adaptation as different contexts arose.

Based on the above, this study followed a qualitative research approach with explorative, descriptive, and contextual research designs.

3.2.1 Qualitative approach defined

Leedy and Ormrod (2019:228) assumed that all qualitative approaches have two things in common. Initially, it focuses on the phenomena that occur in the actual world, and secondly, it involves apprehending and studying the complexity of the phenomena. A qualitative research approach offers a comprehensive understanding of the human experience and the context in which they transpire (LoBiondo-Wood & Haber 2018:103).

The enquiry, therefore, focused on the actual or real experiences of student midwives during completion of midwifery register as well as the difficulties that arose within the clinical environment during placement in the maternity units.

3.2.2 Characteristics of qualitative approach

The qualitative research is an intellectual approach used to describe life experiences from the perspective of the persons involved (Grove et al 2013:69).

- The philosophical foundation of qualitative research defines a view of science and guides the selection of methods and the criteria of rigor.
- Gathers information where members encounter a difficult situation in a natural environment (Creswell 2018:180).
- The qualitative approach is a method that uses open-ended methods to gather data, such as interviews, focus groups, observation, and the scrutiny of documents.
- Recurrently involves combination of different data collection methods, such as triangulation (Polit & Beck 2017:463).

3.2.3 Advantages of qualitative approach

- Helps to maintain initial insights into what has previously been a little-studied topic or phenomenon (Leedy & Ormrod 2019:30).
- Assists to expose key problems, obstacles, or enigmas that take place within a phenomenon.

- A qualitative approach allows the researcher to explore and understand the human experience (Loots 2016:14).
- The qualitative approach describes lifetime encounters, cultures, and social progressions from perspectives of persons involved (Gray et al 2017:62).
- The qualitative approach is a method used to study human experience and understanding from the viewpoint of the research participants when the action takes place (Brink et al 2018:104).
- The qualitative approach explores experience and diversity rather than quantifying; it highlights experiences, descriptions, and the narration of feelings and experiences rather than their dimension, as stated by Kumar (2014:14).

3.2.4 Disadvantages of qualitative approach

Rahman (2016:104) highlights the following disadvantages of the qualitative research approach:

- Sometimes the focus is more on meanings and experiences and in the process, contextual sensitivities are left out.
- A lesser sample size sometimes raises the issue of generalisability to the whole population of the research.
- Clarification of data and analysis may be more multifaceted.
- Policymakers sometimes prefer to quantify performances and in social sciences, quantitative orientations are frequently assigned more regard.

3.2.5 Explorative research design

Creswell and Creswell (2018:104) explain that, in a qualitative project, the author will describe a research problem that can best be understood by discovering the concept or phenomenon. Exploratory research is used to probe a topic when the variables and theory base are unknown. In this study explorative research design was used to get in-depth information regarding the completion of midwifery register. Exploratory research, according to Neuman (2014:38), refers to a study whose purpose is to discover the dimensions influencing a particular spectacle or to develop, if not refining a hypothesis, about relationships between phenomena. It is a scientific departure when the study phenomenon is new, implying nothing is known about it or

little is known about it. Additionally, Houser (2018:137) revealed that when not much has been researched about the topic or the population being studied, the investigator dips in listening to the participants and builds an understanding based on what is provided and heard.

3.2.5.1 Advantages of explorative research

Kumar (2014: 13) outlines the following advantages:

- It is when a study is undertaken where little is known about the topic.
- It is usually carried out when a researcher wants to explore an area about which little or no knowledge is available about the phenomenon.
- It addresses an issue or problem in need of a resolution (Grove et al 2013:66).
- The goal is to create an intervention that benefits the population.
- It is usually done to understand the needs of a specific population.

The study adopted an explorative design as it is an ideal design to probe and gain understanding of the lived experiences of student midwives regarding filling in of midwifery register. This enabled the solicitation of in-depth knowledge from the participants so that a clear picture of the problem under study could be obtained. Ultimately, the specific needs of student midwives regarding midwifery register completion were identified and recommendations in this regard were made.

3.2.6 Descriptive research design

A descriptive research design, according to Gray et al (2017:200), must adequately answer a research question of “What is?” or to “What degree?”. Additionally, Kumar (2019:15) states that descriptive studies attempt to systematically describe a situation, problem, phenomenon, amenity, program or to describe the living conditions of a community. The foremost aim of such studies is to describe what is common concerning the issue under study.

3.2.6.1 Advantages of descriptive research

Burns and Grove (2017:44), and also Creswell and Creswell (2018:104), explain that descriptive studies are conducted;

- When little is identified about a topic.

- Permits the researcher to describe phenomena in real-life situations.

In the proposed study, the student midwives described their experiences in detail, thus shedding light on new meanings, what and how often something existed so that categorisation of the experience could occur. Additionally, the study highlighted that challenges faced when completing the midwifery register were numerous and therefore prevalent. The aforesaid advantages are, therefore, especially pertinent to the study as not many research studies focus on the midwifery register and the experiences that the researcher wants to elicit, relate to real-life situations.

3.2.7 Contextual research design

Howarth, Devers, Moore, O' Caithain and Dixon-Woods (2016:105) explain that the term "context" has its etymological roots in the Latin *contextus*, meaning "joining together". There is an interplay between intervention and context and, progressively, context is seen as having effects so powerful that it may shape or co-construct complex intercessions and therefore cannot be considered separately from those interventions. Mason (2018:66) states that the point of choosing a setting is usually that it provides a usual context or situation for the generation of data. The actual context, pertinent to this study, focuses on student midwife interventions regarding the completion of the midwifery register in a maternity unit's settings or contexts during the clinical allocation.

3.2.7.1 Immediate

Immediate context denotes the natural environment in which real-life experiences take place. In the study, participants described their experiences as relating to the completion of the register in all maternity units to which they were allocated.

3.2.7.2 Specific

Specific context is predisposed by various factors such as time of day and alteration of space. This study specifically focused on factors such as the support and availability of resources and procedures in the clinical learning environment.

3.2.7.3 Meta

Meta context refers to images of acquaintances in the societal structure and the participants. The study included participants mainly from lower socio-economic backgrounds, as well as different races with their own ethnic and cultural origins and belief systems.

3.3 RESEARCH METHOD

Kumar (2014:39) aptly states that an extremely significant feature of a research study is the use of the appropriate methods. Research methodology refers to how the study was carried out to solve the research problem or to answer the research question (Brink et al 2018:187). The discussion below elicits all procedures used to conduct the study.

3.3.1 Research setting

Polit and Beck (2017:510) explain that setting is the actual site and the place where the study respondents are situated and where the research is conducted. The research took place at a nursing campus in Nelson Mandela Bay District, Eastern Cape. There are five midwife obstetric units and one tertiary hospital; this is where students are allocated during midwifery training. The population for this district is 1,267,000 (Statistics South Africa 2019). The district is situated on the western portion of Algoa Bay along the South-Eastern Coast of South Africa, east of the Garden Route, and faces the Indian Ocean. A solitary public main nursing college with five subsidiary nursing campuses was established by the Legislature of the Province of the Eastern Cape (South Africa 2003:4). The nursing education institution under study is a public nursing campus and is funded by the Eastern Cape DoH. It is one of the five main campuses in the Eastern Cape and is accredited by the SANC. The campus has a total number of 267 students registered for the R425 diploma course leading to registration as a nurse in (General, Psychiatry, Community) and Midwifery.

3.3.2 Population

LoBiondo-Wood and Haber (2018: 213) describes the population as a distinct set with specified properties and can be made of people, animal, objects or events.

Bordens and Abbot (2014:159) describe population as the whole set of individuals or objects having some mutual characteristics.

The population in the case of this study is the full complement of 75 fourth-year student midwives, which includes those repeating a year. The SANC-approved course that they are registered for is a R425 diploma programme that leads to registration as a nurse (General, Psychiatry, Community) and Midwifery (R425 1985).

3.3.3 Accessible population

Polit and Beck (2017:306) explain that the accessible population is a subsection of the entire population and known as the study population. This is the population to which the researcher can apply their conclusions and from which the study sample is chosen. The study comprised of fourth-year student midwives, including students repeating a year, and individually chosen participants that met the eligibility criteria for the study.

Gray et al (2017:331) define inclusion sampling criteria as characteristics that a subject or element must hold to be part of the study population.

Inclusion criteria:

- Student midwives in the fourth-year level of study.
- Student midwives repeating the fourth year of study are allowed to participate.
- Student midwives should be 18 years of age or above.
- Student midwives who gave consent and agreed to participate in the study.

Exclusion criteria:

- Student midwives in third year of study.
- Students under the age of 18.
- Student midwives who were not keen or would not give consent to take part in the study.

3.3.4 Sampling and sampling method

Bosch (2017:27) simplistically refers to sampling as something that has to be used according to specific criteria. Additionally, sampling, according to Grove et al (2013:37), is the process of selecting subjects, events, behaviours, or elements for taking part in the study and includes probability and non-probability techniques.

3.3.4.1 *Non-probability sampling*

Non-random methods are used to choose elements in non-probability sampling. The drawback, therefore, is that it is difficult to estimate the element's probability of being incorporated in a particular sample (LoBiondo-Wood & Haber 2018:216). In the study, non-probability sampling ensured a form of representativeness because the population of interest is known. In the case of the study, the known population is fourth-year student midwives.

3.3.4.2 *Purposive sampling*

Leedy and Ormrod (2019:242) refer to purposive sampling entails selecting individuals or objects that will produce the most information about the topic under investigation. Purposive sampling is especially appropriate when there is easy access to a group that shares similar characteristics and circumstances. In the case of this study, it is fourth-year student midwives. As mentioned, fourth-year level student midwives were chosen to be participants because they had been to various midwifery units for at least one year to practice skills and complete midwifery register. The students were more relevant to respond to the research questions.

3.3.5 Sample size

Mason (2018:69) postulates that qualitative samples are usually small for practical details, particularly in terms of time and money. Kumar (2014:246) states that in qualitative studies, the size is less important and advocates that the more homogenous the group, the easier it will be to reach data saturation. Fourth-year midwifery students are homogenous because they must complete the same SANC required procedures to complete the midwifery register.

Mashigo (2016:32) states that qualitative researcher, using purposive sampling, does not know beforehand the number of participants required and therefore sampling should continue until saturation occurs. Researchers generally continue to engage participants until they have reached redundancy or data saturation, which means that nothing new emerges from the discussions (LoBiondo-Wood & Haber 2018:94). Based on the above statements, saturation of data determined the size of the sample in the enquiry.

3.4 DATA COLLECTION APPROACH AND METHOD

Brink et al (2018:45) refer to the data collection method as a procedure of collecting information. Data collection is a precise systematic gathering of information that is pertinent to the research aim and objectives (Gray et al 2017:743).

Data collection commenced during Level 1 of the COVID-19 pandemic when mobility was allowed based on correct social distancing, the wearing of masks, hand sanitation, and gatherings of not less than 50 people were allowed. Approvals from the Unisa Ethics Committee, Department of Health Ethics Committee, The Nursing College Ethics Committee, and the Maternity Hospital Personnel Development Department were received before data collection.

3.4.1 Preparation for data collection

Student midwives were approached by the researcher via student's group WhatsApp to introduce the study and to request their voluntary participation. This is the platform utilized by midwifery lecturers to communicate with student midwives when they are in maternity units. Student midwives who confirmed willingness to participate in the study were then asked to give verbal informed consent. Students were informed about the planned interview dates. Due to physical distancing policy, the researcher sent informed consent form to study participants via emails or WhatsApp messages. The informed consent form contained 4 spaces for signatures: for the participant, witness, researcher, and researcher's witness as well. The researcher then set up an appointment with participants to discuss voluntary participation, the nature of the study, objectives and to hand out information sheets.

3.4.2 Venue preparation for data collection

A well-ventilated room was booked in advance. During each interview, a participant was provided with a face mask that was worn during interviews. For hand hygiene, the researcher and the participants' hands were sprayed using 70% alcohol-based sanitiser. A social distance of at least 1.5 to 2 meters was maintained between the researcher and the participant.

Any participant, who demonstrated any fear concerning contracting COVID-19 during participation, and who wished to withdraw from participation, was not coerced. Instead, all participants' rights were upheld.

3.4.3 Data collection method

Interviews involve voiced communication during which the participant affords report to the researcher according to Gray et al (2017:403). The format of the interview can be unstructured, semi-structured, or structured. The researcher of this study chose unstructured individual interviews, which are described by de Vos et al (2011:348) as a "conversation with a purpose". An interview guide with open-ended questions was used to encourage conversation between researcher and participant during interviews.

Data obtained from unstructured individual interviews were recorded on a voice recorder so that the participants verbatim could be used as a referral base during data analysis. Additionally, field notes were also recorded as a source of reference (Mason 2018:160). Duration of the interviews ranged between 60 minutes to 90 minutes. The timing of interviews should be convenient to both the interviewer and participant (Brink et al 2018:145), therefore; interviews took place at the most convenient time of the participants. The interview venue was a private classroom with a 'do not disturb' sign. In this way, privacy during interviewing times was assured. The researcher refrained from ridiculing ethnicity and accents as these would influence the responses from the participants.

3.4.3.1 Advantages and disadvantages of using interviews

3.4.3.1.1 Advantages of using interviews:

- According to Kumar (2019:227), interviews are further suitable for complex situations. It is the most suitable approach for studying complex areas as the interviewer has the chance to prepare a respondent before asking sensitive questions and to explain complex ones to the respondent personally.
- It is useful for collecting detailed information. In an interview situation, an investigator can obtain detailed information by probing. Hence, in situations where detailed information is required, interviewing is the preferred method of data collection. In this study, the researcher has developed probing questions to encourage the flow of information from the participants.
- Information can be supplemented. An interviewer can supplement the information obtained from responses with those gained from non-verbal reactions. During the interviews, the researcher has noted all non-verbal reactions and has posed follow-up questions related to that reaction.
- Questions can be explained. It is less likely that a question will be misunderstood as the interviewer can either repeat a question or put it in a form that is understood by the participant. The researcher structured all questions using simple terms related to the problem. Questions were repeated if there was a need to do so. English was used and student midwives understood the language as it was the medium of class instruction and during experiential learning during clinical placement.
- Application the interviews is wider. Any type of population such as children, the handicapped, illiterate, or very old can be interviewed. The researcher opted for one-on-one interviews to encourage a free flow of information, as some participants are not willing to talk in a group. Moreover, individual interviews aided the researcher to maintain good personal relations and co-operation with the participants

LoBiondo-Wood and Haber (2018:255) state that, in conjunction with an interview, the researcher knows who is giving answers. The researcher had an opportunity of interviewing student midwives that are known to the researcher. To avoid bias,

researcher used bracketing during interviews to set aside researcher's beliefs (Grove et al 2013:60).

3.4.3.1.2 *Disadvantages of using interviews:*

(Grove et al 2013:424) outlined the disadvantages of using interviews as follows:

- Interviewing requires more time.
- Interviews can cost more money.
- The sample size is usually restricted to save time and cost,
- Subject prejudice is always a threat to the validity of the findings (Grove et al 2013:424).
- During one-on-one interviews a participant might be distressed, if the anguish is severe, it might be necessary to refer the participant to a counsellor or therapist for assistance (de Vos et al 2011:360).

3.4.3.1.3 *Researcher as key instrument*

Throughout interviews, the researcher was instrumental in the data collection from beginning to end. Participants were informed regarding the process to be undertaken. Informed consent forms were signed before the commencement of one-on-one interviews. The enquirer enhanced the interview to produce data directly related to participants' actual experiences. Additionally, the researcher remained open to suggestions, ensured cultural sensitivity, and allowed the participants to lead when it was required.

3.4.4 Data collection instrument

Various instruments or methods are available for determining a variable, the researcher must select the best one for the specific study (Gray et al 2017:495). Additionally, Mason (2018:188) simplistically states that qualitative data can take a range of forms such as interviews, audio recordings, interview notes, and field notes. The data collection instrument chosen for the study was semi-structured interviews using an interview guide for individual interviews. The interview guide was developed with great care and consideration with a specific focus on the study aims, objectives, and research questions. An introductory question initiated the participants' narration

of their experiences after which the probing questions followed. A final exit question was posed to the participants so as not to exclude any additional information that the participants wanted to add and to ensure that data saturation was reached. The study supervisor as well as a fellow researcher was consulted when developing the instrument to ensure rigour in the study.

3.4.4.1 Formulating effective questions

Kumar (2019:232) states that the way questions are asked, to a great extent, determines the response that the researcher is likely to receive from the participants. Additionally, Kumar (2019:232) suggests the following when preparing questions:

- Use simple and everyday language: The researcher used English as it is the language used during classroom teaching and in the clinical field during clinical placement.
- Do not use ambiguous questions: The researcher developed questions in such a manner that each question contains one meaning to avoid different interpretations.
- Do not use double-barrelled questions: The researcher avoided, by all means, asking a question within a question.
- Do not ask leading questions: The researcher developed questions that do not lead the participants in a certain direction, and therefore open-ended questions allowed participants to discuss and express their views regarding the issue.
- Questions asked should not be based on assumptions: The researcher posed a broader question that is: *What is your experience regarding completion of midwifery register in maternity units?* Several probing questions were posed to get more responses around the topic under study.

3.4.5 Testing of data collection instrument

A pilot study is a mini form of the study to make sure that data collection instrument works the way it is presumed it will (Bordens & Abbott 2014: 28). Additionally, Gray et al (2017:54) state that a pilot study is a smaller-scale study performed with the same research population, setting, intervention if any, and plans for data collection

and analysis. A pilot study can be useful, not only for trying out approaches but also to support influences and rationale for strategies (Vos et al 2011:240).

For the proposed study, a pilot study using the same participant inclusion criteria as the real study was conducted using two participants who did not take part in the main study. The reasons for piloting the study was to develop or to refine the data collection instrument and to identify problems with a study design, as advocated by Burns and Grove (2011:44). Interviews were audio recorded after the audio-recorder was pre-tested for sound quality to prevent faults. No major adjustments were needed after conducting the pilot study except, as mentioned above, that the interview time was increased, only when needed, to 60 minutes to ensure that data saturation was reached.

3.4.6 Ethical considerations related to data collection

Ethical considerations, as advocated by Creswell and Creswell (2018:93), were applied in the study:

Respect the site and disrupt as little as possible: Permission to use a private venue for interviews was sought. A 'do not disturb' sign was attached to the interview room entrance.

Avoid deceiving participants: The participants were comprehensively well-versed regarding what their participation entailed, especially that there would be no monetary gain for the researcher or the participant. Additionally, participants were unambiguously informed of the study aims, objectives, and significance.

Respect potential power imbalances: A reciprocal relationship of mutual respect and trust was emphasised amongst the researcher and participants. The researcher assumed researcher role rather than that of a lecturer so as not to adversely influence the participants.

Avoid exploitation of participants: The participants of the study were informed that they could withdraw from the study at any time. Additionally, they were made aware that research results would be available to them and that they would not be subjected to any form of harm, be it physical, emotional, social, spiritual or emotional.

Collecting harmful information: The researcher upheld the ethical code of protection of participant privacy. Additionally, participants were informed that should they regard specific information as too sensitive to disclose, they were at liberty to not disclose it.

3.5 DATA ANALYSIS

Qualitative data analysis is a process that involves reducing narrative data to themes and categories with the help of the coding procedure. (Brink et al 2018: 46). Data analysis was based on Tesch's 8-steps data analysis method according to Creswell and Creswell (2018:271). A qualified coder was sourced to independently code data using the provided protocol by the researcher. The researcher and coder agreed on the good purpose of enhancing trustworthiness. In this investigation, Tesch's 8-steps for data analysis were applied as follows:

Step 1 – Transcribe all interviews verbatim

The enquirer gleaned a sense of the whole process by thoroughly transcribing interviews verbatim. This facilitated the researcher to get the comprehensive background and understanding of the transcripts.

Step 2 – Repeatedly read through transcripts

The researcher picked up and read the transcripts one by one to establish the meaning of the of the narrative data whilst going through it. The researcher questioned the sense of the transcript of the interview while trying to probe what it was about. Ideas were jotted down in the transcript margin.

Step 3 – Read to make sense of transcripts and make notes

Emerging topics were listed. Similar topics were assembled and coded, which were then grouped based on the repetition of thought used in verbatim transcriptions. Topics that were not similar were grouped, after which distinct thoughts reflected in the margins were recorded.

Step 4 – Pick transcripts one by one to get opinions whilst coding and analysing at the same time

The researcher perused the list and again went through the data. Topics and clusters were abbreviated and coded. Each segment of transcription was assigned a code in the transcript margin using a different ink colour to denote the topic that it represented.

Step 5 – Clustering of similar concepts and topics to identify emerging themes

Themes, categories, and sub-categories were established from coded data and associated texts. The list was condensed to the grouping of related topics, theme meanings, categories, and subcategories. The inter-relatedness of categories was marked with inter-related lines.

Step 6 – Abbreviate identified codes and align with appropriate text segments

Codes were written alphabetically after a decisive decision on the abbreviation for each category was made. Likeness was checked by using a list of all codes, words, content and themes that were refined from time to time. Lastly, similar codes were grouped so that they fit in the description.

Step 7 – Write topics as codes and write next to appropriate text segments

A preliminary analysis was held after data belonging to each category was assembled. Additionally, a meeting between the researcher and co-coder was held to reach a consensus on themes, categories, and sub-categories that each one has identified.

Step 8 – Categories now emerge from the assembled material

The final themes, categories, and sub-categories emerged. All transcribed raw data were submitted to the co-coder for validation of the findings. The co-coder analysed the data findings from the independent coder, and findings were like those of the primary coder.

The eight steps engaged the researcher in a systematic process of analysing textual data. Variations may exist in this process, for example, some researchers may colour-code different categories on transcripts. In this study, data analysis was done

to organise and provide structure to elicit meaning. Participants elicited meaning from their point of view rather than the researcher's perspective.

3.6 DATA MANAGEMENT

Flick (2014: 371) postulates that data must be prepared before it can be analysed. Participants verbatim were recorded on a voice recorder and field minutes were documented especially for gesticulations and nonverbal demonstrations. The participant responses and observations that were recorded were then transcribed electronically. Transcribed data were protected using a computer with personalised password protection known only to the researcher. Back-up transcribed data was captured on a separate memory device and kept in an office with a strict locking facility. Participant anonymity, privacy, and the protection of personal information as per the Protection of Information Act, no 4 of 2013, were upheld throughout the process.

3.7 TRUSTWORTHINESS

Trustworthiness in qualitative research is comparable to validity in quantitative research and guarantees that data collection and analysis are accurate and that the findings are a precise expression of what the participants want to express (Vuso 2017:16). In the study, Lincoln, and Guba's model in de Vos et al (2011:419) guided the fidelity of the study. In qualitative research, the following criteria are imperative namely, credibility, dependability, transferability and confirmability.

3.7.1 Credibility

Credibility refers to assurance in the certainty of data and the analysis of data, according to Polit and Beck (2017:559). Furthermore, Botma et al (2010), as cited in Vuso (2017:17), describe credibility as the genuineness of the findings and truth-telling in a study using various methods.

For the proposed study, the researcher used the following strategies recommended by Creswell (2013) in Brink et al (2018:158) to ensure credibility:

3.7.1.1 Prolonged engagement

Prolonged engagement means remaining in the field until data saturation has been reached. To achieve this, the researcher spent enough time with the participants during the discussions until copious amounts of information about the topic were obtained.

3.7.1.2 Triangulation

Triangulation is obtained by asking different questions, requesting different sources, and using different methods. For this study, the researcher asked different questions on the same phenomenon to get information about the issue under study.

3.7.1.3 Member checks

Member checks are done to assess the participants' goals, correct obvious errors, and provide additional volunteer information (Meyer 2012:47). For this study, the researcher assessed the participant intentions, provided frequent response to the participants, and allowed them to confirm the data as the data collection progresses.

3.7.1.4 Peer debriefing

Peer debriefing is done by seeking the ideas of peers outside the study who has a comparable academic status as the researcher to appraise and express their views on the research data. In this study, the researcher made use of a peer, namely, a colleague and fellow researcher as well as the study supervisor, to discuss the research process and findings.

3.7.1.5 Persistent observation

Persistent observation refers to looking for numerous influences through a process of continual and tentative analysis to determine what is relevant and what is not. In this study, the participants were directed by the research questions, and the researcher ensured that the participants remained focused to give only the relevant responses to answer questions.

3.7.2 Dependability

Dependability refers to the obligation of testimony that, if it were to be repeated with identical (or similar) participants in the same (or similar) context, its findings would be similar (Brink et al 2018:159). De Vos et al (2011:420) also postulate that dependability is the degree to which the study can produce the same results when repeated with the same participants in similar situations.

The researcher requested assistance from specialists in qualitative research during the interviews. Additionally, the researcher comparatively consulted similar study topics and contexts to enhance dependability.

3.7.3 Transferability

Transferability refers to whether the findings of the research can be relocated from a particular situation or case to another (de Vos et al 2011:420). Moreover, Babbie, and Mouton (2009), in Vuso (2017:17), state that transferability is described as the generalisation of the findings of the study to a larger population or the pertinency of the findings to other participants or contexts. The researcher selected information-rich participants, strove to achieve data saturation, and provided a dense description of data to enhance transferability. Dense descriptions included verbatim from participants themselves.

3.7.4 Confirmability

According to Brink et al (2018:159), confirmability refers to the possibility for congruency of data in terms of accuracy, relevance or significance. It is concerned with establishing whether data represents the information provided by the participants and that the interpretations are not fuelled by the researcher's imagination.

The researcher transcribed data from the tape-recorder in verbatim and field reports were used to enhance data accuracy.

3.8 PROTECTION OF THE RIGHTS OF THE STUDY INSTITUTIONS

Ethics is described as a system of decent values that is concerned with the degree to which research procedures adhere to professional, legal, and social responsibilities to the study participants (Polit & Beck 2017:727).

3.8.1 Ethical clearance

The rights of the institution were protected by obtaining the ethical clearance certificate from the Research Ethics Committee from the Department of Health Studies at the University of South Africa (UNISA), REC-24081052, (Annexure A).

3.8.2 Permission

The researcher followed the departmental procedures to apply for approval from health institution (Annexure D.) Permission to conduct the study was approved by the Eastern Cape Department of Health Research Ethics Committee, (Annexure E); Dora Nginza Tertiary Hospital Chief Executive Officer (CEO), (Annexure I) and the principal of the nursing college where the study was conducted (Annexure G). Permission from the Principal was cascaded to Heads of Departments (HOD's) at the nursing college where the study took place. Relevant lecturers were engaged as gatekeepers to avoid disruption of classes.

3.9 PROTECTION OF THE RIGHTS OF THE PARTICIPANTS

3.9.1 Obtaining informed consent

Participants of the study were requested to give informed consent so that they could exercise the right to participation (Annexure K). Information leaflets, verbal information about the study, and what is expected of them so that they could make an informed decision on participation in the study, were provided (Annexure J). Nobody should ever be coerced into participating in a research project because participation must always be voluntary (de Vos et al 2011:117).

For the purpose of this study, the researcher adhered to main principles as advocated by National Commission for the Protection of Human Subjects of

Biomedical and Behavioural Research (Gray et al 2017:161) and (Brink et al 2018:29), namely: respect for persons, beneficence and justice;

3.9.2 Respect for persons

Respect for persons means that the participants have a right to self-determination and the freedom to participate in research studies (Brink et al 2018:29). Participants should be treated as autonomous agents who have the freedom to conduct their lives as they choose without external controls. Participants should be allowed to withdraw from the study without the risk of prejudice or penalty.

3.9.3 Beneficence

Beneficence requires the researcher to do good and to avoid causing the participants harm, whether physical, psychological, emotional, reasonable, social, or legal.

The researcher should therefore safeguard the participants from discomfort and harm and there should be more benefits in comparison with harm. To adhere to the principle of beneficence, the Unisa Ethics Committee endorsed the proposed study before it was conducted to avoid any harm, as mentioned in the previous statement. The institutions involved were protected from reputational risk or harm, and the same protections were put in place for the institutional employees involved in the research. Therefore, the researcher did not mention the institutions and personnel in any report whatsoever, as the reputation of some could be damaged. During the interviews, an audio recorder and field notes were taken. The participants were protected by not using real names, but codes or numbers were issued for each participant. An independent counsellor was recruited by the researcher so that participants who are affected emotionally could be referred to them.

3.9.4 Justice

Justice means that human subjects should be treated fairly and should receive what is due, according to Brink et al (2018:30). The privacy of the participants must be maintained and if participant information is to be shared, they have a right to determine the extent, as well as the circumstances, under which private information should be

shared. This includes personal and sensitive information. The researcher should therefore note that recording conversations, sharing participant information without participant consent, examining activities through one-way mirrors, and using concealed equipment is culpable of invading the participants' privacy. In the study, the participants were selected fairly and exclusively for reasons directly related to the research problem. Any deals made with participants were honoured and respected. Cultural tradition and values were respected. The researcher kept the participants' names separate from records such as transcripts to protect their identities.

3.10 SUMMARY

The Chapter discussed, inter alia, the design, and methodology for the study. Ultimately these two components have answered the research questions, namely, what are student midwives' experiences and challenges when completing the midwifery register?

CHAPTER 4

PRESENTATION OF RESEARCH FINDINGS

4.1 INTRODUCTION

Research design and methods applied to student midwives' experiences regarding completion of midwifery register at a nursing college in the Eastern Cape were discussed in the previous chapter. Chapter 4 presents data analysis and research findings of the study. Data collection and analysis transpired against the backdrop of the research objective, which was to explore student midwives' experiences regarding completion of midwifery register at a nursing college in the Eastern Cape. Ten student midwives participated in face-to-face interviews regarding the completion of the midwifery register at a nursing college in the Eastern Cape. In this regard, the following objectives were attained:

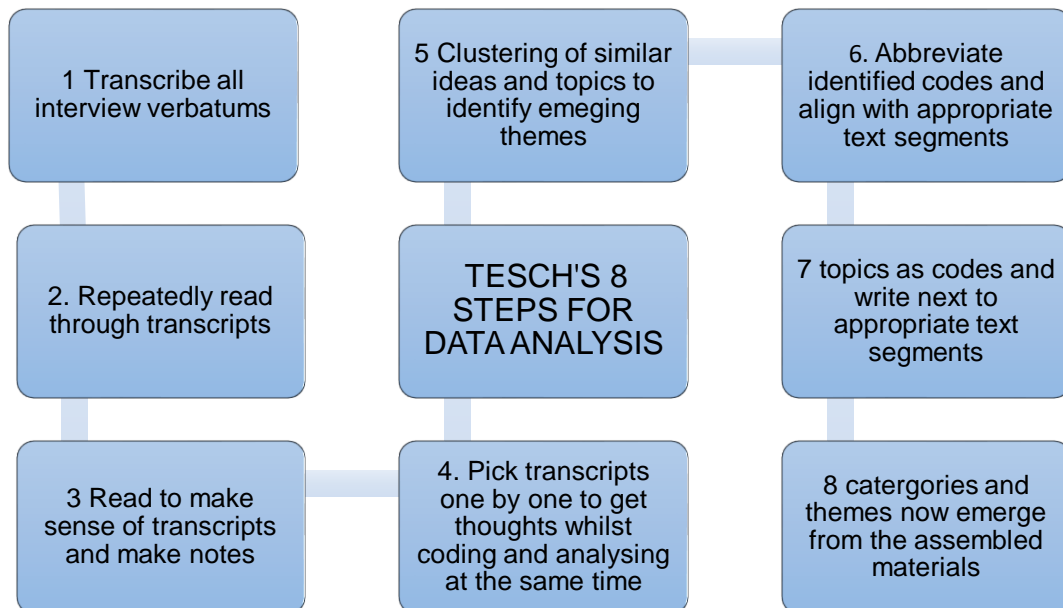
- To explore and describe the experiences of student midwives regarding completion of midwifery register.
- To determine the challenges experienced by student midwives regarding completion of midwifery register.

4.2 DATA ANALYSIS AND MANAGEMENT

Grove, Burns and Gray (2013:46) state that data analysis lessens, assembles, and gives sense to data. The process is much more detailed and involves reducing the volume of raw information, scrutinising significance from trivia, identifying significant patterns, and providing a reference for what data reveals (de Vos 2011:397). Flick (2014:5) informs that data analysis in qualitative studies is a scientific procedure. This involves arranging and sorting verbal and visual material so that it can be interpreted in statements about what is understood or what it represents. As is typical of qualitative research, data analysis commenced parallel with data collection. As per adherence to the scientific data analysis method, data was stringently kept in its actual state. Additionally, the field notes were kept in their original form and all material was kept under lock and key to prohibit admittance to it. The data analysis

exercise that has been employed as a whole, is depicted below. It was adapted and simplified from Tesch's 8 steps of data analysis (Creswell 2014:198).

Figure 4.1 Illustrates the steps followed during data analysis



Researcher's own work

Adapted version of Tesch's 8 steps for data analysis

4.3 RESEARCH RESULTS

Data collection was a trying exercise due to the COVID-19 pandemic social isolation protocol. The method of data collection had to be adjusted on more than one occasion. The process properly commenced in March 2021 and continued until late August 2021. The researcher found the experience very heartening as the participants indulged freely and of their own volition. Ultimately the process culminated in dominant themes, subthemes, and categories.

4.3.1 Sample characteristics

LoBiondo-Wood and Haber (2018:92) state that, in utmost qualitative studies, the researchers are looking for a purposeful or purposively chosen sample. This is done to select samples who can irradiate the phenomenon they want to study. The researcher purposefully selected 4th-year student midwives on the pretext that they were easily accessible and that they had been allocated for at least 12 months in

maternity units and would therefore be able to provide rich data. The data analysis elicited the sample characteristics, as illustrated in Table 4.1.

Table 4.1 Demographic characteristics of the participants (n=10)

Participants	Age	Gender	Level	Record of completed cases in the Midwifery register			
				Antenatal (40)	Delivery (20)	Postnatal (30)	Neonatal-care (15)
P1	36	Female	4 th level	40/40	8/20	0/30	15/15
P2	31	Male	4 th level	40/40	0/20	0/30	0/15
P3	26	Female	4 th level	40/40	7/20	7/30	15/15
P4	22	Male	4 th level	40/40	13/20	0/30	15/15
P5	28	Female	4 th level	38/40	20/20	1/30	10/15
P6	24	Female	4 th level	40/40	5/20	0/30	0/15
P7	23	Female	4 th level	40/40	1/20	30/30	13/15
P8	37	Female	4 th level	40/40	9/20	10/30	0/15
P9	48	Female	4 th level	22/40	3/20	10/30	10/15
P10	31	Female	4 th level	20/40	5/20	20/30	15/15

Researcher's work

4.3.1.1 Age of the participants

To protect identity of participants, the researcher used pseudonyms for each participant. A letter P and subsequent numbers were used in that regard. According to Table 4.1, five out of ten participants' age ranged from 22 to 28 years old (n=5). These were followed by those who were 31 to 37 years old (n=4). Only one participant was 48 years old (n=1). Understandably, the majority were above 20 years old to 30 years, as they were still basic students. The participant over 40 years of age was on study leave. The study managed to seek their experiences regarding the completion of the midwifery register despite their different ages.

4.3.1.2 Participants' gender

Two males and 8 females took part in the interviews, bringing the total to 10 participants. Notably, the bulk of the participants were females, as nursing has

predominantly been a female profession. In-depth data were obtained from all participants irrespective of their gender.

4.3.1.3 Level of training

All participants were midwifery students at level four of training. The researcher purposefully targeted these students as they were just about to exit the course and were expected to have completed most of the midwifery register components.

4.3.1.4 Participants' status regarding completion of midwifery register

Data collection revealed to the researcher that most of the participants were floundering to complete the register, even though they were allocated to maternity units for no less than 12 months. Most noticeable was the fact that most of them had achieved less than 50% of the deliveries and post-natal procedures. Since the students were on lockdown restrictions for the COVID-19 pandemic, midwifery students were far behind with the skills for their 3rd-year level. Therefore, in their 4th-year level, they were still completing 3rd-year skills and were in the process of being allocated for intrapartum and postnatal care. It was clear that register completion in the antenatal units was stress-free and to a lesser extent, in the neonatal units, skills were achieved with relative ease.

4.4 SUMMARY AND INTERPRETATIONS OF THE RESEARCH FINDINGS

In this section, the summary and interpretation of results are illustrated. From findings of this study, it has been learned that majority of study participants faced challenges regarding completion of midwifery register during their clinical placement.

Following an extensive data analysis exercise, the participants' responses revealed 5 themes namely: Theme 1 positive aspects related to the completion of midwifery register; theme 2 personal experiences regarding completion of the midwifery register; theme 3 challenges faced by student midwives to complete the midwifery register; theme 4 deterrent factors to completion of the midwifery register and lastly, theme 5 impact of non-completion of midwifery register.

These are indicated in Table 4.2 below.

Table 4.2 Themes, subthemes, and categories elicited

THEME	SUBTHEME	CATEGORY	
1. Positive aspects related to the completion of the midwifery register	1.1 Mentored in certain areas	1.1.1 Adequate guidance and clarification regarding completion of midwifery register	
	1.2 Praised by registered midwives	1.2.1 Appreciation of midwifery students	
2. Personal experiences regarding completion of midwifery register	2.1 Negative psychological responses	2.1.1 Self-blame and anger	
3. Challenges faced by student midwives during completion of midwifery register	3.1 Shortage of staff	3.1.1 Student midwives used as workforce	
		3.1.2 Workload of midwives	
		3.1.3 Inadequate supervision	
		3.1.4 Inadequate lecturer /Student ratio	
	3.2 Contributions to incomplete register	3.2.1 Insufficient time to complete register	
	3.3 Limited learning opportunities	3.3.1 Too many midwifery students versus delivery cases	
		3.3.2 Limited experiential learning due to COVID-19	
	3.4 Inadequate teaching and practice resources	3.4.1 Lack of delivery equipment	
3.4.2 Inadequate teaching resources			
4. Deterrent factors to completion of the midwifery register	4.1 Patient related factors	4.1.1. Attitudes of patients towards male student midwives (accoucheurs)	
		4.2 Midwives and Lecturer related factors	4.2.1 Negative attitude of midwives
			4.2.2 Absenteeism of qualified midwives
	4.3 Student related factors	4.2.3 Lack of accompaniment by lecturers	
		4.3.1 Dodging and misuse of learning opportunities/time deliberately	
		4.3.2 Lack of knowledge, skills, and competency	
5. Impact of non-completion of midwifery register	5.1 Delay in commencement of community service	5.1.1 Pressure to qualify for community service	
		5.1.2 Fear of financial loss	

4.4.1 Theme 1: Participants expressed positive experiences related to completion of midwifery register

The participants articulated positive experiences regarding the completion of midwifery register. This theme revealed two subthemes, namely: mentored in certain areas and praised by registered midwives.

4.4.1.1 Subtheme 1.1: Mentored in certain areas

Participants expressed that they were mentored when placed in certain areas for midwifery clinical learning. This subtheme saw an advent of one category, namely: Adequate guidance and clarification regarding completion of midwifery register.

4.4.1.1.1 Category 1.1.1: Adequate guidance and clarification regarding completion of midwifery register

Participants reported that in the Midwife Obstetric Unit (MOU) they were supported by qualified midwives and lecturers. In that regard, they were guided on how to complete the midwifery register. This category is supported by the following citations:

One participant said:

“My first delivery was at MOU... there.... There at least the sister (Registered Midwives) guided us on how to complete the register, because most of them were com-serves (Community Service Nurses) so they know the register. So, they sat down, guided us how to fill in the register, also about the rules of the college that you need to observe the patient for two hours before you write the patient”. P4

Two participants attested to that and said:

“Maybe I cannot say that is the lecturer because they explain the register... let alone that we forget everything (smiling). The lecturers explain the register thoroughly, so I cannot put a blame on them. Umm...sometimes you forget or maybe you didn't listen well in class....so we are facing those difficulties”. P1

“With regards to antenatal that was fine we were drilled by sisters with ANCso ANC was quiet easy to understand and also nursing the babies and staff, the feedback of these it’s easy to understand”. P7

4.4.1.2 Subtheme 1.2: Praised by registered midwives

The study participants expressed positive experiences about the praises and appreciation from doctors and registered midwives.

4.4.1.2.1 Category 1.2.1: Appreciation of midwifery students

Participants were applauded in maternity units though they were facing some difficulties. The following quotes confirm that:

“The doctors and midwives were applauding us because they can see that we are trying to keep things intact and bear in mind you don’t have much experience you only trying your best. ... instead, they appreciate the fact that you are here to assist, they appreciate the small things you are doing even your mistakes they try you see mam”. P4

“Midwives are short staffed and they want us to come back and work as midwives and they always encouraging and putting us under their wings because they appreciate”. P9

4.4.2 Theme 2: Participants narrated personal experiences regarding completion of midwifery register

The participants expressed personal experiences regarding completion of the midwifery register. The following extracts demonstrate that instead of having a positive perception of completing the register, the participants endured emotional and psychological impairment.

4.4.2.1 Subtheme 2.1: Negative psychological response

The participants lamented that they experienced negative psychological reactions as a result of the difficulty in completing the midwifery register. This subtheme saw the emergence of one category, namely: Self-blame and anger.

4.4.2.1.1 Category 2.1.1: Self-blame and anger

Participants blamed themselves for not achieving objectives during their placement in maternity units.

One participant expressed anger and stated that:

“I feel...I feel disappointed, very disappointed on myself and I feel very angry at myself (sad face, sobbing) ...because at the end of the day I have no one else to blame, like I had opportunities to reach out, I know for a fact that there are staff members, lecturers and other students who wanted to help me, so it was myself...but it was just for me to speak up, but I was even scared to speak up...I’m angry at myself disappointed”.P6

Another participant said:

“Even one day when I was not there, you miss a lot and you are left far behind because that 1 day a delivery come and you are not there so you miss that delivery”.P3

4.4.3 Theme 3: Participants reported challenges faced during completion of midwifery register

The participants bemoaned that they experienced several challenges which made it difficult to complete the midwifery register. This theme saw the emergence of four sub-themes, namely: the shortage of staff; contributions to an incomplete register; limited learning opportunities, and inadequate teaching and practice resources.

4.4.3.1 Subtheme 3.1: Shortage of staff

Most participants pointed out that they could not complete the midwifery register because of staff shortage. The following four categories emerged from the subtheme: student midwives used as workforce; increased workload of midwives; inadequate supervision and inadequate lecturer/student ratio.

4.4.3.1.1 Category 3.1.1: Student midwives used as workforce

Student midwives performed non-nursing duties during clinical allocation and felt overworked when staff members were absent due to leave or sickness. This factor contributed to the non-performance of midwifery procedures and difficulties in

completing the midwifery register. The following participants explained the frustration experienced:

“Uhm ... they want us to work ...only....as a workforce then go, they don't care about our register “. P3

Sad looking **Participant 5** echoed as follows:

“Also with human resource, there were no general assistants at times and we are mopping floors...I was mopping (hey !!!) ma'am it was hard and I didn't mind...I didn't mind because we have to keep things intact I didn't have a choice, Come delivery time and all trollies are dirty you have to run to the sluice room to clean a dirty trolley first...eish....it was hard ma'am really.(Sad looking)”

4.4.3.1.2 Category 3.1.2: Workload of midwives

The increased workload of midwives in maternity units harmed the teaching and coaching of students during clinical placement and this has led to difficulties in the completion of the midwifery register.

Two participants said:

“In the labour wards mam... there are... umh... emergencies and there are also transfers in and there is also like 3 sisters (qualified midwives) in each delivery room with each one having 3 patients ... so the workload there is very difficult... (Sad looking).” P4

Two participants emphasised:

“So, with me the sister will just say... I 'm busy with four patients... I am not going to sign that book now”. P10

“In labour ward there is no time, for that one-on-one guidance, because sister is always busy here and there”.P2

4.4.3.1.3 Category 3.1.3: Inadequate supervision

Student midwives should always work under supervision of the qualified midwife during clinical placement to prevent medico-legal hazards. Most participants verbalised that they were left alone to perform the skills unsupervised.

The following quotes confirm this:

“Sister is going to call us... “come and do this”. or no I am going to leave you alone you can pv (per vaginal examination) and that one must do the blood pressure.” P4

“Sometimes mos. (but) mam the ward is busy and there is this shortage of staff. yes... And then when you go to the sister you find out that the sister is busy and say, “I’m busy, I don’t have time.” P3

4.4.3.1.4 Category 3.1.4: Inadequate lecturer/student ratio

In this study, the participants reported that lecturers were not visible in some maternity units because of the high numbers of students to take care of. Due to a high number of student midwives versus the few numbers of lecturers, it was difficult to provide proper teaching and supervision regarding the completion of the midwifery register.

The following participants said:

“I think with regarding completing my register and skills as well there is not enough lecturers in comparison to the students, so...there is like 20 students for 1 lecturer and that lecturer has to do all 20 students and its unfair on the lecturer and the ratio of those are incorrect... lecturers are teaching different levels, the 3rd years and 4th years, it’s the workload actually because there is a lot of us in ne class, there is more than 80 students, I haven’t seen any lecturer in the units coming to assist us maybe if they are coming, they will be there to do the skills. I think the reason for them not coming is that some classes have 100 students which is a lot and they had also post basic students.” P9

Two participants said:

"I think with regarding completing my register and skills as well there is not enough lecturers in comparison to the students, so..... there is like 20 students for 1 lecturer and that lecturer has to do all 20 students and its unfair on the lecturer and the ratio of those are incorrect".P7

"Though they teach it at college but when you are in the wards they do come again and check it so that if there are mistakes they can be prevented early".P1

4.4.3.2 Subtheme 3. 2: Contributions to incomplete register

The subtheme contributions to incomplete register emerged and yielded one category namely: insufficient time to complete the midwifery register. The one category allied to inhibition to completion of the midwifery register by the student midwives.

4.4.3.2.1 Category 3.2.1: Insufficient time to complete register

Time was always a challenge for student midwives to complete the midwifery register in maternity units according to the experiences of the participants.

The following quotes attests to that:

"laughing loudly ... there is no time... no there is no time...even I haven't started to fill in the register because when you come from night shift 7 to 7 you are tired and when you wake up its time to prepare to go to work...even on duty you cannot feel in the register, the only time is at home during the weekend and you have filled in you come to the sister and ask the sister who was assisting you to sign for you...that's the only time sister will sign only when you fill in properly...". P4

"there are times when the labour wards is busy there will be no time to write it in the register".P9

4.4.3.3 Subtheme 3.3: Limited learning opportunities

This subtheme revealed two categories namely: too many students versus delivery cases and limited experiential learning due to COVID-19. The two categories reduced the pace to acquire midwifery skills and resulted in the delay in the completion of the midwifery register.

4.4.3.3.1 Category 3.3.1: Too many students versus delivery cases

Most of the participants revealed that there were too many midwifery students from different institutions against fewer learning opportunities. This had caused a delay in obtaining midwifery skills to complete the register.

Two participants stated that:

“you have to share obviously with other students and the university students are also there and we like ok you get this one I get that one, and at times we don’t get a lot of patients that come in and deliver...uhm...I need deliveries!!! (raising her voice).” P7

“Where there is like 10 students 11 students so large numbers of students we struggle to get the procedures”. P4

4.4.3.3.2 Category 3.3.2: Limited experiential learning due to COVID-19 pandemic

Participants stated in frustration that due to COVID-19 pandemic, only few students were allowed per shift in maternity units. That has led to less time spent in some maternity units and had contributed to difficulties in the completion of the midwifery register.

The following quotes emphasises these frustrations:

“Umh.... We are not alone as X- (name of the college) student there are students from different institutions and now due to this COVID-19 it’s become too complicated you cannot be allocated as many as before so there is no time. ...due to this COVID-19 it is difficult to do 1000 hours”. P8

“Because of COVID-19 as well now that the library if you need a book you photocopy it and leave it you are not allowed in big numbers”.P7

4.4.3.4 Subtheme 3.4: Inadequate teaching and practice resources

Inadequate teaching and practice resources harmed the appropriate teaching of student midwives during clinical practice. The subtheme yielded two categories namely: lack of delivery equipment and inadequate teaching resources.

4.4.3.4.1 Category 3.4.1: Lack of delivery equipment

Student midwives should be taught the use of appropriate instruments to carry out midwifery skills before entering cases in the midwifery register. The participants stated that there was a gross shortage of delivery equipment which negatively affected their documentation of midwifery skills and the completion of the midwifery register. The midwives improvised most of the time and that affects patient care negatively. The lack of proper equipment might cause risks to the student midwife, the mother, and the unborn baby.

One participant reported as follows:

“In the institutions like what I have said the shortage of scissors so we can’t do the skill step by step and we have to make a plan to cut the umbilical cord, and sometimes there is no scissors even to cut the episiotomy, or they are blunt you have to use the blade so you have to improvise”. P8

P9 corroborated as follows:

“Uhm... with the equipment there is always not enough equipment to accommodate all the patients in the labour wards...you run out of linen as well and let the patients lie on the mattresses with the linen savers. The whole situation is causing a delay you must wait for other people to finish their patients and then you start with yours which in a way will delay the completion of the midwifery register.”

4.4.3.4.2 Category 3.4.2: Inadequate teaching resources

To promote teaching and learning for midwifery students nursing institutions should have adequate teaching resources. The participants raised concerns regarding the

inadequate resources at the college, which inhibited mastering of midwifery skills and resulted in difficulties during the completion of the midwifery register during clinical placement.

One participant mentioned the following:

“There is not enough resources there at the college, our simulation is so small and then it can’t accommodate us so that we can see what is done there, so you have to divide us into two so if you teach this group a skill when you go to another group maybe the content is not the same, so the simulation labs are small to accommodate all students, and also the equipment is short”. P8

Another participant said:

“we find it difficult because like if I’m doing the skills for PPH(post-partum haemorrhage)....there you don’t really have a picture of what is happening, because you want to see there is an emergency, so the material at times is not enough so that they can show us step by step”.P2

4.4.4 Theme 4: Deterrent factors to completion of midwifery register

Factors that impeded student midwives from acquiring midwifery skills can lead to a frustrating time in their efforts to complete the midwifery register. Such factors are manifold. Below are the responses that verify that there were many deterring factors regarding the completion of the midwifery register.

4.4.4.1 Sub theme 4.1: Patient related factors

These factors contributed to difficulties when completing midwifery register during the students’ allocation in maternity units and yielded one category namely: attitudes of patients towards male midwives (accoucheurs).

4.4.4.1.1 Category 4.1.1: Attitudes of pregnant patients towards male student midwives (accoucheurs)

Male participants experienced a negative attitude displayed by some pregnant women. This had caused a drawback to male student midwives (accoucheurs) as they missed the opportunity to deliver those patients, which subsequently affected the completion of the midwifery register.

The following male participant expressed frustration:

“With the patients.... it’s only Somalian patients that do not allow you to touch them, they don’t allow a man to work with them so for us males it was very difficult, if its Somalian patient we are not going to get that delivery and we miss that delivery because of cultural reasons so it’s very difficult for us and the young ones...umm.... Will be shy... and say...”no I don’t want male nurse in the room”, so we will be excused so you don’t need to witness that one so...for us mam...it’s very difficult in maternity wards than female students, even if you are doing a pv if you ask permission, they won’t allow you.” P4

“Of cause some patients has to be begged for me as a male student to examine them, some just refuse, but some after health education they do agree, I explain to them that I am a professional”. P2

4.4.4.2 Subtheme 4.2: Midwives and lecturer related factors

Midwives and lecturers both have a teaching function and coach midwifery students during clinical placement. The subtheme yielded three categories namely: negative attitudes of midwives, absenteeism of qualified midwives, and the lack of accompaniment by lecturers. The categories contributed negatively to the completion of the midwifery register in maternity units.

4.4.4.2.1 Category 4.2.1: Negative attitudes of midwives

Participants raised concerns regarding the attitude displayed by midwives in the maternity units. The negative attitudes of midwives delayed the student midwives in completing the midwifery register.

P5 validates that midwives’ attitudes were negative as cited in the following quotation.

“but at times these midwives make us feel that we are forward at times...there is this sister they call us names like “Nomaphunga” (a person that is moving too fast/or you think you are smart) as a student, try and relax you know in nursing you will get tired we were also like that, at times you are excited, you want this to be done, you show enthusiasm to show

that you want to know this ma'am, it's not nice to be lost and you asking too much...yes as a student you have to ask. Those things are discouraging ma'am very discouraging."

Two participants said:

"So with me the sister will just say...I am busy with maybe 4 patients I am not going to sign that book now". P10

"Sisters don't know this register and they say our lecturers must come and teach us they refuse to assist us". P1

4.4.4.2.2 Category 4.2.2: Absenteeism of qualified midwives

The absenteeism of qualified midwives in maternity units contributed negatively to the completion of the midwifery register during the clinical placement of student midwives. As articulated by the participants, the absence of qualified midwives led to a lack of checking and endorsement of midwifery skills before they are recorded in the midwifery register.

The following study participants had the following to share:

"You will find out maybe there is no staff there maybe it is the sister in charge only with the students, so we are trying to help the whole day, we are busy trying to help the sister in charge because nurses are sometimes absent in the wards". P3

"I was supposed to go to theatre to see a caesarean section but I didn't go because we were short staffed most sisters were not on duty so I couldn't go". P10

"I even lost the deliveries because I had to go to theatre to hand over patients instead of the sister because she had to remain in the unit". P9

4.4.4.2.3 Category 4.2.3: Lack of accompaniment by lecturers

Lecturers were not visible in maternity units to accompany, teach and supervise the midwifery students. The lack of the accompaniment of midwifery students by lecturers had deprived the students of teaching and mentoring by lecturers.

The study participant verbalised that:

“No, I haven’t seen any lecturer in the units coming to assist us maybe if they are coming; they will be there to do the skills. I think the reason for them not coming is that some lecturers are teaching different levels, the 3rd years and 4th years, it’s the workload actually because there is a lot of us in the class, there is more than 80 students up to a 100 which is a lot and they had also post basic students”. P9

*“Im sure the only challenge is that lecturers don’t go enough to check on us especially in the first allocation and we are still very lost, just to do a round...just to do a round, maybe just to do one lesson for an hour, guide us”.*P5

4.4.4.3 Subtheme 4.3: Student related factors

Among factors that related to incompleteness of midwifery register, subtheme student-related factors emerged. The subtheme revealed two categories namely: dodging and misuse of learning opportunities/time deliberately and the lack of knowledge, skills, and competency. The two categories had a negative influence on the completion of the midwifery register.

4.4.4.3.1 Category 4.3.1: Dodging and misuse of learning opportunities deliberately

From this study, participants alluded to the deliberate misuse of learning opportunities and dodging clinical placement and this contributed negatively to the completion of the midwifery register. The study participant agreed to that fact and said:

“Eish mam... For me mam I just go to work, but when I’m tired I just dodge...”.

P1

The other participant agreed to have wasted time deliberately and the following chronicle attests to that:

“I had more than enough time (boldly said) but I wasted my time... I wasted my own time...seeing that like in 3rd year there was no problem with time and allocation and ...I fail my psychiatry module in third year and I repeated it ...and you are allocated in psychiatry and midwifery and still I did not use that

time...and now I was 4th year last year and COVID-19 happened and I was allocated in midwifery...I don't think time is a problem beside COVID-19 last year". P6

4.4.4.3.2 Category 4.3.2: Lack of knowledge, skills, and competency

Most participants of the study reported that they were always unsure about the performance of midwifery skills during the management of patients in maternity units. Uncertainties during skill performances resulted in the incorrect recording of midwifery skills in the midwifery register and this had delayed the completion of the midwifery register.

The following participant verbalised that:

"that's the delivery part I am talking about, there is that part again in the register about the pelvic assessment I don't know how to fill it in there, so when we ask the sister, they say it's not done anymore, also the part of the PVs there is information there to fill in there like the sutures but I'm not sure what to write in there". P9

Another participant said;

"I have witnessed the suturing and the episiotomy....so far for me the challenge is the PV (vaginal examination), seeing that I haven't done a lot of deliveries, I struggle mam ...I really struggle so when I'm doing it I can't really tell what it is that I feel". P6

4.4.5 Theme 5: Impact of non-completion of midwifery register

The negative experiences related to the impact regarding the non-completion of the midwifery register emerged in the study. The theme is characterised by the following subtheme:

4.4.5.1 Subtheme 5.1: Delay in commencement of community service

Most of the participants were aware that non-completion of midwifery register on record time would delay commencement of community service. The subtheme

revealed two categories namely: pressure to qualify for community service and fear of financial loss.

4.4.5.1.1 Category 5.1.1: Pressure to qualify for community service

Participants of the study were pressured to complete the midwifery register and at least 1000 hours during clinical placement in maternity units to qualify for community service. The participants' responses below demonstrate that they felt pressured to complete the midwifery register to commence community service on time.

As quoted below, study participants said:

“You feel so bad because you want to finish everything that you are allocated to but there is no time....there is no time to fill in that and by the time I have to go and comm-serve I had stay behind and work to finish all the things that I have to finish like skills and you have to finish the hours before you go otherwise you have to stay behind and others will go to comm-serve and you stay behind to finish up the register”. P4

“It's when we are rushing for comm-serve (community service) mam...our last days (giggling)...we know that we are forced to come and submit the registers.” P3

Two participants validate that there was pressure to commence community service as per the following excerpt:

“I actually fell in love for midwifery because of the register, and it makes you realise how broad it is... you see ma'am and it exposes us to different conditions, and I know that I have to complete the register otherwise I will not go for comm-serve”. P5

“There is a competition among us students I don't want to remain at the college. I cannot I have to go and comm-serve mam”. P1

4.4.5.1.2 Category 5.1.2: Fear of financial loss

In this study, participants emphasised the fear of losing a salary. The students are motivated to complete the course in record time so that they earn a salary after student life.

Two participants pointed out that:

“You cannot go to comm-serve then also financial...(Laughs)... you lose out on your salary... more money... and don’t benefit from courses they offer in comm serve (community service).” P1

“Life will be difficult because we are looking after families therefore it is important to finish this register to get a full comm-serve salary mam”. P10

4.5 SUMMARY

Chapter 4 presented an in-depth description of the study findings relating to student midwives’ experiences concerning completion of midwifery register. The process was spearheaded by implementation of Tesch’s 8 steps for data analysis, and enabled the emergence of five main themes, eleven subthemes, and 21 categories. The participants’ demographic data and background were presented. The participants verbatim clarified the categories comprehensively.

CHAPTER 5

INTERPRETATION AND DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Chapter 4 presented the research findings related to student midwives' experiences regarding completion of midwifery register. Chapter 5 links purpose of the study, objectives, and research questions, as well as research design, to the findings and interpretation of results. This research produced five themes, eleven sub-themes and 20 categories. In auditing study findings, a rigorous literature review was undertaken for scientifically providing reference arguments for agreeable and contrary evidence as originating from other preceding investigations. A literature review exercise was used to appraise results to facilitate the formulation of recommendations and conclusions.

5.2 PURPOSE OF THE STUDY

The purpose of this qualitative study was to explore and describe experiences of student midwives regarding completion of midwifery register. From the findings of the study, recommendations were made for midwifery lecturers, clinical midwives, and student midwives on ways to combat the challenges of completing midwifery register.

5.2.1 Research objectives

The research objective was:

- To explore and describe the experiences of student midwives regarding completion of midwifery register.

5.2.2 Research questions

The following question guided the study:

- What were the experiences of student midwives regarding completion of midwifery register?

5.3 RESEARCH DESIGN AND RESEARCH METHOD

For this study, a qualitative, descriptive, explorative, and contextual research design was used to gain insight regarding student midwife experiences of completing midwifery register. Furthermore, the chosen design was best suited to elicit personal accounts of what the students had to go through whilst completing the register so that the information obtained was rich and wholesome.

A non-probability sampling technique was employed to ensure comprehensiveness during data collection since the population of interest was chosen based on the ability to supply most pertinent information. The sample in this study consisted of 10 fourth-year student midwives comprising of eight females and two males whose ages ranged from 22 to 48 years. Unstructured individual interviews were conducted, and audio recorded. The interviews took place at a nursing college within time frames of between 40 minutes to 90 minutes. To guarantee rigour and trustworthiness, criteria of credibility, dependability, transferability, and confirmability were applied as advocated by Lincoln and Guba in de Vos et al (2011:419).

5.4 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

The study findings revealed that, even though there were positive experiences relating to the completion of the midwifery register, most of the experiences were fraught with challenges, frustration, and despair. The discussion below elicits the thematic, sub thematic and categorical findings against the backdrop of the research purpose, objectives, and questions. Theme 1 discussed positive experiences related to completion of midwifery register, theme 2 consisted of personal experiences regarding completion of midwifery register, theme 3 discussed the challenges faced by student midwives to complete the register, theme 4 discussed deterrent factors to completion of midwifery register and lastly, theme 5 consisted of impact of non-completion of midwifery register. The discussions below are focused on the aforementioned themes:

5.4.1 Theme 1: Participants expressed positive experiences related to completion of midwifery register

Participants expressed positive experiences related to completion of midwifery register in the first theme. It resulted in one subtheme, namely: midwifery students felt that they were mentored in certain areas, and one category, namely: adequate guidance and clarification regarding completion of midwifery register. Most of the participants found completion of midwifery register, maternity units, without challenge. Study findings by Brunstad et al (2016:138) also reflected positivity in that participants could integrate their learning when assisted and guided by registered midwives.

5.4.1.1 Subtheme 1.1: Mentored in certain areas

Evidence from literature proves the need for hospital management to provide support strategies for effective experiential learning in the clinical setting (Rikhotso et al 2014:1164). This means that students should be adequately guided and mentored during clinical placement.

5.4.1.1.1 Category 1.1.1: Adequate guidance and clarification regarding completion of midwifery register

Most participants expressed that their mentoring in the midwife obstetric unit (MOU) was adequate. Staff commitment to teaching and learning for the student to accomplish outcomes contributes greatly to the students' progress in the CLE. Moreover, achievement of learning outcomes is largely dependent on a good clinical accompaniment experience that includes regularly checking clinical progress. A study done in Belgium by Vermeulen et al (2019:4) also elicited positive findings in that students were assigned a supervisor who coached and supported them during placement.

Conversely, a study done in an undeveloped country such as South Africa by Rikhotso et al (2014:5) found a total lack of student support during clinical placement. In this instance, inadequate mentoring and support contributed negatively to teaching and learning. Molefe (2011), in a study by Maphuthi (2016:20), suggests that students should be accompanied to facilitate learning opportunities. As cited by the participants, it stands to reason that in the MOU midwives were able to assist midwifery students as they only manage normal deliveries while those in labour wards manage complicated and referred-in patients.

5.4.1.2 Category 1.2: Praised by registered midwives

In this study, the subtheme, midwifery students praised by registered midwives emerged and the category, midwifery students received appreciation will be discussed below. This subtheme is aligned with participant's experiences. Positive staff /student appreciation goes a long way to motivate and boost morale. These, in turn, lead to a confident, willing, and inspired student.

5.4.1.2.1 Category 1.2.1: Appreciation of midwifery students

A few students expressed joy for the fact that, at times, they were complimented for doing a sterling job in the clinical field. A study by Power (2016:867) also reported feelings of pride in their achievements. The assertion is that recognition and praising contribute to emotional well-being and self-esteem, which further motivates novice students to perform better. Dissimilar sentiments were expressed by Muleya et al (2015: 579) namely, that adverse feedback prevents students from attempting new skills and this means that the student will remain unskilled in most of clinical tasks. To encourage and motivate students during clinical placement, midwives should continue to praise students for their outstanding performance. MOU must be structured in a manner that students are motivated and acknowledged to enhance their psychological wellbeing. This will also improve their intrinsic satisfaction and the possibility of retaining them in the profession as confident midwives.

5.4.2 Theme 2: Participants narrated personal experiences regarding completion of midwifery register

A few participant responses regarding the effect of midwifery register completion indicated that the experience personally took its toll on them.

5.4.2.1 Subtheme 2.1: Negative psychological responses

Register completion was cited as being emotionally draining by some participants. The study findings below corroborate this. Incidents of fear and worries before and during clinical placement resulted in poor interpersonal relations between students and clinical midwives during clinical allocation (Atakro 2017:5). To alleviate stress during clinical placement in maternity units, midwifery students should be offered debriefing sessions post clinical allocation to vent their experiences. Additionally, a study in Norway by Brunstad et al (2016:139) found that participants could interpret unpleasant emotions such as embarrassment into insecurity as they started doubting themselves.

5.4.2.1.1 Category 2.1.1 Self-blame and anger

Students should take responsibility for their own learning (Eastern Cape Department of Health: Midwifery Study Guide 2021). Simelane (2013:151) recommended that students should be more conscious of their training rather than simply seeking out comfort zones. The assertion is that the type of emotional response can be related to several challenges related to the completion of the midwifery register and other negative experiences. In most cases, a lot is expected from the student midwives, which places more pressure on them to perform beyond their capabilities. Ham and You (2018:228) revealed that nurses are predisposed to rage due to expectations for controlling negative emotions when providing health care services. In this study, self-blame could be attributed to an inadequate caring attitude from seniors. The scarcity of acceptance and emotional support can cause student midwives to become frustrated and to react negatively.

It is apparent that dodging and misuse of learning opportunities by some student midwives, also adversely impact their emotional wellbeing by amounting to self-blame, punishment, and rage.

Lecturers and qualified midwives must offer an empathetic listening ear to the student midwives to alleviate their habit of bottling up their emotions. Ham and You (2018:228) suggested a supportive clinical environment by providing educational interferences for applicable assertive anger expression. These new behaviours could be encouraged by establishing a positive CLE that enhances an appropriate communication of anger and frustration. Student midwives should be allowed some time to reflect on their experiences regarding completion of midwifery register. Some form of debriefing sessions can also assist student midwives to find a way of expressing their frustrations in an assertive healthy manner.

5.4.3 Theme 3: Participants reported challenges experienced during completion of midwifery register

Anecdotal and empirical evidence suggests that student midwives in underdeveloped countries encounter abundant challenges whilst trying to achieve learning outcomes such as completion of midwifery register. By way of confirmation, 41% of participants found the ward environment to be negative and that this was both a local and international trend (Phiri 2017:43).

5.4.3.1 Subtheme 3.1: Shortage of staff

In this study, shortage of resources emerged. The subtheme is characterised by four categories namely: student midwives used as workforce, workload of midwives, inadequate supervision, and inadequate lecturer/student ratio. The impact of shortage of staff is reflected below:

5.4.3.1.1 Category 3.1.1: Student midwives used as workforce

The category of student midwives used as a workforce is linked to the shortage of resources, especially human resources. As recent as May 2021, the World Health Organisation sounded the warning on a global scarcity of 900,000 midwives (WHO, 2021). Furthermore, the WHO also noted that COVID-19 pandemic has exacerbated this issue, as shortages were due to midwives who succumbed to the pandemic. During clinical placements in maternity units, 4th-year level midwifery students were left alone to perform midwifery skills such as conducting a delivery without supervision.

They were regarded as qualified midwives by clinical midwives and as such, they got delayed in attainment of their midwifery skills, which resulted in a lack in completion of midwifery register. Vuso and James (2017:135) found that the scarcity of staff in maternity units prevented students from completing their registered due to lack of accompaniment by midwives. It is also a common course that, in this kind of situation, it would be difficult for midwifery students to focus on the clinical learning outcomes related to midwifery skills.

The participants of this study verbalised their frustrations as they were used as part of the workforce during their clinical placement, instead of working towards achieving their midwifery goals and objectives. Magobolo and Dube (2019:4) found that students absented themselves as they did not want to be used as part of the workforce in the units. Improvement in staffing norms enhances the adequate support and supervision of midwifery students during clinical placement. Furthermore, a study by Thopola and Lekhuleni (2016:981) confirmed that students were seen as segment of workforce, and they had to manage pregnant women without any assistance. The use of midwifery students as part of workforce in maternity units prevented them from acquiring midwifery skills which then resulted in non-completion of midwifery register.

5.4.3.1.2 *Category 3.1.2: Workload of midwives*

Efficient student support and mentoring require ample time and patience. The current study revealed that majority of participants felt that midwives' increased workload contributed to them not honouring their teaching, mentoring, and supportive role. To support this, Vermeulen et al (2019:5) state that in most hospitals, labour wards were experienced as busy and demanding. In this regard, due to business, midwives did not have enough time to supervise students and to properly assess them in completion of their midwifery register. The outrageous workload also harms the psychological wellbeing of the qualified midwives, and thus renders them unfriendly and unwelcoming to student midwives. In this instance, burnout is likely to thrive with dire consequences such as absenteeism, increased sick leave, and further neglect of novice student midwives. The findings of several studies concur with this study.

Muthathi et al (2017:218) found that increased midwife workloads revealed that midwives faced many challenges. Agreeably, Atakro's (2017:6) study findings elicited that a heavy workload influences the kind of attention that midwives pay to students.

Midwives play a dual role in clinical learning environments, like that of teaching and supporting midwifery students and patient care. Muleya (2015:578) found that the staff was very busy to help the students when the mentor is off duty. Supervision is occasionally difficult in the clinical learning environment when clinical midwives are dealing with substantial numbers of student midwives (Pama 2017:53). Consistently, Bweupe et al's (2018:374) study findings revealed that the increasing student population makes it more difficult for midwives to monitor students effectively and most of the clinical staff is not trained in clinical supervision. Understandably, midwives are also responsible for a myriad of responsibilities such as administration, patient care, teaching, and research. Failure to supervise student midwives could be related to inadequate time management, thus ignoring the teaching role. Alternative measures can be put in place such as an adequate number of preceptors to assist midwives regarding support of student midwives in the completion of their midwifery registers.

5.4.3.1.3 *Category 3.1.3: Inadequate supervision*

It has been established in this study that inadequate supervision of student midwives during clinical placement was evident. Supervision is the dynamic process of directing, guiding, and influencing the outcome of an individual's execution (Meyer, Naude, Shangase & van Niekerk 2013:224). Furthermore, clinical supervision is the time during which students in clinical environment require expertise of the midwife or facilitator for guidance and supervision. Mampunge and Seekoe (2014:59) state that the midwifery curriculum in the integrated four-year diploma course requires the nurse educator to facilitate learning in class and to conduct clinical accompaniment that involves clinical supervision of student. In addition, this will ensure integration of theory into practice (Mampunge & Seekoe 2014:58). The integration of theoretical and clinical learning will enhance the hassle-free completion of midwifery register.

The experience of researcher is that accompaniment of students during clinical placement is always challenging as lecturers among other things are occupied with teaching other groups of student midwives, attending workshops and accountable for administrative duties.

The business of midwifery lecturers deprives student midwives of first-hand coaching and supervision. Therefore, clinical supervision by lecturers is not sufficiently accomplished. Inadequate supervision of midwifery students, by clinical midwives, due to pressured workload was also highlighted by the participants. The increased workloads of midwives resulted in inadequate supervision. In maternity units, midwives are always with students, and therefore, informal teaching should be regarded as teachable moments (Bruce et al 2011:256). Staff shortages and overcrowding in the nursing units create an environment in which there is no time to coach and supervise students (Meyer et al 2013:101). It stands to reason that student midwives were inadequately supervised by clinical midwives and lecturers through their clinical placement in maternity units, and this had resulted in poor completion of the midwifery register.

5.4.3.1.4 Category 3.1.4 Inadequate lecturer/student ratio

The participants were vocal about number of lecturers and stated that they were not adequate to supervise and provide support to a huge number of students. Midwifery students require adequate support and mentoring from midwifery lecturers during their clinical placement in maternity units. The number of registered midwifery students is always high for each level that is 3rd and 4th-year levels as compared to the number of midwifery lecturers. This causes a strain on the limited number of midwifery lecturers. Participants in a study by Okello (2015:34) confirmed that tutors/lecturers were few to take care of many students, and their heavy workload prevented lecturers from adequately supporting and accompanying students throughout their clinical placement in maternity units. In this case, it will be difficult to give individual attention required by students due to challenges in completing midwifery register.

The participants in this study pointed out that lecturers when they were available, they accompany students as they were many and the geographical locations of maternity units. The assertion is that there should be an acceptable number of lecturers versus that of the midwifery students to provide adequate individualised teaching and support, especially in midwifery. To that effect, Maphuti (2016:63) recommended that to augment the few lecturers, preceptors should be employed to mentor and support midwifery students. According to Malwela et al (2016:999), to curb the shortage of midwifery lecturers, midwives should be willing to assume their teaching role. Training hospitals need to develop and equip midwives through regular in-service training sessions on the role of coaching and mentoring the midwifery students (Malwela et al 2016:1001). In this regard, both midwives and lecturers will collaborate and share responsibility concerning performance of skills and completion of midwifery register.

5.4.3.2 Subtheme 3.2: Contributions to incomplete register

Contributions to an incomplete register emerged as subtheme and resulted in two categories, namely: poor orientation regarding completion of register and insufficient time to complete register. Midwifery register, per se, is not backed up by many scientific studies, resulting in limited study corroborations and comparisons. This study therefore will add in a meaningful way to the body of knowledge regarding it.

5.4.3.2.1 Category 3.2.1: Insufficient time to complete register

Time is a much-needed resource for both midwives and students when teaching and learning midwifery procedures. Completion of midwifery registers on its own requires ample time. A participant of this study bemoaned that time was insufficient for them to complete midwifery register during clinical placement. Insufficient time to complete the register could be attributed to various factors such as being engaged in non-nursing duties.

Midwifery students were used as part of the workforce that has consumed most of their time. Consistently, a study Pama (2017:25) found that time was not enough for students to complete their midwifery register during clinical allocation. A lot of time is required for meticulous documentation of care rendered to midwifery client. As a result, time might not even be adequate for student to record the performed skill on

midwifery register. Similar sentiments are shared by Gray, Downer and Capper (2019:37) indicating that documentation is also a time-consuming skill. In that regard, students felt that some time for record-keeping should be included in their required clinical practice hours (Gray et al 2019:37).

Another time-consuming practice that delays the actual completion of midwifery register is that student midwives usually make a draft before the formal entry of the case. Subsequently, more time is spent chasing qualified midwives to recheck, approve and sign the entered case, which further delays the students' performance of other skills (Gray et al 2019:13). It is also notable that midwives are overwhelmed by daily activities such as patient care, administrative work, research and therefore have less time shared for student support. It was further demonstrated by Malwela et al (2016:997) that when students were in level 4 as finalists, midwives viewed them as their colleagues and they were left alone to perform midwifery skills, which caused further delays and insufficient time to complete midwifery register. Participants in a study by Phiri (2017:173) also complained about not having enough time to complete clinical requirements. It is essential, therefore, that students are granted time to complete their midwifery registers after performing midwifery skills. Agreeably, a study by Okello (2015:42) recommended that balanced timetables should be drawn where students have adequate time for practical components of the curriculum.

5.4.3.3 Subtheme 3.3: Limited learning opportunities

Limited learning opportunities in this study emerged as the subtheme and it was characterised by two categories namely: too many students versus delivery cases and limited experiential learning due to COVID-19.

Setumo (2013:59) believes that learning opportunities should be discussed with students so that they know exactly what is required. Furthermore, learning opportunities should be ample to ensure that learning requirements are achieved without much of a struggle. The following categories emerged from the study.

5.4.3.3.1 Category 3.3.1: Too many midwifery students versus delivery cases

Vermeulen et al (2019:6) state that an increase in number of students in maternity units has been noted which has formed a competitive atmosphere in terms of learning prospects. In this study, participants reported that there were too many midwifery students versus delivery cases, and they ended up fighting or sharing clinical skills, such as deliveries. These findings are not new in the literature. The wrath of simultaneous presence of student midwives results in a lot of animosity and uneasiness in the ward. According to Masoumeh, Fariba, Shahnaz and Majid (2019:526), the situation was worsened by the presence of students from different institutions such as doctors on internship and advanced midwifery students. This kind of rivalry in competition among different students is exacerbated by the fact that they all must meet a significant number of midwifery cases to achieve expected qualification requirements. The worst-case scenario is that a huge number of students is harming the student and patients' mental state (Masoumeh et al 2019:526).

The paucity of learning opportunities against the increased volume of students has become the norm, especially in the Eastern Cape. Mathebula (2020:25) found that the cause of the imperfect learning opportunities at the CLE was due to students experiencing contest with students from other health educational institutions. Mbakaya et al (2020:10); Meyer (2012:64) and Arkan, Ordin and Yilmaz (2018:131) corroborate the study findings when participants stated that they fought among themselves to claim procedures to fill in the register. The challenge of fighting for opportunities to complete midwifery register, therefore, has a catastrophic impact on the interpersonal relationship among the peer students. In attempting to curb the congestion of student midwives during clinical allocation, collaboration between the nursing education institutions and maternity units should be formed. This strategy can enhance planning together as well as the mutual consideration of the common resources required for quality midwifery clinical learning and completion of the midwifery register.

5.4.3.3.2 *Category 3.3.2: Limited experiential learning due to COVID-19*

Most students lamented that they could not complete midwifery register because of limited experiential learning due to COVID-19. Understandably, students experienced limited learning due to the COVID-19 pandemic, which was declared as a world-wide public health problem by the WHO (Sogut et al 2020:246). Subsequent lockdown situations required all nursing education institutions to abide by strict regulations, such as the social distancing protocols. As a result, only few midwifery students were allowed in maternity units. Limited number of midwifery students in each placement deprived students of adequate clinical exposure to the midwifery skills and this resulted in the delay of skills accomplishment for the completion of the midwifery register. In support, Luyben, Flemming and Vermeulen (2020:779) revealed that to prevent spread of the virus, teaching and clinical placement were suspended.

According to Ahmed, Allaf and Elghazaly (2020:778) to curb the spread of COVID-19, all worldwide experiential learning was annulled which had dire consequences in the form of missed opportunities on students' clinical learning and competencies. Notably, the midwifery students in this study were also not spared from the COVID-19 regulations and lockdowns. In the process of suspension of clinical placement and studies, it is worth noting that students also experienced anxieties related to the pandemic. Fear of contracting the virus could be instrumental for midwifery students not attending experiential learning, which subsequently led to the incompleteness of their midwifery registers. Students must receive psychological support and intense education regarding use of personal protective equipment (PPE) so that they do not miss out on experiential learning and completion of midwifery register.

5.4.3.4 *Subtheme 3.4: Inadequate teaching and practice resources*

Participants of this study reported that they experienced inadequate teaching and practice resources. This subtheme formed two categories, namely: lack of delivery equipment, and inadequate teaching resources, which are discussed below:

5.4.3.4.1 Category 4.1: Lack of delivery equipment

During discussions with participants, it emerged that drastic shortage of resources has negatively affected completion of midwifery register. Lack of infrastructure and material resources modelled enormous challenges to midwifery and nursing education among Sub-Saharan African countries (Bvumbwe & Mtshali 2018:9). Sadly, in South Africa, according to Mhlongo (2016:47), apparatus that is essential for patient care is often not available or, if available, is not in good working order. Thopola and Lekhuleni (2019:5) found that due to the limited material resources, student midwives improvised, thus endangering the lives of the pregnant mother and foetus. It can therefore not be stressed enough that material resources are vital and can save the life of mother and child. The participant in this study narrated that they struggled when taking care of pregnant women due to shortage of equipment.

They also mentioned their inability to adequately witness the procedures due to limited space in the simulation laboratory. This has caused a delay in performance of their skills and eventually in non-completion of midwifery register. In agreement, Atakro (2019:6) revealed that midwives, in numerous hospitals in Ghana, are forced to invent when performing many procedures. Improvisation during skills performance does not allow students to integrate theory into practice and therefore, there is always a gap between the two components (Atakro 2019:6). The assertion is that in improvisation during the performance of midwifery skills, students will learn improper techniques of such procedures, thus compromising the competency and completion of midwifery register. A similar study by Phuma-Ngaiyaye, Odejumo and Dartey (2017:217) discovered that owing to shortage of equipment, students finished clinical experience without meeting the expected skills. This, in a way, compromises the integration between theory and practice. The dire effects of shortage of equipment entail learning theory without application (Phuma-Ngaiyaye et al 2017:217).

The current study shared a similar concern in that the participants cited an inconsistency amid what was taught in class and the real practice due to the shortage of equipment. Shortage of equipment does not only negatively affect the completion of the midwifery register but also compromises quality of patient care (Jiyane 2021:67). Bvumbwe and Mtshali (2018:9) recommended that the

government and department of health should allocate adequate funds for procurement of equipment at nursing education institutions and practices.

The availability of teaching resources will enable quality education and enhancement of competency in midwifery skills and adequate completion of midwifery register. Furthermore, when appropriate equipment is utilised to perform midwifery skills, student midwives will internalise the art of performing midwifery skills for a stress-free recording of skills in midwifery register.

5.4.3.4.2 *Category 3.4.2: Inadequate teaching resources*

The participants of this study voiced out concerns regarding inadequate and use of outdated teaching resources during demonstration of skills in the simulation laboratory. To support this, a study conducted by Mampunge and Seekoe (2014:59) found that the shortage of equipment in simulation laboratory inhibits integration of theory into practice. Meanwhile, a sound teaching experience, including adequate teaching resources, is valuable to hone students' knowledge and skills so that integration of theory and practice takes place.

The state of inadequacy of equipment deteriorated due to manikins being broken and not replaced. To add to use of outdated teaching resources, students had to wait for lecturers to borrow equipment, such as neonatal resuscitation models, from emergency medical services (EMS). This affected the clinical teaching of midwifery skills. Similarly, Bvumbwe and Mtshali (2018:7) and Phuma-Ngaiyaye et al (2017:218) also echoed challenges resulting from the lack of material resources. Just to mention one of the challenges, it has been noted that inadequate teaching resources for midwifery students affected students' acquisition of clinical competence. Therefore, the aim of lecturers in augmenting inadequate equipment for demonstration of skills was to ensure apt demonstration of midwifery skills that will enhance completion of midwifery register.

In preparation of midwifery students for clinical practice, a simulation is utilised to demonstrate midwifery skills, and this takes place in a simulation laboratory. In the process of demonstration of skills with adequate resources by midwifery lecturers, students learn a step-by-step art of doing procedures in a safe environment to

enhance their competency. Agreeably, students who practiced in a well-furnished setting were more likely to have a constructive attitude towards clinical practice (Aragaw et al 2019:3).

Therefore, simulation laboratory experience using adequate resources before the clinical placement of student midwives is regarded as vital to skills acquisition.

The clinical laboratory experience moulds the student midwives to be prepared for clinical placement. Therefore, it is essential that equipment used in the simulation laboratory be adequate and in good working order to enhance the skills acquisition, and so that register completion is hassle-free.

5.4.4 Theme 4: Participants expressed deterrent factors to completion of the midwifery register

The participants of this study raised deterrent factors regarding completion of midwifery register and these jeopardised the opportunity of completing midwifery register on time during clinical placement. Just to mention a few deterrent factors, participants mentioned patient-related factors which emerged as subtheme of the study, and one category, namely, attitudes of patients towards male midwives.

5.4.4.1 Subtheme 4.1: Patient related factors

During individual interview sessions with the participants, they demonstrated challenges encountered during patient care in maternity units.

5.4.4.1.1 Category 4.1.1: Attitudes of patients towards male midwives (accoucheurs)

The Regulation R425 (SANC 1985) stipulates that all students, male or female, who are registered to qualify as a midwife, are expected to complete the set clinical skills. Two male participants of this study highlighted, with concern, challenges they experienced while rendering care to patients during their clinical placement in maternity units. The Eastern Cape DoH (2009) recruitment and selection of R425 diploma course students stipulate that 10% of each intake should constitute males. Over the years each intake will have a group of male students admitted for the course. Therefore, male midwives registered for 4-year diploma course are not

exempted from midwifery training and therefore they should undergo such training to be registered as male midwives (accoucheurs).

Two participants of the current study expressed outrage when they were unfairly refused the opportunity to perform skills, more especially on Somalian women, because of their culture, as well as very young women; this has caused delays in skills acquisition and completion of midwifery register. The refusal of some women to be managed by male midwives might be culture related. Contrary to this statement, there is evidence that some women prefer male midwives (Nyaloti 2018:28). A study on the arrogances of expectant women towards male midwives revealed that younger women preferred male midwives because female midwives were rude to pregnant patients (Nyaloti 2018:28).

Male midwives also verbalised that during the period of acquiring midwifery skills to fill in midwifery register, they experienced setbacks in antenatal care as well as the labour ward. Nursing is a feminine occupation and study findings revealed that most nursing activities are feminine in nature (Chinkhata & Langley 2018:85). Pregnant women are expected to be taken care of by female midwives. It is common, therefore, that those pregnant patients will not be comfortable when examined by male midwives. As a strategy to put pregnant patients at ease and to promote trust, participants echoed that the female clinical midwives always ensured their presence during midwifery procedures. Agreeably, to support this, Modiba (2017:198) stated that to gain the trust and co-operation of patient to improve quality of care, the midwife should have the opportunity to understand her background and culture. In this case, male midwives experienced challenges in providing care to young and Somalian women and this has caused a delay in acquisition of procedures for their completion of midwifery register. A robust education and psychological reassurance should be availed to pregnant women regarding males being part of midwifery to alleviate anxiety.

5.4.4.2 Subtheme 4.2: Midwives and Lecturer related factors

The lecturer as well as clinical midwife is the primary role-players concerning students achieving their learning outcomes, such as the register completion. Midwives and lecture-related factors emerged and produced two categories namely:

negative attitude of midwives, absenteeism of qualified midwives, and lastly, lack of accompaniment by lecturers.

5.4.4.2.1 Category 4.2.1: Negative attitudes of midwives

Most participants expatiated that midwife displayed negative attitudes towards them and as a result, challenges were experienced during completion of midwifery register in maternity units. A study conducted by Motsaanaka et al (2020:2) concurs with this as participants expressed their lack of inspiration by using notions such as deterred and not interested, because of professional nurses' negative attitudes towards them. Similarly, a study by Atakro (2017:7) found that students were called names, harassed, and were in most cases made scapegoats for any misconduct in the ward. The negative attitudes of clinical midwives will promote absenteeism, dodging of student midwives, and most of all they will miss the opportunity to achieve their midwifery skills. A sound relationship between student midwives and clinical midwives is essential for the achievement of skills in a conducive environment. A poor relationship can lead to hindrance and demotivation on the part of the student and this, in turn, will harm the student's learning outcomes (Khapagawani & Useh 2013: 184). To mention just a few, factors leading to negative attitudes of clinical midwives such as increased workloads, high absenteeism rate of midwives and high student volume in maternity units harmed the support and mentoring of student midwives. In that case, if relationships between midwives and student midwives remain poor, midwives will not be able to fulfil their teaching roles. Setumo (2013:74) found that students reported evil relationships between themselves and clinical midwives in maternity units, and the study proved that they did not assist students in achieving their learning outcomes.

The participants of this study recommended that midwives should create a welcoming, encouraging, and supportive clinical environment for them to practice and acquire midwifery skills in a conducive environment. Additionally, Motsaanaka et al (2020:6), in their study, recommended that a student-friendly environment should be promoted to transform the negative emotional experiences of students into positive emotional experiences. A student-friendly environment will enable students

to achieve their objectives and successfully complete midwifery register during clinical placement.

5.4.4.2.2 *Category 4.2.2: Absenteeism of qualified midwives*

Most participants of this study reported a high absenteeism rate of midwives and this has affected their clinical learning regarding the checking and endorsement of their midwifery register. Midwives were absent from duty for reasons such as sick leave, poor working conditions, and responsibility leave. A study by Vuso and James (2017:135) revealed that the scarcity of staff in maternity units inhibits student midwives from completing their midwifery requirements. As a result, the few present midwives did not cope with huge number of students. Mhlongo (2016:81) also revealed that there is an escalating level of midwife absenteeism.

During clinical placement, student midwives depend on clinical midwives for mentoring, support, supervision, and lastly, for checking and the endorsement of the midwifery register. It has been highlighted by the study participants that during the absence of clinical midwives, they were used as part of the workforce and had to engage in non-nursing duties as well as perform their midwifery skills unsupervised. Therefore, in their absence, there was inadequate supervision, so much so, that the midwifery students missed out on opportunities to practice, internalise, and master the art of performing skills to acquire competencies. Midwives play an important role in lessening disparity between what is known and what is practiced (Thopola & Lekhuleni 2016:978). In this case, student midwives were left unsupervised most of the time during their clinical placement and they did not receive assistance to acquire midwifery skills for completion of midwifery register.

5.4.4.3 *Category 4.3: Lack of accompaniment by lecturers*

Most participants were vocal about the lack of accompaniment by lecturers to support and supervise them. Clinical accompaniment is a process by a nursing education institution to facilitate assistance and support to learner by educator at clinical facility to ensure achievement of learning outcomes (SANC 2011:4). Bosch (2020:19) postulates that the importance of accompaniment is to be mentored or

guided by a person in the nursing profession with innovative skills and knowledge in a particular discipline. The participants of this study verbalised their understanding of lack of accompaniment by lecturers and, among others, they mentioned the shortage of midwifery lecturers, transport challenges, teaching other year levels, doing administrative tasks, attending workshops, and being involved in research programs.

The South African Nursing Act (South Africa, 2005) requires nurse educators to spend at least 30 minutes per fortnight per student in the clinical setting to guarantee proper integration of theory and clinical practise. Sadly, this was difficult for midwifery lecturers to achieve. Setumo (2013:24) suggested that during clinical placements in maternity units, it is vital that midwifery lecturers visit students and physically facilitate learning in clinical area. The reasons for the lack of accompaniment by lecturers were mentioned by two participants, such as shortage of staff, the lecturers' inability to visit a huge number of student midwives, and the scattered location of maternity units. A study by Mbakaya et al (2020:8) concluded that sporadic presence of lecturers in the clinical areas contributed to challenges experienced during clinical placement. The expectation is that lecturers can provide emotional support and assist students to overcome several challenges related to midwifery skills and completion of midwifery register.

A study by Senti (2013:58) discovered that absence of lecturers to mentor students was a challenge as lecturers were not visiting clinical areas to accompany students. This caused students to be unsure of whether they were on the right track in terms of performing midwifery skills. Student midwives preferred lecturers for supervision because it was easier to approach them when confronted with a clinical problem (Mbakaya et al 2020:8). The participants of this study expressed their annoyance when lecturers were not visiting them during their clinical placement when students from other institutions were fully accompanied. The participants recommended that lecturers should make time to accompany students at least twice a week during the clinical placement, as this would enhance completion of midwifery register.

5.4.4.3 Subtheme 4.3: Student related factors

5.4.4.3.1 Category 4.3.1: Dodging and misuse of learning opportunities/time deliberately

Two participants admitted that they were dodging and misusing the learning opportunity deliberately; these students did not meet the requirements of the register and eventually, the community service commencement was delayed.

Students who absent themselves from clinical areas, miss important information on the procedures performed in that specific clinical area (Magobolo & Dube 2019:2). Furthermore, participants in a study by Vuso (2017:62) felt that students should take responsibility for their learning in the clinical area, but instead, the students were taking benefit of the lack of supervision by engaging in unsuitable conduct during learning time. The clinical midwives who were supervising the students were reporting that the students allocated to them were not committed to clinical practice and their learning. The participants were dodging and misusing time deliberately for various reasons such as, sharing the same shift with midwives that treated them disrespectfully and absenting themselves from areas where they were treated as part of the workforce. It has been recommended that midwives should treat students with respect, as students are not yet part of the workforce.

5.4.4.3.2 Category 4.3.2: Lack of confidence, knowledge, skills, and competency

Some students indicated that they lacked the knowledge and confidence to perform skills due to a lack of skill practice time. This has resulted in the incorrect recording of skills in midwifery register. Students should be given enough time to practice skills in the simulation laboratory to master the art of performing skills before practicing in clinical settings. Muthathi et al (2017:215) state that a simulation laboratory is an educational facility in which a learner can be taught and be able to practice clinical skills before using them in clinical settings. In midwifery, the practice of midwifery skills takes place in a clinical laboratory where dolls capable of animation are used to mimic pregnant women and new-born babies. To cite just one example, a birthing doll is used to demonstrate a woman giving birth.

Therefore, if students are not granted the opportunity to practice midwifery skills in simulation laboratory, a lack of confidence, knowledge, skills, and competency becomes evident. This, in the end, will create difficulties in completion of midwifery register.

Three participants of this study expressed their uncertainty during skills performance in the clinical setting. Additionally, a study authored by Senti (2013:60) also found that the participants were not sure of whether they were doing the right thing while they were giving feedback to live patients. To enhance competency during skills performance, students should be allowed enough practice time in simulation laboratory so that remedial intervention can be instituted timeously to enhance completion of midwifery register.

5.4.5 Participants expressed impact of non-completion of midwifery register

Completion of midwifery register provides the gateway to qualification as a registered midwife and community service commencement. This is what student midwives greatly aspire to achieve. Many factors delay register completion and community service commencement. Such factors are briefly discussed below: With regards to difficulty of register completion, which is synonymous with meeting midwifery requirements, a study by Pama (2017:25) found that meeting midwifery requirements can be difficult to achieve and therefore students will not commence community service in time.

5.4.5.1 Subtheme 5.1: Delay in commencement of community service

The delay in commencement of community service emerged as subtheme of the study and is characterised by two categories, namely: the pressure to qualify for community service and the fear of financial loss. Most participants felt that time spent in the midwifery units was too short for skills learning and practice, and as such, students leave the area having not achieved competence. The unwanted impact of non-competence of midwifery skills during clinical allocation therefore delays in commencement of community service.

Student midwives will only be registered on condition that they have successfully completed the course of study, have complied with programme objectives, as well as further requirements for the award of the qualification concerned (SANC 1985).

5.4.5.1.1 *Category 5.1.1: Pressure to qualify for community service*

The qualification for community service can only be achieved upon completion of midwifery register. Most participants were anxious about not completing the midwifery register within the stipulated time frame. A study by Sogut et al (2020:246) highlighted that frequency of anxiety among students has expanded rapidly in recent years due to external factors such as success pressure. Challenges experienced by student midwives during entire midwifery training were enormous, but due to their dedication and commitment, others managed to complete the midwifery register on time.

The participants of this study expressed their fears of financial loss when the stipulated SANC clinical hours are not accumulated within the specified period. Fear of financial loss is elaborated on below. According to the SANC, for the student to start community service one should have met all components of R425. The midwifery requirements should be evident in the completion of the midwifery register (SANC, Regulation, 425 of 1985). Midwifery lecturers and midwives must collaborate in this aspect and ensure that students competently meet all requirements stipulated by the SANC.

5.4.5.1.2 *Category 5.1.2: Fear of financial loss*

Some students expressed discontent regarding the fact that their failure to complete the register timeously would result in financial discord as it would mean that the monthly bursary granted to students would be discontinued. Nursing is regarded as a secured job where students are provided by a bursary or stipend and the family does not bear the expenses of education, and it is easy to get employment after completion of the course (Mallah, Khan, Buriro, Baloch & Parveen 2018:17). Midwifery students are bursary holders funded by the Department of Health and the purpose of funding is to assist student to purchase textbooks, uniforms, pay for accommodation, taxi/bus fares, and meals.

But this is not the case as most of participants are from a lower socio-economic background, and they have a liability of playing a dual role as that of being a student and that of being the breadwinner to cover for high family demands. Therefore, financial difficulties are prominent among such students, and they contribute to psychological and emotional implications as well as attrition of students (Jacobs, Scrooby & du Preez 2019:6).

Students from other provinces are not exempted from effects of financial loss, a study conducted in Kwazulu-Natal province regarding bursary system revealed that students worked in shops during weekends and days off to augment bursary funds (Jacobs et al 2019:4). Additionally, participants in a study by Simelane (2013:51), concur that challenges regarding financial loss resulted in lack of transport fares to the college and clinical areas. Financial loss can take its toll on students' health and emotional state, which subsequently led to poor performance and inability to complete the midwifery register. Given the low economic state of South Africa, if student does not complete the register, they will be left without the bursary.

It is recommended that students receive full support and mentoring from both lecturers and clinical midwives for them to meet their clinical objectives. Additionally, on meeting objectives and the SANC prescribed requirements, student midwives will successfully qualify as midwives and proceed for commencement of their remunerated community service for one year (SANC 2020).

5.5 CONCLUSIONS

The study aimed to explore and describe student midwives' experiences regarding completion of midwifery register at a nursing college in the Eastern Cape. Indeed, participants described experiences during their clinical placements in maternity units in detail. The main positive experiences were linked to adequate support received maternity units, feelings of worthiness, and being valued by clinical midwives at times and lastly but most importantly that midwifery register was indeed explained to them.

The participants were steadfast that in terms of midwifery register completion, negative experiences far outweighed the positive ones and stated that they were too many and at times too taxing. Negative experience citations included, inter alia, a psychological strain, as well as resource and learning opportunities deficiencies. It was the register completion impediments that the participants found to be most frustrating. These were register complexities and allotted time lamentations, COVID-19 pandemic limitations, atrocious registered midwife attitudes and poor duty commitments, lecturers not performing their accompaniment role, patient gender preferences, and anxiety regarding ability to complete the midwifery register so that community service placement could be affected. A lack of dedication to registering the completion on the part of the participants was acknowledged by student midwives.

5.6 RECOMMENDATIONS

The study findings expedited recommendations pertinent to the midwifery academia, clinical midwifery practitioners, and midwifery research as well as midwifery students. These are:

5.6.1 Recommendations for midwifery academics

- Lecturers should advocate that the Eastern Cape DoH should curtail each intake of students to between 50-60 instead of 80-100 to prevent student congestion in both class and clinical and by so doing, enhance the quality of midwifery training.
- Ensure that students have the know-how regarding their register completion, which should be done in stages to be aligned with the maternity unit that students are allocated to.
- Conduct regular midwifery register review based on the input of student midwives who are required to complete it.
- Liaise with clinical midwives to consult on ways to make the register simple and uncomplicated.
- Have a register orientation session with the clinical midwives so that they are familiar with it and have a common understanding regarding how to complete it.

- Hold register completion debriefing sessions to monitor clinical progress each time student midwives return to class. This must be done to avoid psychological and emotional strain.
- Ensure the method of midwifery skill performance is uniform and known by both clinical midwives as well as student midwives. This can be part of a capacity-building program for clinical midwives that are held quarterly at the nursing education institution.
- Spend more time doing the clinical accompaniment of students to assess and put them on the right path and by so doing, allay all anxieties. This will assist in bridging the gap between theory and practice regarding midwifery skills and completing the midwifery register.
- Strongly motivate and lobby the management for more midwifery preceptors to alleviate the undesirable lecturer-student ratio.

5.6.2 Recommendations for clinical midwife practitioners

Clinical midwives should:

- Have regular meetings as a means of collaborating in the teaching, supervision, and support of the students. In these meetings, challenges and appropriate solutions will be shared among the lecturers and the clinical team.
- Midwifery clinical learning outcomes should be provided to the midwives to guide them on how to assist the students regarding the skills and completion of midwifery register.
- Vociferously and continuously lobby management to ensure adequate daily staffs complement to ensure that midwives can perform their duties as well as mentor, support, and teach students as well. Motivations should be based on topical situational analyses.
- Create a strong awareness of the shortage of equipment so that management can take notice and replace or repair equipment that is in a state of disrepair.
- To develop a guide to be used by the midwives on how to handle difficult students. This will show a gesture of support to midwives.
- Create a clinical environment that is welcoming and supportive of student midwives.

- Have a positive attitude that resonates with student friendliness as well as an open-door policy.
- Develop a good work ethic to foster team spirit and be a positive role model for students.
- Show interest and commitment to assist students to achieve their learning outcomes. These outcomes must be provided by the nursing education institution before the student's clinical placement.
- Hold discussions regarding students who are experiencing difficulties and taking strain in the clinical area.
- Ensure that each unit has an up-to-date procedure manual that guides the student as to how to perform midwifery skills.
- Allow student midwives "study time" for at least one hour so that they can complete the registration and address their challenges.
- Have awareness of gender, stereotypical and ethnic preferences in midwifery and make sure that males are not excluded from performing skills.
- Buddy male students in midwifery and encourage them to maintain decorum and high professional standards especially when dealing with female patients.
- Regularly collaborate with lecturing staff as regards student midwife clinical requirements.

5.6.3 Recommendations for midwifery students

- There should be a consistent orientation every year just to keep them abreast of the SANC requirements and midwifery register.
- Students must be made aware that the responsibility for their education and training lies with them. The student should be subjected to a written affirmation of this.
- There should be recourse for inappropriate and unacceptable behaviours and attitudes such as deliberate and wilful neglect of their studies.
- Students found to be wanting in areas of confidence, knowledge, and skill should be timeously identified so that remedial intervention can be instituted.
- Time management and professionalism should always be emphasised on the students to encourage completion of midwifery requirements on time.

- Peer support and supervision should be encouraged to mimic good behaviour from others without being corrected by lecturers.
- Students can be encouraged to keep a reflective diary regarding daily activities and experiences about midwifery experiential learning and register this will help them to deal with those experiences in an acceptable manner.

5.6.4 Recommendations for nursing education institution

- Equipment for the simulation laboratory should be procured for demonstration of midwifery skills.
- Teaching videos should be developed by the NEIs for easy reference by the students on how to complete midwifery register.
- Midwives should be invited to join the demonstration skills by lecturers to ensure consistency in the practice of such skills.
- NEIs should liaise with SANC to accredit enough health facilities including private hospitals to accommodate the huge number of midwifery students.
- Ensure collaboration between different NEIs regarding the planning and placement of students for experiential learning. This will help to alleviate a huge number of students at the same time and place and to avoid competition for midwifery cases.
- NEIs should have measures in place to control absenteeism and dodging of student midwives.

5.6.5 Recommendations for further research

The following research topics are suggested:

- Completion of midwifery registers involving students at the other main campuses and universities in the Eastern Cape as well as other provinces in South Africa.
- Studies should be conducted regarding the effects of COVID-19 pandemic on midwifery education and training, especially, in the South African context.
- A study should be imperative to understand the experiences of midwives regarding student teaching and the completion of the midwifery register. This

will help in understanding their daily challenges regarding the completion of the students' midwifery register.

- Research can be done to develop guidelines to support both the students and the midwives regarding the completion of the midwifery register.

5.7 CONTRIBUTIONS TO THE STUDY

The study will augment the body of knowledge by scientifically providing data regarding completion of the midwifery register. Furthermore, a database for other researchers and the worldwide community will be made available. Additionally, policymakers, decision-makers, and relative stakeholders will be more informed regarding the completion of the register so that challenges can be avoided. Finally, the Eastern Cape Department of Health will be able to gain insight into the midwifery register completion and thus adapt and review it so that it becomes more student-friendly.

5.8 LIMITATIONS OF THE STUDY

Contextually, the design of this study was confined to a particular setting or situation and as such, limitations can be attached to it. The fact that the chosen participants hailed from one nursing campus out of 5 campuses in the Eastern Cape infers a study limitation. Additionally, the fact that the study was confined to a nursing campus only and not to universities further adds to its limitations. The study's finds, therefore, do not lend themselves to generalisability as results cannot be transferred to all midwifery students, all nursing campuses and universities in the Eastern Cape.

5.9 CONCLUDING REMARKS

The main aim of this study was to explore and describe the experiences of student midwives regarding midwifery register completion. The overriding phenomena that emerged from the participants' personal accounts were feelings of angst, frustration, fear, as well as feelings of seclusion due to inadequate support from the lecturers as well as clinical midwives. Having to deal with time constraints in which to complete the register also proved to be a very harrowing experience.

Participants also fervently lamented the complexity and format of the register and the recurring theme with each participant that was focused on having to fill three pages for each time they had delivered a baby.

“Make things as easy as possible, but no easier”

Albert Einstein.

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ANNEXURES

ANNEXURE A: Approval from University of South Africa



COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

20 January 2021

Dear Wendeline Nolulamo Tobeka Sogobile

NHREC Registration # :
Rec-240816-052
CREC Reference # :
31622208_CREC_CHS_2021

Decision:
Ethics Approval from 20 January
2021 to 20 January 2024

Principal Researcher(s): Sogobile WNT (email: tsogobile82@gmail.com)

Supervisor (s): Dr. SH Khunou (email: khunosh@unisa.ac.za)

Title: Student midwives' experiences regarding completion of midwifery register at a nursing college in the Eastern Cape

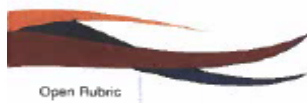
Degree Purpose: MA research project

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for three years.

The *low -Risk application* was *reviewed* by College of Human Sciences Research Ethics Committee, on **24 November 2020** in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in



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Pretorius Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
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the approved application.


4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.
5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No fieldwork activities may continue after the expiry date (**20 January 2024**). Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

The reference number 31622208_CRECHS_2021 should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.

Yours Sincerely,

Signature :



Dr. K.J. Malesa
CHS Ethics Chairperson
Email: maleskj@unisa.ac.za
Tel: (012) 429 4780

Signature : pp



Prof K. Masemola
Executive Dean : CHS
E-mail: masemk@unisa.ac.za
Tel: (012) 429 2298



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**ANNEXURE B: Permission letter from Nursing College Office, Eastern
Cape**

10 Chestnut Street
Algoa Park
Port Elizabeth
6200
23 March 2020

The Principal: Lutha College of Nursing
Private Bag x 0028
BISHO
5605

Dear Dr. Thakathi

RE-RESEARCH STUDY

**REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT THE NURSING
COLLEGE**

Herewith, I request permission to conduct the study at the college. I am a Master's student currently registered with the University of South Africa.

The title for my dissertation is: **STUDENT MIDWIVES' EXPERIENCES REGARDING THE COMPLETION OF THE MIDWIFERY REGISTER AT A NURSING COLLEGE IN THE EASTERN CAPE.**

The main purpose of the study which will follow a qualitative approach, is to explore and describe the experiences of student midwives regarding the completion of the midwifery register during clinical placement.

Focus groups will be used for interviews to collect data. The results of the study will assist to formulate recommendations regarding how to combat challenges facing student midwives with completion of the midwifery register during clinical placement.

I promise to uphold all ethical principles relating to research studies and on completion of the study, I will make the findings available to all stakeholders involved in midwifery training.

The study will be conducted under the supervision of Dr. Khunou from the Department of Nursing Science at the University of South Africa.

Should you have any queries, you may contact the supervisor of the study.

Dr. S. Khunou
University of South Africa
Contact No: 012 – 429 6290
Email: khunosh@unisa.ac.za

Researcher:
Mrs. W.N.T. Sogobile
Contact No: 0844366013
Email: tsogobile82@gmail.com

Thank you for consideration in this matter.

Yours sincerely

Mrs. W.N.T. Sogobile.



ANNEXURE C: Letter of approval; Nursing College -Eastern Cape



Province of the
EASTERN CAPE
HEALTH

Room 46• 2nd Floor • East London Central Office, 40 Lennox Road, Amalinda, East London, 5200 / Private Bag X0028 • Bhisho •
5605 • Eastern Cape, REPUBLIC OF SOUTH AFRICA
Tel.: +27 (0)43 7009 9702 Fax: +27 (0)43
Website: www.echealth.gov.za Email: psmashudu@gmail.com

Enquiries: Dr. SENTI - (QA and Research Manager) (0732670797)

MEMORANDUM

TO	MRS. SOGOBILE W.N.T.
FROM	DR. JE BEREDA-THAKHATHI: ACTING COLLEGE PRINCIPAL: LILITHA COLLEGE OF NURSING
SUBJECT	PERMISSION TO CONDUCT RESEARCH IN LILITHA COLLEGE OF NURSING
DATE	03.02.2021

1. The subject matter above refer
2. This correspondence serves to confirm that permission is hereby granted for you to conduct research in Lilitha College of Nursing, the topic being: **STUDENT MIDWIVES' EXPERIENCES REGARDING COMPLETION OF MIDWIFERY REGISTER AT A NURSING COLLEGE IN THE EASTERN CAPE**
3. The College will be waiting to beforwarded the results/recommendations from your study for implementation purpose by the college campuses.
4. The organization takes this opportunity to wish you success in your studies.

.....
Dr. JE Bereda-Thakhathi: Acting College Principal

Lilitha College Of Nursing

United in achieving quality health care for all
Fraud Prevention line: 0800 701 701
24 hour call centre: 0800 0323 64
Website: www.ecdoh.gov.za



ANNEXURE D: Letter seeking permission from Eastern Cape Department of Health Research Ethics Committee

10 Chestnut Street
Algoa Park
Port Elizabeth
6200
26 January 2021

Eastern Cape Department of Health
Research Ethics Committee
Lilitha College of Nursing
East London

Dear Mr. Merile

RE-RESEARCH STUDY

REQUEST FOR PERMISSION TO CONDUCT RESEARCH STUDY

Herewith I request permission to conduct research at the college. I am a Master's student currently registered with the University of South Africa.

The title for my dissertation is: **STUDENT MIDWIVES' EXPERIENCES REGARDING THE COMPLETION OF MIDWIFERY REGISTER AT A NURSING COLLEGE IN THE EASTERN CAPE.**

The main purpose of the study which will follow a qualitative approach, is to explore and describe the experiences of student midwives regarding the completion of the midwifery register during clinical placement.

Individual interviews will be used for data collection. The results of the study will assist to formulate recommendations regarding how to combat challenges facing student midwives with completion of the midwifery register during clinical placement.

I promise to uphold all ethical principles relating to research studies, and upon completion of the study, I will make the findings available to all stakeholders involved in midwifery training.

The study will be conducted under the supervision of Dr. Khunou. S.H. from the Department of Nursing Science at the University of South Africa.


Should you have any queries, you may contact the supervisor of the study.

Dr. S. Khunou
University of South Africa
Contact No: 012 – 429 6290
Email: khunosh@unisa.ac.za

Researcher:
Mrs. W.N.T. Sogobile
Contact No: 0844366013
Email: tsogobile82@gmail.com

Thank you for consideration in this matter.

Yours sincerely

Mrs. W.N.T. Sogobile. 
26/01/2021

**ANNEXURE E: Letter of approval; Eastern Cape Department of Health
Research Ethics Committee**



Enquiries: Yvonne Sixelo

Tel no: 079 074 0859

Email: Yvonne.Sixelo@echealth.gov.za / yvonne@pamec.com

Date: 02 February 2021

**RE: STUDENT MIDWIVES' EXPERIENCES REGARDING COMPLETION OF
MIDWIFERY REGISTER AT A NURSING COLLEGE IN THE EASTERN CAPE.
(EC_202102_002)**

Dear Mrs W.N.T. Sogobile

The department would like to inform you that your application for the abovementioned research topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress update on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Eastern Cape Health Research Committee secretariat. You may also be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

SECRETARIAT: EASTERN CAPE HEALTH RESEARCH COMMITTEE

**TOGETHER, MOVING THE HEALTH SYSTEM
FORWARD**



ANNEXURE F: Letter seeking permission from the principal of the Port Elizabeth Nursing Campus

10 Chestnut Street
Algoa Park
Port Elizabeth
6200
26 January 2021

Eastern Cape Department of Health
Research Ethics Committee
Lilitha College of Nursing
East London

Dear Mr. Merile

RE-RESEARCH STUDY

REQUEST FOR PERMISSION TO CONDUCT RESEARCH STUDY

Herewith I request permission to conduct research at the college. I am a Master's student currently registered with the University of South Africa.

The title for my dissertation is: **STUDENT MIDWIVES' EXPERIENCES REGARDING THE COMPLETION OF MIDWIFERY REGISTER AT A NURSING COLLEGE IN THE EASTERN CAPE.**

The main purpose of the study which will follow a qualitative approach, is to explore and describe the experiences of student midwives regarding the completion of the midwifery register during clinical placement.

Individual interviews will be used for data collection. The results of the study will assist to formulate recommendations regarding how to combat challenges facing student midwives with completion of the midwifery register during clinical placement.

I promise to uphold all ethical principles relating to research studies, and upon completion of the study, I will make the findings available to all stakeholders involved in midwifery training.

The study will be conducted under the supervision of Dr. Khunou. S.H. from the Department of Nursing Science at the University of South Africa.

Should you have any queries, you may contact the supervisor of the study.

Should you have any queries, you may contact the supervisor of the study.

Dr. S. Khunou
University of South Africa
Contact No: 012 – 429 6290
Email: khunosh@unisa.ac.za

Researcher:
Mrs. W.N.T. Sogobile
Contact No 0844366013
Email: tsogobile82@gmail.com

Thank you for consideration in this matter.

Yours sincerely

Mrs. W.N.T. Sogobile.



ANNEXURE G: Approval letter from college the principal of Port Elizabeth Nursing Campus



**Lilitha College of Nursing in Association with the Consortium of Universities
(WSU, NMMU & FORT HARE)
PORT ELIZABETH • Eastern Cape
Private Bag X6047 • PORT ELIZABETH • 6000 • REPUBLIC OF SOUTH AFRICA
Tel.: +27 (0)41 373 7829 • Fax: +27 (0)4 373 2614 • Website: www.ecdoh.gov.za
[@info.ecprov.gov.za](mailto:info@ecprov.gov.za)**

TO: Mrs. W.N.T. Sogobile
University of South Africa

FROM: The Campus Head
Lilitha PE Campus

DATE: 2021/02/18

SUBJECT: Permission to conduct Research Study (Topic: Student Midwife's experiences regarding completion of the midwifery register at a Nursing College in the Eastern Cape).

The above matter refers: This serves to inform you that your application to conduct research at PE Campus on the above topic is granted.

You are requested that the data collection be conducted within the rules of the Ethics Committee.

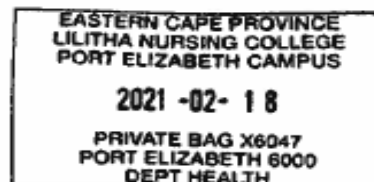
Please communicate with our campus research chairperson for logistics arrangements on the days of data collection: Ms. Matshotyana (084 449 3544).

The Campus wishes you well in your studies and we hope that you will share your findings and recommendations with the campus, for the betterment of future service delivery.

Thanking you in advance.

Compiled by:
L.H.Zonke


Campus Head



2021.02.18
Date



United in achieving quality health care for all

Fraud Prevention line: 0800 701 701
24 hour call centre: 0800 0323 64
Website: www.ecdoh.gov.za



ANNEXURE H: Letter seeking permission to conduct the study; Maternity hospital/PDD, Eastern Cape.

10 Chestnut Street
Algoa Park
Port Elizabeth
6200
23 March 2020

Eastern Cape Department of Health
Personnel Development Department
Dora Nginza Hospital
Spondo Street
Port Elizabeth

Madam,

RE: RESEARCH STUDY

Herewith, I humbly request permission to conduct a research study. I am a Master's student currently registered with the University of South Africa.

The study title is: **STUDENT MIDWIVES' EXPERIENCES REGARDING COMPLETION OF THE MIDWIFERY REGISTER AT A NURSING COLLEGE IN THE EASTERN CAPE.**

The main purpose of the study which will follow a qualitative approach, is to explore and describe the experiences of student midwives regarding the completion of the midwifery register during clinical placement.

One-on-one interviews will be used for data collection. The results of the study will assist to formulate recommendations regarding how to combat challenges facing student midwives with completion of the midwifery register during clinical placement.

Data collection will not interfere with classes and clinical practice attendance because it will be done outside of working hours. The session will take approximately 30-45 minutes. Participation in the study is completely voluntary.

Insights gained from student's descriptions will be used to formulate recommendations regarding how to combat challenges facing midwifery students with completion of midwifery clinical workbook during clinical placement.

I promise to uphold all ethical principles relating to research studies and upon completion of the study, I will make the findings available to all stakeholders involved in midwifery training.

The study will be conducted under the supervision of Dr. Khunou from the Department of Nursing Science at the University of South Africa.

Should you have any queries, you may contact the supervisor of the study.

Dr. S. Khunou
University of South Africa
Contact No: 012 – 429 6290
Email: khunosh@unisa.ac.za

Researcher:
Mrs. W.N.T. Sogobile
Contact No: 0844366013
Email: tsogobile82@gmail.com

Thank you for consideration in this matter.

Yours sincerely

Mrs. W.N.T. Sogobile.

W.N.T. Sogobile
23/03/2020

ANNEXURE I: Approval letter Maternity Hospital/PDD, Eastern Cape



Room DG15 • 1st Floor • Dora Nginza Hospital • Spondo Street • Zwide • Port Elizabeth • Eastern Cape
Private Bag X11951 • Algoa Park • Port Elizabeth • 6005 • REPUBLIC OF SOUTH AFRICA
Tel: +27 (0)41 406 4028 • Fax: +27 (0)41 406 4206 • Caroline.vacu@ECHEALTH.gov.za

INTERNAL MEMORANDUM

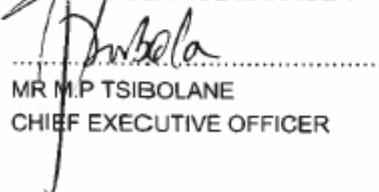
TO	MR M.P TSIBOLANE – CHIEF EXECUTIVE OFFICER
CC	MR R.M BUQA – NURSING SERVICE MANAGER
FROM	MS C.K VACU – TRAINING & DEVELOPMENT MANAGER
SUBJECT	REQUEST TO PERMIT MRS SOGOBILE, W.N.T TO CONDUCT RESEARCH ON STUDENT MIDWIVES' EXPERIENCES REGARDING COMPLETION OF THE MIDWIFERY REGISTER AT A NURSING COLLEGE IN THE EASTERN CAPE
DATE	19.02.2021

Dear Sir

This memo serves to seek your approval for Mrs Sogobile, W.N.T to conduct research on the above-mentioned topic at Dora Nginza Regional Hospital Obstetric and Gynae domain. Mrs Sogobile is a lecturer for Midwifery at Lilitha College of Nursing. She is doing Masters in Nursing under the University of South Africa (UNISA). She is conducting her study under the supervision of Dr Khunou. Her application to conduct this research has been approved by Lilitha College of Nursing, UNISA and the Eastern Cape Health Research Committees. Please see attached documents as proof.


MS C.K VACU
TRAINING & DEV. MANAGER


MR R.M BUQA
NURSING SERVICE MANAGER


MR M.P TSIBOLANE
CHIEF EXECUTIVE OFFICER

DATE 19.02.2021
RECOMMENDED / NOT RECOMMENDED

DATE 23/02/2021
APPROVED / NOT APPROVED

United in achieving quality health care for all

24 hour Call centre: 0800 0323 64
Website: www.ecdh.gov.za



Ikamva eliqambileyo!

ANNEXURE J: Participant's information leaflet

PARTICIPANTS' INFORMATION LEAFLET

Researcher's Name: Wendeline Nolulamo Tobeka Sogobile
Study Title: Student midwives' experiences regarding completion of the midwifery register at a nursing college in the Eastern Cape

Institution: UNISA
Student number: 31622208
Contact No.: 0844366013

Dear participant

I am a Master of Nursing student at UNISA's Department of Health studies.

You are kindly invited to volunteer your participation in this research project titled "Student midwives' experiences regarding the completion of midwifery register at a nursing college in the Eastern Cape."

The following information is provided to enable you decide on whether to participate or not:

The objectives of the study are:

- To explore and describe the experiences of student midwives regarding the completion of the midwifery register.
- To determine the challenges experienced by the student midwives with regard to the completion of the midwifery register.

Why are you being invited to participate?

The phenomenon of student midwives' challenges in completing the midwifery register at the nursing college has been noted with great concern. The researcher is interested in obtaining views regarding the above mentioned phenomenon. Your participation is thus valued as it is expected to shed insight, experiences and expertise on the subject matter.

Can you withdraw from this study even after having agreed to participate?

Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet

to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason.

What are the potential benefits of taking part in this study?

It is expected that the findings and/or recommendations will serve to correct the challenges experienced by student midwives regarding completion of the midwifery register.

Are there any negative consequences for your non-participation?

The study seeks to obtain your experiences on the study matter. There is therefore, no expected inconvenience and/or discomfort for you. Importantly, your decision not to answer any question will be respected and observed.

Will the information you convey and identity be kept confidential by the researcher?

You have the right to insist that your name not be recorded anywhere and that no one, apart from the study supervisor and qualified external coder will have access to it.

With regards to this study, your answers will be given a code number or a pseudonym and you will be referred to in this way in the data, any publications, or other research reporting methods such as conference proceedings.

Your answers may be reviewed by people responsible for making sure that research is done properly, including the transcriber, external coder, and members of the Research Ethics Review Committee.

How will data be safely secured?

Electronic information obtained through voice-recording will be stored on a password protected computer that is safely secured in an access controlled office at a nursing college in the Eastern Cape. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. Electronically stored data will be permanently deleted from the hard drive of the computer through the use of a relevant software programme.

Is there any compensation in any form, including gifts of any kind for your participation in this study?

There will be no compensation in any form, including gifts or of any kind for your participation in this study.

All cost will be borne by the researcher, you will therefore, not be expected to carry any costs in whatsoever form in relation to this study.

Has the study received ethics approval?

This study has been subjected to written approval from the UNISA's Research Ethics Review Committee of Health Studies and Department of Health Research Ethics Committee (East London). Copies of both are herewith attached.

This study has received written approval from the Research Ethics Review Committee, Unisa. A copy of the approval letter can be obtained from the researcher if you so wish.

How will you be informed of the findings/results of the research?

If you would like to be informed of the final research findings, please contact Wendeline Nolulamo Tobeka Sogobile on 0844366013 or at tsogobile82@gmail.com.

Similarly, should any additional information be required, or want to contact the researcher about any aspect of this study, please contact Mrs Wendeline Nolulamo Tobeka Sogobile at 0844366013 or tsogobile82@gmail.com

Should you have concerns about the way in which the research has been conducted, you may contact the study supervisor, Dr SH Khunou on 0767240146 or khunosh@unisa.ac.za. You can further contact the research ethics chairperson of the CAES General Ethics Review Committee, Prof EL Kempen on 011-471-2241 or kempeel@unisa.ac.za if you have any ethical concerns.

Thank you for taking time to read this information sheet and for participating in this study.

Thank you.

Wendeline Nolulamo Tobeka Sogobile



ANNEXURE K: Informed consent

INFORMATION AND INFORMED CONSENT FORM.

Researcher's name: Mrs. W.N.T. Sogobile

Title of the research project is: STUDENT MIDWIVES' EXPERIENCES REGARDING COMPLETION OF THEIR MIDWIFERY REGISTER AT A NURSING COLLEGE IN THE EASTERN CAPE.

I.....hereby give consent to participate in the-above mentioned project.

I have read the accompanying letter explaining the purpose of the research project and understand that:

- My participation is voluntary.
- I may decide to withdraw at any time without penalty.
- My identity will be protected at all times.
- All information obtained will be treated in the strictest confidence.
- My name will not be identifiable and used in any reports.
- A report of the findings will be provided to me in the form of a research report, which will be kept at the campus head office.

I may seek further information on the project from the researcher or her supervisor on the following contact numbers:

Researcher:

Mrs W.N.T.Sogobile

Cell Nr: 0844366013

Fax Nr: 041 373 2614

Tel Nr: 041 373 0288

Email: tsogobile82@gmail.com

Supervisor:

Dr. Khunou

Contact No: 012 – 429 6290

Email: khunosh@unisa.ac.za

Signature:

ANNEXURE L: Interview guide

INTERVIEW GUIDE FOR INDEPTH INTERVIEWS

Researcher's Name : Wendeline Nolulamo Tobeka Sogobile
Institution : UNISA
Student number : 31622208
Contacts : 0844366013

Research Title

Student midwives' experiences regarding completion of midwifery register at a nursing college in the Eastern Cape.

Participant Instruction: Please feel free to answer the following questions.

The following open ended questions will be posed to participants of the study.

Introductory question

- What is your experience regarding completion of the midwifery register in maternity units?

Probing questions

- Explain your experience about filling in of the midwifery register during clinical allocation.
- Which competencies were difficult to achieve during your clinical placement in maternity units?
- Explain to me the level of guidance and support you received regarding filling in the midwifery register.
- Did you have enough time to complete the midwifery register during allocation in maternity units?
- Were there any nursing college related factors that contributed to difficulties in completion of midwifery register?
- Were there any lecturer/facilitator factors that contributed to difficulties in completion of the midwifery register?
- Were there any institution (maternity) related factors that made it difficult to complete the midwifery register?
- Were there any clinical midwives and mentor related factors that contributed to difficulties in completion of the midwifery register?
- Was there any resource related factors from college that made it difficult to complete the midwifery register?

- Was there any resource related factors from clinical institutions that made it difficult to complete the midwifery register?
- Were there any patient related factors that inhibited you from completing the midwifery register during clinical placement?
- Were there any personal factors that made completion of the midwifery register difficult?
- What aspects would have made completion of the midwifery register easier if it was difficult to complete?

Exit question

- Is there any additional information you would like to mention about your learning experience during clinical allocation in maternity units?

Probes in order to minimize misunderstandings

- Can you tell me more about this?
- Can you give an example of that?
- Can you tell me something else about that?
- Help me understand what do you mean by that?

Thank you for valued participation in this study.

.

ANNEXURE M: Interview transcript

INTERVIEW TRANSCRIPT 9

Venue: College boardroom

Age: 48 years

Gender: Female

Duration: 1 hour 4 min

Date: 13 July 2021

Time: 13h30 to 14h34

Key words: R=Researcher

P=Participant

Skills obtained so far: 3/20 deliveries; 10/15 babies nursed; witnessed 2 normal births; mothers nursed 10/15; 10/20 PVs & ANC 22/40 palpations.

R: Good afternoon student. How are you doing today?

P: Good afternoon ma'am. I am good thank you.

R	What is your experience regarding completion of the midwifery register in maternity units?
P	<i>I have got a challenge.....but I can't say it's a challenge as such, I'm concerned about the antenatal part, I'm not sure is supposed to be fitted in there because the patient has already attended antenatal and now when you get a patient that is unbooked I have got a challenge there because I don't know how to go about filling in that part....that's the delivery part I am talking about, there is that part again in the register about the pelvic assessment I don't know how to fill it in there, so when we ask the sister they say its not done anymore, also the part of the PVs there is information there to fill in there like the sutures but I'm not sure what to write in there. Again, with the fontaneles with the fontanelles you get mos the anterior and the posterior so with each do you say you feel both or? Because the baby might present with the posterior one.....so the register is difficult to fill in some areas are not that clear.... maybe the information it's not clearer enough ja for us to understand.</i>
R	Ok if you are saying the information or register is not clearer to understand. Did you get or you did not get any clarification in class maybe before you were allocated in the maternity units?
P	<i>Yes.... I think the lecturer clarified some of the things and I remember I have made some point/notes with my pencil like where we have to plot I did made some notes, the weight you plot with a green pen, the temperature in black and the lecturer has explained that we have to nurse 30 mothers example 10 in antenatal ward; 10 post normal births and 10 post caesarean ward.</i>

R	Tell me now if all those things were taught at the college, what becomes a problem now when you have to enter those in your register?
P	<i>I don't know what is the problem.... maybe it was too much information at one time and the forgetfulness in between, I did the notes but I'm not sure when I get there what to write so its too quick at time and you don't grasp, so I blame my self because I keep on forgetting.</i>
R	I understand in the units you are not working alone there is always a person around you. Do you ask from people who assist you when you are doing the skills?
P	<i>We do ask and others would say yho... "its been so long and our register was not like yours", you see</i>
R	How was the register filling in other areas other than labour wards?
P	<i>The filling in of the antenatal part was not that difficult...but the thing was the practical part neh....you have to fill in all those at times you cant really feel which side is the C shape and when time goes on you practise and practise and the you can feel if the head is engaged and you feel excited when you can feel it by yourself....so far the sisters at antenatal were very helpful</i>
R	Explain your experience about filling in of the midwifery register during clinical allocation.
P	<i>Uhhhh....I would say with the delivery side if you fill in the first page it doesn't mean it will go easier when you go to the next page because you are dealing with the different patient at that time and different information from the book of the patient, at times maam maybe you get....maybe the first partogram was filled up nicely and then you get to the second patient you see there are gaps but with those gaps in those partograms I experienced in labour ward that sometimes it depends on the PVs of the different persons, because I might feel a 4 then I plot a 4 and when you come you say no man its not 4 it's a 3 now you don't want to plot back to that 3 because the 4 is already there how are you....then what are you going to say I have seen the other sisters just leave a blank space there, so there is a breakage in that partogram so you get a challenge to fill in the next delivery.</i>
R	So a student now tell me what do you do when you note gaps on the partogram and they were not supposed to be there?
P	<i>I for one I do ask the sister.... But how am I supposed to go about to write that partogram with gaps and the sisters wont give you a straight answer, so you just have to go with that one and just fill in though, but there is no straight answer.</i>
R	Explain which competencies were difficult to achieve during your clinical placement in maternity units..

P	<i>Actually I do have a challenge with the delivery itself, I haven't got a real delivery that I feel its..yes...my own delivery, the 3 deliveries I have got I always got the assistance from the sister....so I would to have one that I would say this is my own, done everything and she must just stand there but not touch my patient. At the clinic we had a patient that came with high blood pressure and the patient had to be given Magnesium Sulphate regime to stabilise the patient, and I could remember ohhh this was taught in class, so we managed the patient and we referred the patient to hospital.</i>
R	Explain the level of guidance and support that you received regarding filling in of the register.
P	<i>Yes actually starting from the antenatal clinic, the sisters were very helpful and the sisters from the labour wards and they mentioned that midwives are short and they want us to come back and work as midwives and they always encouraging and putting us under their wings because they appreciate the extra help. So the sister will sign for us when we are done entering the skill but I cannot mention about 1 or 2 that gives us problems at times, but eventually they sign.</i>
R	Did you have enough time to complete the register during the allocation in maternity units?
P	<i>No.....not at that particular moment...at times you would make notes with your pencil there in the book and maybe you take a photo when it comes to a push, and there are times when the labour wards is busy there will be no time to write it in. The sisters sign there in front to say they I did the delivery with her so that they don't forget you when you write the whole delivery, so to confirm late they will just look at the front page and they will also check the delivery register in maternity to confirm....but you can't finish it that time.</i>
R	So, if the ward was busy most of the time and you mention that you also take photos of the file. Where and when do you fill in the information in your register?
P	<i>Those that are filled in in pencil you have to write them over in ink before the sister signs, they don't want to sign work done in pencil because they say you might erase the information and write wrong things there. With the photos as soon as you come home, and you take a rest for an hour or something like that you have to get back and write because if you pile up its going to be too much.</i>
R	Is there maybe a situation that you fill in the register at home and the following day the sister who assisted you is not there to sign?
P	<i>Yho....at the present moment I haven't had that situation...so I can't really say but I know it will be a problem if I cannot a person who assisted me. I did experience some problem in writing then I will get back to that sister or the sister's assistance about what am I supposed to write.</i>
R	Who else do you ask for assistance when you are stuck in terms of writing in your register?

P	<i>I do ask some of my peers and some I make a note in pencil and just find someone who will explain to me.</i>
R	Were there any nursing college related factors (simulation) that contributed in difficulties in completion of the midwifery register?
P	<i>What we do at the college it's a simulation so its not the same as in practical like patients so you get a bit of a challenge because there we are using dolls and here it's a live human being....so there will always be a challenge.</i>
R	Explain to me the actual challenge in simulation because you are taught that way and the lecturers mimic real life situations during simulation
P	<i>I think it's the mind set of the student because we tend to relax and say that one is a simulation and when you get to real patients ...it is a reality and you become nervous and your mind set...ja..</i>
R	How do you feel now as a student in real life emergency situations? Are you adequately prepared to manage those situations?
P	<i>Yes you become ready... but when you come to a hospital setting, the reality like the team members, the sister in charge it also depend on the sister in charge if he or she is someone who is panicking she will make all of you panick and if someone is cool you can work together nicely and at times they scream not that they want to scream at you and afterwards they will say.. "no man I was under pressure". And when they send you for things you are lost because when you get there maybe they were busy and orientation was not done so you do not know where to find things.....you have to find your own way around...you see ..maybe they say... "bring me catheter No.18 there", and you don't know where to go. We only got the orientation today, when we started yesterday, they were so busy, we just came and worked and find our way.</i>
R	Were there any lecturer/facilitator factors that contributed to difficulties in completion of the register?
P	<i>I can't think of anything, because the only thing that I remember is that the lecturers of midwifery make sure that they explain the register before going to clinical you even let us practice the partogram before we go for allocation preparing us so that we don't get lost. I would also suggest that the lecturer come and visit us there it would be a nice gesture for lecturers to see if we are going somewhere with the register.</i>
R	Tell me more about the lecturers and clinical visits.
P	<i>lecturers are teaching different levels, the 3rd years and 4th years , it's the workload actually because there is a lot of us in ne class, there is more than 80 students , I haven't seen any lecturer in the units coming to assist us maybe if they are coming, they will be there to do the skills. I think the reason for them not coming is that some a 100 which is a lot and they had also post basic students.</i>
R	Were there any institution (maternity) related factors that made it difficult to complete the register?

P	<i>Ummm.....with the equipment like here there is always not enough equipment to accommodate all the patients, like in the labour ward you run out of sterile scissors and you have to use sterile razor blade to cut the cord and the razor blade is sharper than the scissor an you can cut yourself, you run out of linen as well and let the patients lie on the matrasses with the linen savers. The thing is we also struggle with HB (haemoglobin meter), the HGT (haemo gluco test machine) and then you have to run around. The whole situation is causing a delay you must wait for other people to finish their patients and then you start with yours.</i>
R	Were there any clinical midwives and mentor related factors that contributed to difficulties in completion of the midwifery register?
P	<i>I haven't experienced any problem with the clinical midwives, I think one other thing is you the attitude of the student as well. I am one person that would....always make my life easier for myself even if the sister say... "pick up that thing" ...I will pick it up smiling because I know I am expecting something from them and also those difficult clinical midwives you make them soft mos.....as if they are testing you I don't know you just work on their attitudes. There are some that are good at teaching and they love teaching....there was sister X in neonatal ward hayi shame she loves teaching and sister B in labour wards....she would say "bring me sinto (syntocinon) from the fridge" ...what did your lecturers tell you about syntocinon? Then we have each to say something and she ids doing this to check if we are listening in class and she will continue with teaching if we are stuck.</i>
R	Any experience maybe with those that are not keen to teach?
P	<i>Yes, there are those that are not willing, and you have to ask always...." Sister what is this for, what is this for. So they will only give you answers when you ask</i>
R	Were there any resource related factors from the college that made it difficult to complete the register?
P	<i>Yhooo so far there are things there at the simulation lab, I can't think of anything that is not there, we've got mos our mothers and the babies and placentas I can't think of anything. I wish there can be always someone in the simlab for you to go there and practice and when lecturers are not there you can just go. It must be someone who is well informed, a person who knows midwifery or everything regarding the skills and she can answer all our questions. We also want this person to follow us in the units to assist us with the skills and look after us.</i>
R	Were there any resource related factors from clinical institutions (maternity) that made it difficult to complete the midwifery register?

P	<i>Ummm.....with the equipment like here there is always not enough equipment to accommodate all the patients, like in the labour ward you run out of sterile scissors and you have to use sterile razor blade to cut the cord and the razor blade is sharper than the scissor an you can cut yourself, you run out of linen as well and let the patients lie on the mattresses with the linen savers. The thing is we also struggle with HB (haemoglobin meter), the HGT (haemo gluco test machine) and then you have to run around. The whole situation is causing a delay you must wait for other people to finish their patients and then you start with yours.</i>
R	Were there any clinical midwives and mentor related factors that contributed to difficulties in completion of the midwifery register?
P	<i>I haven't experienced any problem with the clinical midwives, I think one other thing is you the attitude of the student as well. I am one person that would.... always make my life easier for myself even if the sister say... "pick up that thing" ...I will pick it up smiling because I know I am expecting something from them and also those difficult clinical midwives you make them soft mos.....as if they are testing you I don't know you just work on their attitudes. There are some that are good at teaching and they love teaching....there was sister X in neonatal ward hayi shame she loves teaching and sister B in labour wards....she would say "bring me sinto (syntocinon) from the fridge" ...what did your lecturers tell you about syntocinon? Then we have each to say something and she ids doing this to check if we are listening in class and she will continue with teaching if we are stuck.</i>
R	Any experience maybe with those that are not keen to teach?
P	<i>Yes, there are those that are not willing, and you have to ask always...." Sister what is this for, what is this for. So they will only give you answers when you ask</i>
R	Were there any resource related factors from the college that made it difficult to complete the register?
P	<i>Yhooo so far there are things there at the simulation lab, I can't think of anything that is not there, we've got mos our mothers and the babies and placentas I can't think of anything. I wish there can be always someone in the simlab for you to go there and practice and when lecturers are not there you can just go. It must be someone who is well informed, a person who knows midwifery or everything regarding the skills and she can answer all our questions. We also want this person to follow us in the units to assist us with the skills and look after us.</i>
R	Were there any resource related factors from clinical institutions (maternity) that made it difficult to complete the midwifery register?

P	<i>I would say in the clinical institutions there is a shortage of staff and we have got mos for an example a labour wards that has got three labour rooms and each must be covered by two midwives each time and the front side...the admission ward there also there are two sisters and there is a ward they admit the latent phase women, I think they are not covered because of the shortage of staff, so there will be only one midwife and they will be assisted by the assistant nurse if you as a student you are not there, they should employ midwives.</i>
R	Tell me what the situation is when there is only one midwife and you are there as a student?
P	<i>Hey...its...its very difficult because it happened now last time with the strike of the taxis, so the sisters couldn't come on duty and there was a time that I worked with a sister that was taken from the high care and hayi it was difficult yhoo (worried look)..i even lost the deliveries because I had to go to theatre to hand over patients instead of the sister because she had to remain in the unit.</i>
R	How did you feel then to take over duties of the sister being a student?
P	<i>Fortunately for me when we came first to the labour wards, sister took all of us one per day to theatre for orientation and she taught us to handover a patient as if she knew there would be a crisis. So we were taking turns to go with the sister to theatre. For now, we haven't gone inside the theatre to catch the babies, but they will take is in the near future.</i>
R	I am happy that you have assisted during a crisis and has shown willingness to learn.
P	Were there any patient related factors that inhibited you from completing the register during clinical placement?
P	<i>Uhhmmm.....i think its....when you get those unbooked patients and you don't really know anything about the patient, so you have to start afresh though you are in the labour room and you find out they only come when they are in labour now, now you have to struggle ask those questions and it's a long way. You do find patients that do not co-operate at times and you have to explain to them the reason for doing the skill and all the dangers of the pregnancy...pregnancy has got those lots of danger signs and especially if you did not come to book and maybe the patient is diabetic, or hypertensive or even immuno compromised you just have to have a way to speak to those patients. Also those that are maybe Gravidity 3 they are the ones that are giving problems, they have been there before.</i>
R	Now if they come when they are in labour unbooked, are you allowed to enter those patients in your register?
P	<i>No..... I think you have to follow (monitor) your patient at least for 2 hour before delivery and you can enter that patient in your register, so you will just miss that delivery for your register.</i>
R	Were there any person factors that made the completion of the register difficult?

P	<i>Ohh ...ok ..personally I don't think I had any personal problems because I make sure that if I am allocated for a week....let me strike while the iron is still hot and get to it by the end of the week when I move out of that unit I get my signatures, like now I have made my notes of my mothers nursed so I will just go and write them in my register and sister will sign for me tomorrow. I have never missed a day in allocation except for one day during the taxi strike.</i>
R	I am happy that you showed responsibility by not absenting yourself from the units. What aspects would have made completion of the register easier if it were difficult for you?
P	<i>I....I...think the... the only problem I think its like too much to fill in, they should cut some of the I don't think the antenatal part should be there in the delivery, and the pelvic assessment I don't think its necessary because the sister are saying it is no longer done.</i>
R	Is there any additional information that you would like to mention about your learning experience during clinical allocation in maternity units?
P	<i>They should allocate us enough time in labour because twenty deliveries is a lot at least 15 weeks in labour wards because there is a lot of us in the institutions, there is G (name of the university) and others so it is a problem to get the skills. So most of the time we discuss as students and share patients but mostly we will deliver and the university students care for the baby because they have that part in their register and their allocation is longer than ours.</i>
R	On that note let me thank you for availing yourself for the interview. Thank you so much.
P	<i>Thank you mam.</i>

ANNEXURE N: Certificate from Co-Coder

CLIENT/STUDENT: Ms T Sogobile

THIS IS TO CERTIFY THAT:

Dr David Morton has coded the following qualitative data:

Individual interviews

For the study:

**STUDENT MIDWIVES' EXPERIENCES REGARDING COMPLETION OF MIDWIFERY REGISTER AT A
NURSING COLLEGE IN THE EASTERN CAPE**

A study by

Ms T Sogobile

Declaration:

I declare that the researcher and independent coder (D Morton) have reached a consensus on the major themes of the data during a number of consensus discussions. The client/student has been provided with a report.

Signed:



Dr David Morton (PhD, PGCE, MA, BA(Hons), BA)

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ANNEXURE O: Turnit In Report

ANNEXURE P: Grammar Editors Letter

<p>S. Ferreira</p> <p>7 Krog Street Alexandria Eastern Cape 6185</p> <p>Cell: 074 457 5336</p>	 <p>PO Box 15439 Emerald Hill Port Elizabeth 6011</p>
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To whom it may concern

This document serves to confirm that the following thesis paper has been checked:

Student: Tobeka Sogobile
Student number: 31622208
Date: 20/11/21

This paper has been checked for:

1. Grammar
2. Spelling
3. Punctuation
4. Other formatting errors

I have left my comments in the review section of the document.

Should you have any further enquiries, please do not hesitate to contact Jolene.

Kind regards

Simoné Ferreira

