

INTEGRATION OF MIDWIFERY NURSING SCIENCE THEORY WITH CLINICAL PRACTICE IN SELECTED TRAINING HOSPITALS OF VHEMBE DISTRICT, LIMPOPO PROVINCE

By

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A thesis submitted in fulfilment of the requirements for the degree:

Magister Curationis (MCur)

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DECLARATION

I, **Thivhulawi Malwela**, declare that the thesis "**Integration of Midwifery Nursing Science Theory with Clinical Practice in Selected Training Hospitals of Vhembe District,Limpopo Province**" hereby submitted for the degree **Magister Curationis (MCur)** at the University of Venda has not been submitted previously by me at this or any other institution, that it is my own work in design and in execution, and that the sources that I have quoted have been indicated and acknowledged by means of complete references.

Thivhulawi Malwela : T Malwela

Date Signed : 05/05/2014

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DEDICATION

This study is dedicated to my two sons, Nndondeni Godness and Muphulusi Joshua, together with the youth of Rock of the Living Hope Church,Makonde UAFC Assembly.

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I thank God, my Creator and Saviour, Who allowed me to live up to this date and gave me the wisdom and strength to pursue this study.

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ABSTRACT

Integration of nursing theory with clinical practice has been a subject of debate in the nursing profession for some time. Now the debate focuses on the possible gap between theory and practice, and whether the gap is negative or positive. Other issues include whether midwives in the wards are still acting as mentors to the students and what lecturers' responsibilities are in the integration of midwifery nursing science theory with clinical practice? The purpose of this study was to identify and describe factors affecting integration of midwifery nursing science theory with clinical practice in the training institutions of the Vhembe District in the Limpopo Province.

The study sought to achieve the following objectives: explore and describe factors that influence the integration of midwifery nursing science theory with clinical practice and describe factors that impinge on the integration of midwifery nursing science theory with clinical practice. The significance of the study was that midwifery nursing science training will be improved as the results of the study as well as students' views expressed in this study would help to explain their expectations from professional midwives and lecturers, which would form the basis for creating a conducive learning environment in class and clinical or practical placements. These results might also be considered in the development of a curriculum that would bridge the gap between midwifery nursing science theory with clinical practice, the well-developed curriculum will produce a competent midwife practitioner who will help in the reduction of maternal and perinatal deaths in the Vhembe District. The community would benefit

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because of reduced stress of maternal and neonatal mortality. The government would benefit and save money following reduced maternal and neonatal death since this will reduce lawsuits.

The study design was qualitative, explorative, descriptive and contextual in nature. The population included professional midwives who have been working in maternity units of the training hospitals for 4 years or more, lecturers who have been teaching the R425 students for 4 years and above and level IV finalist student nurses from Thohoyandou Nursing Campus. Non-probability, purposive sampling was used to select the midwives, lecturers and students participants. Data were collected through in-depth interviews from 3 female professional nurses and 4 female lecturers, the ages of midwives ranged between 30-60years while the ages of lecturers ranged between 40-60years. Focus group discussions were used to collect data from 18 student nurses,4 were males and 14 were females, their ages ranged between 20-40 years. Data were analyzed qualitatively through open-coding. One major theme emerged from the raw data, namely, poor integration of midwifery theory and practice, 4 themes that emerged from the major theme were the following: factors related to teaching and facilitation by lecturers; factors related to learning by students; factors related to midwives in the clinical practice; and factors related to systems in the organization. The results were analyzed and recommendations proposed on the best strategies to enhance integration of midwifery nursing science theory with clinical practice. Trustworthiness was ensured by Lincoln and Guba's model and ethical consideration was ensured.

Keywords: Clinical practice, integration, midwifery theory, training hospitals

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ACRONYMS

ACNM	American College Nurse-Midwives
AIDS	Acquired Immunodeficiency Syndrome
ANA	American Nursing Association
CHRE	Council of Health Regulatory Excellence
CTG	Cadiotocograph
DoH	Department of Health
EMLC	European Midwife Liaison Committee
EMRO	Eastern Mediterranean Region
EURO	European Region
HIV	Human Immunodeficiency Virus
ICM	International Confederation of Midwives
MDG(s)	Millennium Development Goal(s)
NEI	Nursing Education Institution
NMC	Nursing and Midwifery Council
NQF	National Qualifications Framework
PMTCT	Prevention of Mother-to-Child Transmission
PV	Per Vaginal (Examination)
SANC	South African Nursing Council
UK	United Kingdom
USA	United States of America
WHO	World Health Organization

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RULES AND REGULATIONS

R.425 SANC Regulation (R.425) relating to the approval and the minimum requirement for the education and training of nurses (general,psychiatric, community)and midwives leading to registration as amended and directive.

R.2488 SANC Regulation (R.2488) regarding conditions under which registered midwives may carry out their profession.

R.2598 SANC Regulation (R.2598) relating to the scope of practice of persons who are registered or enrolled under the Nursing Act, 1978, as amended.

R.683 SANC Regulation (R.683) relating to the minimum requirements for a bridging course for enrolled nurses leading to registration as a general nurse or psychiatric nurse and guidelines as amended and directive.

R.254 SANC Regulation Diploma (R.254) for registration as a midwife, as amended and directive.

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 Introduction

The theory and practice gap is a discrepancy between what nursing students are being taught in the classroom (theory) and what is experienced clinically (practice) (Corlett, 2000:500). Nursing education has undergone radical changes wherein political decisions were made resulting in governmental reform, which elevated nursing to higher education, namely, the moving of nurse training from hospitals to colleges and universities, thus creating the theory practice gap (Jerlock, Falk & Severinsson, 2003:219). This situation brought the challenge to construct a clinical curriculum based on the traditional scientific knowledge combined with task-orientated training and practical knowledge. The movement also created a gap, that is, a communication breakdown, between those who teach and those who provide nursing care (Jerlock et al., 2003:220).

Due to the above problems, the current cadre of nursing graduates do not seem to be competent, seems to lack confidence and therefore cannot be left alone to manage a unit on the other hand primary aim of nursing education is to produce competent nurse practitioners with confidence who are ready to provide excellent nursing care to society. These practitioners need to be visionary, goal-directed, lifelong learners; and evidence-based researchers. Clinical nursing education would be the primary tool that will assist students to integrate theory with practice. Midwifery training as a field

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specializes in the care of mothers, from conception until confinement and 6 weeks after birth. Midwifery, as a discipline within a Faculty of Nursing Education, is also affected by the South African Nursing Council (SANC) (Regulation No. R2488, 1990:2). There seems to be a gap between midwifery theory and practice as indicated by increased in maternal and neonatal mortality rates as well as lawsuits on maternal care, as a result of incompetent midwifery care. Therefore, this study sought to identify factors that affect the integration of midwifery science theory with clinical practice in training hospitals in the Vhembe district of the Limpopo Province.

1.2 Background to the Study

In 1965, the American Nursing Association (ANA) which is the American regulatory body that controls and regulates nursing and midwifery science training, recommended that nursing training be moved from hospitals to institutions of higher learning within the general system of education. The movement led to the withdrawal of nurse-preceptors and, as a result, affected many countries, including South Africa (Berman, Snyder, Kozier & Erbs, and 2008:26). In the context of this study, a preceptor is an appropriately qualified and experienced first-level nurse/midwife/health visitor who, by example and facilitation, guides, assists and supports students learning new skills, adopting respectful behaviours and acquiring ethical attitudes (Quinn, 2007:356).

These movements seem to have interrupted the efficient integration of theory to practice, as students were away from hospitals for weeks or months. This situation created a discontinuity between the professional nurses in the service and lecturers and was exacerbated by the absorption of preceptors who promoted communication

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between lecturers and practicing nurses in hospital staff. Lecturers and professional midwives need to have a good relationship as both play an important role in the integration of theory with practice (Berman et al., 2008:26).

The United Kingdom (UK) Central Council's Fitness for Practice Report included evidence that newly registered nurses and midwives had significant skills deficits, and that midwives raised concerns that unsuitable students might 'get through' and register as midwives (Fraser & Cooper, 2009; Jones, Maxfield & Levington, 2010:28). A Nursing and Midwifery Council (NMC) commissioned study found that mentors were not prepared to fail students early in a programme. Weak students were often given the benefit of the doubt, including those with a history of poor performance. The result of this may be that the weaknesses and doubts, instead of being addressed, travel with the students onto their next placement and beyond (Bacon, 2010:309).

Worldwide, nursing education today is based on a broad knowledge: biological, social and physical sciences as well as liberal arts and humanities; the curriculum now also focuses on the development of critical thinking and broad knowledge (Berman et al., 2008:26). The curriculum creates many challenges, because it needs radical strategies that will bridge the gap between theory and practice. Many researchers came up with various strategies, but with no solution. The changes have brought a double burden to the integration of theory with practice to produce competent nurse practitioners (Corlett, 2000:500; Jerlock, et al., 2003:220).

In South Africa, a comprehensive course, offered in association with the universities or technikons, was introduced with the objective of preparing a successful student for registration as a nurse (general, psychiatry and community) and midwifery. The

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period of training was set at 4 academic years (SANC.R.425, 1985:1). The enrolled nurses developed through a regulation relating to minimum requirements for a bridging course for enrolled nurses leading to being recognized as a registered nurse or psychiatric nurse (SANC. R683:1). After completion of the bridging course, the enrolled nurses undergo training in midwifery science leading to being certified as registered midwife (SANC R254, 1975:1). In both programmes, hours of clinical experience are 1000hours, and a 3-month block of theoretical learning (Mellish & Brink, 1996:27). During this period, students were seen as the colleges' (not the hospitals') responsibility. This misconception led to interruption of the role of the professional nurse-mentor who facilitates student to integrate theory with practice. Hospital-based professional midwives seem to have dropped their roles as mentors and left students to lecturers who only do clinical accompaniment for a few hours a day (Berman, et al., 2008:26).

In South Africa, midwifery training is offered through two programmes, viz:

1. Regulation for the course leading to the diploma in midwifery for registration as a midwife (SANC R254, 1975:1).

2. Education and training of a nurse (general, psychiatry and community) and midwife leading to a registration, R425 of 1997.

However, for the purpose of this study education and training of a nurse (general, psychiatry and community) and midwife leading to a registration, R425 of 1997 will be chosen. This programme is offered over a period of 2 years as an inclusive package in education and training of a nurse (general, psychiatric and community) and

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midwifery science (SANCR425, 1997:3).

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A curriculum is a plan or design upon which education provision is based; it is the single most important concept in education delivery, encompassing all activities normally included under the umbrella terms 'education' and 'training'(Quinn, 2007:107).Curriculum (theory) adapted from the SANC R425 programme comprises the following: integrating the anatomy and physiology of the female pelvis, foetal skull learned in biological nursing sciences, pregnancy, labour and pueperium (SANC directive for R.425,1997:4; SANC R2488, 1990:1).

Practice is to carry out an action or do repeatedly as an exercise to improve a skill; or exercise oneself in an activity requiring a skill (The Concise Oxford Dictionary, 1990:935). This is to apply theory learned from class to real situations encountered in clinical placement (Quinn, 2007:488). Clinical learning outcomes are a desired end-state of student learning, and describe knowledge, skills, attitudes and values that a student should acquire because of an educational process (Quinn, 2007:112).

The SANC practical learning outcomes for midwifery training include:

a. Comprehensive assessment and care of at least 30 pregnant women, and recorded in a maternity case register book;

b. Performing pelvic assessment on a pregnant woman at 36 weeks gestation;

c. Critically observe, monitor and interpret findings during the course of labour in all stages of labour and provide care, including pain relief under supervision of a midwife or doctor;

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d. Personally deliver at least 15 patients and conduct the second and third stages of labour;

e. Carry out postnatal assessment of the mother and neonate before discharging them home and visit them within 3 days after discharge (SANC R425 directive1997:18; SANC R2488, 1990:1).

At the Limpopo College of Nursing, the curriculum for the *Midwifery Nursing Science* course comprise of: lecture periods which are 180 for Midwifery Nursing Science I; and 200 for Midwifery Nursing Science II. The total number of periods is 380, which is equivalent to 285 hours. The periods are distributed over 7 weeks block, each academic year, over 2 years (Northern Province Nursing College Curriculum, 1997:41). Whereas, the allocation and distribution of weeks for clinical practice is composed of 10 weeks in Midwifery Nursing Science I and 15 weeks Midwifery Nursing Science II, making a total of 25 weeks over 2 years, these 25 weeks are equivalent to 1000hours, which is a minimum requirement for the SANC (Northern Province Nursing College Curriculum, 1997:89). Despite the longer time of exposure to clinical learning opportunities and experiences, student midwives still display fewer competencies than expected at the completion of their midwifery science training. This may be an indication that there is a gap between the facilitation of midwifery science theory and clinical practice.

1.3 Problem Statement

According to Burns and Groove (2005:70), a research problem is an area of concern where there is a gap in the knowledge base and in this case, knowledge needed for nursing practice. De Vos, Strydom, Fouché and Delport (2011:285) explained a

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problem as a point of departure from which specific questions should be developed which, in turn, determines the goals and hypothesis. According to the Department of Health's Saving Mothers Report (2008-2010:iv), South Africa as a country had a challenge of increased maternal and neonatal morbidity and mortality, approximately 4,867 women died in South Africa between 2008 and 2010, with an increase of 867 of the deaths reported in the 2005-2007 report. According to the Department of Health's Saving Mothers Report (2008-2010: 74), Limpopo Province recorded 222 deaths. The Vhembe District Health Information System (DHIS) Limpopo (2011/09/10) revealed that 172 women died in the year 2011. Maternal deaths affect both individual and community by causing grief and stress due to permanent loss. Government was also losing money through the lawsuits connected to negligence and incompetent practices by midwives. The SANC professional misconduct report (2003-2008) registered 843 offences by all categories of nurses and midwifery cases were 135, the third highest number of lawsuits of all the cases, in South Africa. Limpopo Province registered five (5) misconduct cases.

From the 2005 to date, the researcher, a lecturer at the Limpopo College of Nursing has been involved in teaching and accompanying students at maternity units in Thulamela municipality training hospitals, namely, Tshilidzini, Donald Fraser and Siloam. During these sessions, the researcher learnt from nurse managers that newly qualified midwives trained under the R425 programme were mostly incompetent, lacked confidence and could not take responsibilities and clinical decisions. These new graduates were said to be unable to manage a unit independently. The increasing rate of maternal and neonatal death was linked to incompetent midwives. The poor integration of theory with practice during midwifery training is allegedly linked to an

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incompetent care of nurses and midwives. This study, therefore, sought to identify and document factors affecting integration of midwifery nursing science theory with clinical practice in training hospitals in the Vhembe District of Limpopo Province.

1.4 Purpose of the Study

The purpose of this study was to identify factors affecting integration of midwifery nursing science theory with clinical practice in selected training hospitals in the Vhembe District of Limpopo Province.

1.5 Research Question

This study sought to answer the following question: "What could be the factors that affect integration of midwifery nursing science theory with clinical practice in training hospitals in Vhembe district?"

1.6 Objective of the Study

The objectives of the study were to:

- Explore factors that were affecting the integration of midwifery nursing science theory with clinical practice.
- Describe factors that were affecting the integration of midwifery nursing science theory with clinical practice

1.7 Significance of the Study

The researcher believed that this study would help in recommending best strategies and practices to enhance integration of midwifery nursing science theory and practice. The students' views expressed in this study would help to explain their expectations

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from professional midwives and lecturers which would form the basis for creating a conducive learning environment in class and clinical or practical placements. The data obtained from this study would be useful in developing a curriculum that would integrate theory with clinical practice and, hence, bridge the theory-practice gap by producing competent, responsible practitioners who would help to reduce maternal and neonatal deaths. The community would benefit because of reduced stress of maternal and neonatal mortality. The government would benefit and save money following reduced maternal and neonatal death since this will reduce lawsuits. The results of the study could be used by policy makers and other stakeholders in the Department of Health (DoH).

1.8 Definitions of Concepts

1.8.1 Integration

Integration is an act or process of unifying or bringing together (Mosby's Dictionary of Medicine, Nursing and Health Professions, 2009:981). According to the Concise Oxford Dictionary (1990:707), integration is to complete by addition of a part to make a whole. In this study, integration is the process of assisting student midwives to put into practice or to assimilate theory learned in class and real-life practice. According to social learning theory, integration will be the retention process or phase that involves storage and retrieval of what students have been observing in the clinical practice. The students will first organize and symbolically (mental imagination) rehearse the behaviour before they actually perform it. This process helps students to put together modelled behaviour, theory and practice.

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1.8.2 Midwifery Nursing Science

Midwifery is the employment of a person who is qualified by special training and experience to assist a woman in childbirth (Mosby's Dictionary of Medicine, Nursing and Health Professions, 2009:1193). Midwifery can appropriately be a qualification obtained after training as a nurse (Fraser & Cooper, 2009: 1051). In this study, a midwife is a person who has qualified through education and training as a nurse (general, psychiatry and community) and midwife leading to a registration in line with R425 of 1997 and provides care to a mother from pre- pregnancy, pregnancy, through labour until six weeks after delivery. In this study, midwifery is a professional midwife allocated to a maternity unit of a training hospital, who through the social learning theory will assimilate midwifery-nursing science with the motor reproductive process or phase, wherein the student is actually capable of carrying out the observed behaviour and evaluate it in terms of accuracy.

1.8.3 Theory

Theory is a sphere of speculative thought or abstract knowledge or a supposition or system of ideas explaining something (The Concise Oxford Dictionary, 1990:935).Theory is an expression of knowledge within an empiric pattern, or creative and rigorous structuring of ideas that project a tentative, purposeful and systematic view of phenomena (Chin & Kramer, 2008:305). In this study, theory is the content of midwifery science learned in class through lectures or formal classroom instructions.

1.8.4 Clinical Accompaniment

It is a directed assistance and support extended to a student by a registered nurse or

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midwife with the aim of developing a competent independent practitioner. The SANC requires that the students should be accompanied at least for 30 minutes per fortnight in the workplace (The Philosophy and Policy of SANC: 8). This study will adapt social learning theorists' explanations of accompaniment as vicarious reinforcement (strengthening or support) by professional midwives and lecturers.

1.8.5 Clinical Practice

Practice is to carry out an action or do repeatedly as an exercise to improve a skill or exercise oneself on or in an activity requiring a skill (The Concise Oxford Dictionary, 1990:935). In this study, clinical practice is the activity carried out by students in real practice/placement to gain competency in providing maternal and perinatal care. Social learning theory will assimilate clinical practice and the motor reproductive process or phase, wherein the student is actually capable of carrying out the observed behaviour and evaluate it in terms of accuracy (Quinn, 2007:99).

1.8.6 Training Hospital

A training hospital is an institution approved by the SANC in line with the Nursing Act to place nursing students for clinical learning experience (Nursing Act, No.33, 2005). In this study, a training hospital is an institution where midwifery students are placed to practice what they have learned in class to become competent midwives. The social learning theory emphasizes behaviour or modelling more than physical environment. Therefore, social learning theorist may explain a training hospital in terms of cultural, social and emotional stability of the qualified professionals or mentors (Quinn, 2007:99).

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1.8.7 Nursing College

A nursing college is an institution approved by SANC in accordance with the Nursing Act to offer education and training, with the intention of qualifying any person to practice the profession of nursing or midwifery (Nursing Act, No. 33, 2005). In this study, the training nursing college will mean the Limpopo College of Nursing. The social learning theory will explain the college as an environment that will promote student capacity to process information. The competency of the lecturer to give theoretical background will enhance students' ability to pay attention to professional practitioners in the clinical placements.

1.9 Theoretical Framework of the Study

Theoretical framework is the underpinning of a study (Polit & Beck, 2008:754). Burns and Groove (2005:737) defined theoretical framework as an abstract, logical structure of a study that enables the researcher to link the findings to a nursing body of knowledge. Similarly, Brink (2011:208) described theoretical framework as a study framework based on prepositional statements from theories. The researcher had employed social learning/observational learning theory in the identification of factors affecting integration of midwifery science theory with clinical practice. The theory was helpful in identifying factors affecting the students' process of learning. The interview guide for a focus group had been developed based on this theory (Annexure 3b).

1.9.1 Social Learning or Observational Learning Theory

Social Learning or Observational Learning Theory is largely the work of Albert

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Bandura, a behavioural psychologist (Bandura, 2004; Quinn, 2007:98). This theory emphasizes role modelling and vicarious reinforcement. According to the theory, role modelling involves provision of compelling examples by the more experienced nurses who demonstrated desirable professional attitudes and behaviours. More experienced nurses' attitude and actions ensure safety, integrate knowledge with practice, provide guidance and influence the outcomes of clinical supervision.

1.9.1.1 Attributes of a Good Role Model

A good role model is a person that someone looks up to or an individual whom one can choose to model a behaviour, or a person with the attributes that one perceives to assimilate or emulate (Armstrong, 2008:1). For proper integration of theory with clinical practice, a good role model assisted students to put what they had learned in theory to clinical practice, and made them feel welcomed to the nursing profession. This person led by example and did not tell students what needs to be done, she also did it. She invited students to come and watch her and explained many things and narrated what she did, she was open to all sorts of questions and was always ready to clarify students. She engaged students, conveyed and shared her experiences and knowledge about the profession. She allowed communication at all levels of students' understanding and disseminated care with higher order of communication skills. She had general and specific midwifery knowledge and fostered high quality of midwifery care.

The professional midwives in the training hospitals were needed to possess the positive attributes outlined above in order to act as good role models. The students allocated to hospitals had an opportunity to observe well-trained midwives doing their

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daily work. Students had observed clinical skills and interactions with other team members and patients. The whole process of interaction assisted the students to learn professional attitude and techniques. The lecturers who had positive attributes acted as role model during accompaniment, role modelling had been ensured when students saw their lecturers doing their work honestly, skilfully and with determination during accompaniment. The students, therefore, learned midwifery skills by imitating their lecturers' promoting good integration of midwifery theory with clinical practice. Negative role model behaviour like poor communication, negative attitudes and unethical practices interfere with learning by imitation and students will thus fail to integrate theory with practice.

1.9.1.2 Vicarious Reinforcement

Reinforcement is a key changing behaviour, both tangible and intangible motivating reinforcement. Students received rewards and inspiration to replicate the desired behavioural skills (Quinn, 2007:100). In this study, vicarious reinforcement involved imitating the behaviour of the role models when there was reward. Reward was verbal in the form of encouragement and reprimanding bad acts, a token or achievement in the form of exam results. During clinical exposure, when the lecturers praised two or more students who were doing their work appropriately, skilfully and with determination had encouraged students to imitate their role models, i.e. midwives who were competent in order to become competent and get reward. The other students had been encouraged to perform the skills competently as their counterparts to earn praise or reward.

On the other hand, punishment of students for inappropriate behaviour kept other

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students from displaying the same punishable behaviour. Some had been encouraged through imagining themselves as lecturers who were competent and proud of their work, irrespective of the reward. Lecturers had over and again enforced the learned behaviour by not allowing other students to go away with inappropriate behaviours. In this way, there was proper integration of midwifery theory with clinical practice. The theory had four processes, namely: attention phase; retention phase; motor reproductive phase and motivational phase.

1.9.1.3 Attention Phase

An attention phase is concerned with the characteristics of a model and, for example, interpersonal attraction, usefulness of behaviour and frequent contact with modelled stimuli (Quinn, 2007:99). In this study, professional midwives working in maternity units of the training hospitals acted as role models. The professional midwives who were competent with good interrelation skills stimulated the students' attention. The midwives who were able to do a skill, namely, per vaginal examination step by step as demonstrated in class, who were knowledgeable and had good communication skill had encouraged students to pay attention. In such situations, student did not only observe clinical skills, but also learned good interpersonal skills when they saw midwives interacting with patients and their colleagues. The students thus had good opportunity to integrate midwifery theory with clinical practice.

1.9.1.4 Retention Phase

Retention phase emphasizes rehearsal of the observed behaviour, continuous symbolic rehearsal produced competency (Quinn, 2007:99). The students will be taught theory in class and then allowed opportunity to observe a midwife who performed the

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procedure accurately then retained the observed behaviour by first organizing and symbolically rehearsing before they actually performed it.

1.9.1.5 Motor Reproductive Phase

The motor reproductive phases emphasize capability of carrying out the observed behaviour and evaluate it in terms of accuracy (Quinn, 2007:99). In this study, a midwife who led by example, who invited students to come and watch as she performed procedures and was willing to explain anything to students had encouraged them to perform the modelled behaviour under her supervision allowing them to integrate theory with practice. The midwives who were willing to help had also assisted in assessing students' competency before they actually performed their examinations.

1.9.1.6 Motivational Phase

This motivational phase emphasizes reinforcement and reward (Quinn, 2007:99). A reward or positive feedback will influence students to imitate the observed behaviour (Quinn, 2007:99). In this study, reinforcement was the work of the facilitator /lecturer. The lecturers had reinforced the observed behaviour during accompaniment through spot teaching and continuous assessment. The students who passed the assessments were motivated to learn more, thus encouraging them to integrate theory with practice. In this study, reward was positive feedback from the professional midwives and permission to progress to the next level. As students were progressing from lower to higher grade, they also gained insight into the subject matter. Students also set personal objectives to achieve, like completing the course in record time. The students with a goal to complete the course were motivated, thinking that they will get better

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salaries to better their lives. The motivated students were able to apply theory and practice, and thus became competent practitioners. In conclusion, social learning theory is a powerful tool in midwifery training as it allows learning through interaction and complex patterns can be acquired in more efficient ways than trial and error. Learning was, therefore, envisaged as behaviour acquired by observation of modelling which provided the learner with a mental image of observed behaviour, which had served as a guide. Therefore, the process of imitating and imagining good role models and reward assisted the students to integrate theory with practice.

1.10 Research Design and Methodology

The research design of this study was qualitative, explorative and descriptive because the respondents were narrating their own lived experiences. Data collection and analysis had occurred simultaneously, the researcher was intensively involved and field notes were also taken to enrich the data (De Vos, Strydom, Fouché and Delport 2005:75). Detailed information of the design and method are outlined in Chapter 3.

In this study, an explorative and descriptive research design was chosen because of the following reasons:

- The type of design is flexible and unique and evolves throughout the research process; the design has no fixed steps to be followed and cannot be easily replicated;

- It allows for merging various data collection strategies (triangulation) and requires the researcher to be intensively involved, or remain in the field for a long period, and become a research instrument; the unit of analysis in this

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design is holistic, striving for an understanding of the whole.

- The design ensures that the study is done in natural settings where respondents narrate their lived experience.

In this study, research analysis was ongoing to formulate subsequent strategies and to determine when to do fieldwork. Data sources were determined by information richness and observations were modified to enrich understanding (De Vos et al., 2005: 75).

1.10.1 Population and Sampling

1.10.1.1 Population

An accessible population is the portion of a target population to which the researcher has reasonable access, namely, elements within a hospital or unit (Burns & Groove, 2005:342). In this study, the accessible population comprised of midwives who were working in maternity units of Vhembe district training hospitals, student midwives who are at level 4 and undergoing the R425 programme at the Limpopo College of Nursing and lecturers who were facilitating education and training of nurses.

1.10.1.2 Sampling Method and Procedure

Sampling involves selecting a group of people, events, behaviours or other elements with which to conduct a study (Burns & Grove, 2005:34).In qualitative research, non-probability sampling is used. In non-probability sampling, the researcher does not know the members of the population (De Vos et al., 2005:201). This sampling approach also involves non-random sampling since each element does not have an

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equal chance to be selected (Polit & Beck, 2008:340). Non-probability sampling involves several types, including purposive, snowball, theoretical, and volunteers. In this study, purposive sampling method was used. Purposive sampling is referred to as judgemental since it is based entirely on the judgement of the researcher and is composed of characteristics representative of the population (De Vos et al., 2005:202). The researcher had purposively selected the training hospitals and respondents based on the features needed for the study.

In this study, sampling was done in four stages:

- **Stage 1:** Three hospitals which are accessible to the researcher were chosen from 5 training hospitals.
- **Stage 2:** Lecturers who were having 4 and more year's experience of teaching were chosen from Thohoyandou Nursing Campus.
- **Stage 3:** Thohoyandou Nursing Campus student nurses who were in level IV were chosen.
- **Stage 4:** Midwives with 4 years and more experience of service were chosen from the three training hospitals, namely, Tshilidzini, Siloam and Donald Fraser hospitals.

1.10.2 Research Setting

A naturalistic setting is a real life situation where nature takes its course without any interference (Burns & Grove, 2009:359). In this study, the natural setting for lecturers and students was the Thohoyandou Nursing Campus, for the midwives was at their working place, namely, Tshilidzini, Siloam and Donald Fraser hospitals.

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1.10.3 Data Collection and Analysis

Data were collected during in-depth interviews with the lecturers and the midwives to explore and describe factors affecting the integration of midwifery nursing science theory and practice. The focus group interview was used to collect information from the students. The researcher was the main research tool or primary gathering instrument. The researcher used reflexivity, intuition and bracketing to exclude preconceptions of the phenomena in order to enter the world of the participants with an open mind. Permission to record the interview with audiotape was obtained. The researcher conducted the interviews until data saturation was reached. The data collected included the field notes, transcript from the interviews and was analysed qualitatively using Tesch's 8 steps of open-coding as described in Botma et al (2010:223).

1.10.4 Trustworthiness

Trustworthiness constructs and criteria of Lincoln & Guba's model (Lincoln & Guba, 1985; Shenton, 2004) considered for this study, included credibility, transferability, confirmability and dependability (Table 1.1).

Table 1.1: Trustworthiness criteria, strategies and applications

Criteria	Strategy	Application
Credibility	Reflexivity and bracketing	The researcher had critically reflected her own biases preferences and preconceptions. Bracketing was achieved by identifying and holding any preconceived beliefs and opinion about the phenomenon under study.
	Prolonged engagement	During data collection, the researcher ensured that there were adequate resources and time to stay in the field to establish rapport with the respondents.

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	Member check	The transcribed data were shared and discussed with the respondents to ensure that ideas were not twisted
Transferability	Stepwise replication	The data and analysis were then checked for compatibility and similarity; discrepancies were resolved through member checking with the respondents.
	Sampling	The researcher had selected the respondents purposefully; suitable informants with required knowledge and experience were selected.
	Dense description	A detailed description of methodology was done and the research context and setting was sufficiently provided.
Dependability	Audit trail	The researcher had detailed the decision made before and during the research. Nonverbal communication during interviews was documented to enrich data.
	Inquiry audit	The data were scrutinized by an external reviewer to determine dependability and confirmability.
Confirmability	This occurred with: • Credibility • Transferability and • Dependability	The researcher had ensured trustworthiness and rigour, and proved confirmability through credibility, transferability and dependability. The conclusions and interpretation had been derived directly from the data.

1.10.5 Ethical Considerations

Ethical clearance was obtained from the University of Venda Health, Safety and Research Ethics Committee; permission to collect data was sort with the Limpopo Province Department of Health, the Vhembe district and the management of Thohoyandou Campus and the training hospitals. Informed consent was obtained from the respondents (Annexure 2B). The respondents were advised that participation was voluntary and that they could withdraw at anytime if they felt threatened, without

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punishment or victimization.

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1.10.6 Limitations of the Study

In this study, transferability of research findings may not be possible, like most qualitative studies where transferability is not feasible. The researcher had conducted the study in one district and a Nursing College in Vhembe district of Limpopo Province and because the sample size is limited, this cannot lead to generelization the results.

1.10.7 Dissemination of the Study Findings

The research report will be submitted to the Limpopo Province Department of Health, Vhembe district training hospitals and the nursing campus. The results will be submitted to journals for publication. Oral presentations or posters may be presented in organized conferences.

1.11 Layout of the Study Chapters

Chapter 1: Overview of the Study

Chapter 2: Literature Review

Chapter 3: Research Design and Methodology

Chapter 4: Data Analysis, Discussion and Literature Control

Chapter 5: Recommendations, Conclusions and Limitations of the Study

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1.12 Summary

Chapter 1 provided an overview of the study, which included introduction and background, problem statement, purpose and objectives of the study, research questions research design and method, and ethical considerations. The relevant concepts were defined as used in this study. Chapter 2 reviews literature in the context of the study.

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LITERATURE REVIEW

2.1 Introduction

Chapter 1 provided the orientation to the study. This chapter deals with the existing body of knowledge in the field of midwifery training as well as integration of midwifery science theory with clinical practice. It covers a review of literature related to the study.

2.2 Purpose of the Literature Review

A literature review is a critical summary of research on a topic of interest, often prepared to put a research problem in context (Polit & Beck, 2008:757). Mouton (2001:87), defined a literature review as an examination of the existing scholarship or available body of knowledge that helps the researcher to see how other scholars have investigated the research problem that s/he is interested in. The literature review is aimed at contributing towards a clearer understanding of the nature of the problem that has been identified (De Vos et al., 2005:123).

In this study, the researcher reviewed the literature before the data collection to become acquainted with the body of knowledge and to learn how other scholars investigated the research problem. The researcher also wanted to gain insight on academic writing skills and develop a clearer understanding on the topic under study.

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After the data analysis, the researcher discussed the research in the context of the literature reviewed.

The literature review covered the following aspects:

History of nursing and midwifery training;

- Standards for midwifery education and training;
- Integration of theory and clinical practice in nursing and midwifery training in European countries;
- Integration of theory and clinical practice in nursing and midwifery training in South Africa;
- Core competencies for basic midwifery practice;
- Report by the World Health Organization (WHO) on improvement of health care providers;
- Problems that occur due to poor maternal quality care;
- Role of the professional nurse in integration of theory with practice;
- Role of the lecturer practitioner in integration of theory with practice;
- Role of the student in integration of theory with practice; and
- Teaching strategies that promote integration of theory with practice.

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This section provides a descriptive account of nursing and midwifery training, including how its past had shaped the present and how current times are influencing and delineating its future.

2.3.1 Nursing Education: Past, Present and Future

A study done in United States of America (USA) by Scheckel (2009:27) described the sequence of nursing education, starting with a practical nurse, the most basic level, and progressing to more advanced programmes. In the past, nurses were only taught basic skills to render elementary nursing care. This started after the industrial revolution when there was a demand for skilled health care providers during war. A group of young Christian women who moved from rural to urban areas started the training, and the training was 12-18 months. Brooklyn, New York offered the first formal practical nursing course. Integration of nursing theory with clinical practice was not emphasized as the training was: done at bedside, more vocational than comprehensive and training concentrated more on acquisition of skills needed by the specific hospital or area of the need.

During this period, nurses had fewer hours of classroom teaching than practical training. Teaching was based on the needs of the particular hospital rather than on the educational ambitions of the student, and mostly occurred at bedside that requires hands-on experience. The students were taken as workforce and were paid a stipend. This was economical for hospitals as more employees would be students who would be paid less. Academics saw this practice as depriving because learners were denied diversified and intensive or critical learning outcomes, making them to be more

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vocational rather than independent practitioners. Goldmark (1923) recommended higher education standards for practical nurses, and an improved training environment and laws regulating their practice. The recommended major changes included the development of a more comprehensive philosophy.

Brown, White, & Leibbrandt (2006) advocated vocational education for practical nurses and registered nurse education to move to institutions of higher learning. Another recommendation was the elimination of diploma programme to change to a 2-year course of study for student nurses in the college. In 1950, the diploma in nursing was reformed to a bachelor's degree. The changes in the health care system such as rapid advances in medical technology and the expansion of knowledge in the treatment for diseases required nurses to have a sound theoretical preparation. The changes signified the changes in hospital-based diploma programmes and the beginning of nursing education to occur at colleges and universities. The changes allowed both college and university diplomas to acquire competencies in research leadership and critical thinking.

In the 1950s, nurses had the opportunity to obtain a Masters degree. Rutgers University in New Jersey offered a Masters degree in psychiatric nursing—this opened opportunities for Master's studies in nursing, in 1984, and there were too many Masters' degrees. The Master's degrees were mostly preparing nurses for specialities. Recent Masters include a movement towards a clinical nurse leader, with the objective of preparing nurses with a Masters in Education to develop methods for improving patient care and coordinate evidence-based care. However, since the 1920s there was introduction of Doctoral education that prepared nurses for administration and

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teaching roles, and enabled nurses to conduct research and develop nursing knowledge and theories.

In 1965, the American Nursing Association (ANA) published a paper positioning the licencing nursing schools to be prepared in institutions of higher learning (universities). The ANA also stated that the minimum preparation for a professional nurse should be the baccalaureate degree, nursing education which emphasised active participation by the student, rather than passive participation in the learning process. Doctoral programmes are entering a new era; it is proposed that the programmes may become terminal degrees for advanced practical nursing by 2015. This upward mobility aimed at producing a nurse practitioner who is competent and who can be on par with local, national and global demands. This includes a practitioner who is independent with critical thinking skills and evidenced-based research-orientated to bridge the gap between theories with practice and be of assistance in meeting the (Millennium Development Goals (MDGs) by 2015. It was during this period that the problem of integration of nursing theory with clinical practice had started as the preceptors who were assigned to hospitals were redeployed and this left a gap between theory and practice because students were now attached to the universities and colleges (Jerlock et al., 2003:219).

2.3.2 History of Nursing Education in the Eastern Mediterranean Region

The Eastern Mediterranean Regional Office (EMRO) is composed of Bahrain, Egypt, Jordan, Kuwait, Sudan, and United Arab Emirates. These countries had a slow progress insofar as nurse training was concerned until the 1978 Alma Ata declaration on primary health care (PHC). In 1950 there were only 40 schools in the entire region

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and no degrees were offered in nursing. Only girls were allowed to become nurses until 1965 when only 60 schools out of 144 accepted males to train as nurses, only two countries had started with a degree course, and in 1984 one country had started with masters (WHO EMRO, 1998:11). Since 1984, the region has been establishing university education in many countries and a number of countries now have well-qualified nurses with leadership skills. The countries are now trying to establish a well-developed training and education paradigm that will meet global standards. The need to improve nurse training included an increase in the scope of practice. The region is also gearing the training of nurse specialist like nurse educators, intensive care, midwifery, primary health care, etc. Other countries are now offering a Masters in nursing education and specialization in variety of areas (WHO EMRO, 1998:14). This implied that integration of nursing theory with clinical practice was lagging in this region.

2.3.3 History and Future Vision of Nursing Education in Nigeria

The history of nursing and midwifery in Nigeria mimics that in USA and UK. The nursing schools or training of nurses was stated by government as an informal apprenticeship or on the job manipulative skills acquisition in 1949. The training was subservient to institutional rules, regulation of practice and ethical conduct, with minimal opportunities for creativity, accountability, independent clinical decisions or professional development. The programmes provided were basic or post-basic: general nursing (3years/18months); midwifery (3years/1year); psychiatry (3years/1year), respectively. The certificates of these programmes have been quantified to be equivalent to a national higher diploma certificate (Agbedia,

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2012:277). This indicated that the integration of nursing theory with practice was also a problem in Nigeria.

Currently, graduates from these programmes can proceed to university as a direct entry into a four-year programme to obtain a qualification of Bachelor of Nursing Science. At present, no nurse is holding a single qualification; females with a general nursing education typically enrol for midwifery to obtain double qualifications. After years, she can add another qualification making upward movement of nurses challenging. Presently, 18 universities now have multiple programmes that prepare nurses at different levels, masters and doctoral degree (Agbedia, 2012: 277).

The upward mobility was aimed at improving the integration of nursing theory with clinical practice to come up with a skilled nurse practitioner who can practice independently. Nigeria had devised some strategies to improve nursing and midwifery training to bridge the gap between theory and practice. The initiative was necessitated by challenges of increased maternal deaths, shortage of nurses and nurse educators. The strategies will undoubtedly assist universities to produce competent, resourceful nurse practitioners equipped with knowledge and skill that ensure a care that is acceptable and efficient. The strategies include reforming nursing education, setting research priorities, mentoring, integrating technology in nursing education, funding of nursing education, continuous professional development and effecting research criteria for ward sisters (Agbedia, 2012:278).

2.3.4 Transformation of Nursing Education in South Africa

A study done by Mekwa (2000:272) in South Africa on the transformation in nursing education, appraised the structure of nursing education prior to 1994 and present, and

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reflected on some envisaged changes. Since 1899, nursing education evolved and only two programmes existed prior to 1994, i.e., pre-registration and post-registration.

2.3.4.1 Pre-Registration Programmes

Pre-registration programmes entailed a comprehensive 4-year diploma or degree; a two year diploma in general nursing referred to as bridging; a two year certificate leading to registration of an enrolled nurse and a certificate programme leading to registration as an enrolled auxiliary nurse.

2.3.4.2 Post-Registration Programmes

Post-basic degree programmes were aimed at specialization in Nursing Education, Nursing Administration and Community Health Nursing by combinations of two or three programmes. Others were a post basic diploma leading to a variety of single diploma qualifications in the above fields; post basic certificates, honours and masters degrees. In 1997, Nursing Education was moved to institutions of higher learning to assume the same status as education in other professions. This was done under the provision of the Higher Education Act, No.101 of 1977, the process led to loss of employee status by the nursing student and loss of a readily available workforce for health departments. The majority of the stakeholders welcomed the idea and the idea was endorse in the nursing summit in 1999. The SANC released a circular in 2000 stating that enrolled auxiliary, enrolled nursing bridging course, and 1-year midwifery will remain in the workforce until the necessary consultations were completed (Mekwa, 2000:276). The movement from bedside to higher institutions thus created a gap between nursing theory and practice which most researchers are trying investigate

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in order to come up with a strategy that will address this incongruence (Corlett, 2000:500).

2.3.4.3 The Four-Year Comprehensive Course

This course is not a newcomer to the nursing education scene this was the programme that was moved to institutions of higher learning together with the post-basic programmes. The main objective was to promote nursing education to become student-centred rather than lecturer-centred, with the idea of producing a competent, independent, critical-thinking and research-orientated lifelong learner. This change accompanied the recommendation that all learners from this programmes need to be introduced to research. The SANC recommended six principles: outcomes-based learning (OBL), community-based learning (CBL), problem-based learning (PBL), recognition of prior learning (RPL) and research. A survey done in 17 universities and 12 colleges indicated that the majority of universities and colleges adopted these principles (Mekwa, 2000:277). The 4-year comprehensive programme was inherently flawed and counter-productive due to the fact that in South Africa cultural issues force many male graduates to become reluctant to engage in midwifery practice, rendering midwifery qualification redundant for male nurses. There is thus a need to restructure the course, to make it more flexible, and to consider individual rights and preferences (Mekwa, 2000:277).

2.3.4.4 Clinical Experience for Students

The R.425 SANC regulation stipulates the number of hours in all four major subjects to try and measure clinical competency, the prescribed hours may not guarantee the competency rather come up with the measure to control the attainment.Therefore,

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there is a need for clinically based role models or preceptors who will assist students to attain clinical competencies (Mekwa, 2000:277). History indicates that there is still poor integration of nursing theory with practice, irrespective of number of hours spent in clinical facilities.

2.4 Standards of Midwifery Education and Training

2.4.1 Introduction

The purpose of nurse educational standards is to establish quality nursing education in order to protect society by ensuring competent practitioners. Standards should include steps to ensure the value of nurse training, knowledge, skills and attitudes in accordance with current health needs and the current science of nursing. Standards also provide a means of measuring the degree of excellence of educational programmes and comparing it with others. Many countries around the world have developed national standards to control their education and training. The standards were developed with the aim of improving the integration of nursing theory with clinical practice (Nursing and Midwifery Council (NMC), 2009:01).

2.4.2 Global Midwifery Standards

With adoption of the 2002 position statement, the International Confederation of Midwives (ICM) identified the need to establish guidelines for the development of regulatory standards to further enable member associations to achieve regulatory processes appropriate for the practice of midwifery in their country, the standards were meant to improve integration of midwifery theory with clinical practice and to produce competent midwives who will help the country to meet the Millennium Developmental Goals (MDGs).

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In 2005, ICM adopted a further position statement titled "Legislation to Govern Midwifery Practice". This position statement provided a set of statements about what midwifery regulatory legislation should provide. These statements are as follows:

- Enable midwives to practice freely in any setting;
- Ensure the profession is governed by midwives;
- Support the midwife in the use of life-saving knowledge and skills in a variety of settings in countries where there is no ready access to medical support;
- Enable midwives to have access to ongoing education;
- Require regular renewal of right to practice;
- Adopt a definition of the Midwife appropriate to the country within the legislation;
- Provide for consumer representation on the regulatory body;
- Recognize that all women have a right to be attended by a competent midwife;
- Allow for the midwife to practice in her own right;
- Recognize the importance of separate midwifery regulation and legislation which supports and enhances the work of midwives in improving maternal, child and public health;
- Provide for entry to the profession that is based on competencies and standards and which makes no distinction on routes of entry;

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- Provide the mechanism for a regulatory body that is governed by midwives with the aim of protecting the public;
- Provide for regular review of the legislation to ensure it remains appropriate and up-to-date, as midwifery education and practice and the health services advance;
- Encourage the use of peer review and analysis of perinatal, maternal and neonatal outcomes in the legislative review process;
- Provide for transition education programmes in the adoption of new legislation requiring increased levels of competency of the midwife (ICM, 2011:2).

2.4.3 Standards of Midwifery Education and Training in the United Kingdom

2.4.3.1 Academic Standards

Since 2008, the minimum academic level for entry to the midwifery part of register is at the degree level with minimum of 300 and maximum of 360 credits, 60 of which must be at level 9 (NMC, 2009:17).

2.4.3.2 Length of the Programme

The length of training is no less than 3 years equivalent to 156 weeks full-time, full-time not more than 5 years and part-time not more than 7 years, where a student is already registered with the NMC as a nurse the length is 18 months (NMC, 2009:17).

2.4.3.3 Student Support

Students need to be supported both in academic and clinical practice, the teachers and mentors need to have knowledge, skills and expertise needed to support the students

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and be able to identify clinical learning opportunities that will assist students to provide quality care and become competent. Teachers are expected to cover 20% of their teaching time in clinical practice. Together with mentors, teachers need to assist students to integrate theory with practice. Teachers need to conduct clinical audits regularly to ascertain the number of students to be placed at a time to promote a conducive learning environment in clinical areas (NMC, 2009:18).

2.4.3.4 Balance between Clinical Practice and Theory

Since September 2008, the practice to theory ratio that was believed to bridge the gap was no less than 50% of practice and 40% theory to enable students to achieve the NMC standards. During practice, the student is under direct or indirect supervision. Direct is when the practising midwife is in close proximity to student, whereas indirect enables the student to develop confidence and independence. Indirect supervision is easy with more senior students than neophytes in the field (NMC, 2009:19).

2.4.3.5 Scope of Practice Experience

The students are involved with the birthing women, including antenatal, intrapartum and postnatal care, under the supervision of teachers or practising midwives supervision is meant to assist students to bridge the gap between theory and practice (NMC, 2009:19).

2.4.3.6 Supernumerary Status During Clinical Placement

Students cannot be employed to provide midwifery care during training. All clinical exposure should be student led with students having supernumerary status for the duration of training. Supernumerary students are additional to the workforce and they

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are placed in an institution to learn what is required of their learning objective. This led to students doing want is prescribed and not beyond, this affected their opportunity to integrate theory with practice (NMC, 2009:20).

2.4.3.7 Assessment Strategy

To promote the integration of theory and clinical practice, clinical practice was graded and counted as part of the academic award. Summative assessments are done to allow student entry into formative assessments. Re-testing is allowed for those who were not competent at once, and those who fail are not registered with the NMC at the end of the programme and, as such, promote the integration of theory with clinical practice (NMC, 2009:21).

2.4.3.8 Ongoing Record of Achievement

To promote the integration of theory with clinical practice, an ongoing record of achievement, including comments from mentors, must be passed from one placement to the next to enable judgement to be made on the student's progress. This ensures that students will have achieved the clinical competence required, and not just recognized based on students' progress on theoretical achievement only (NMC, 2009:22).

2.4.3.9 Competencies Required Achieving the NMC Standards

Four domains which had included both theory and clinical competencies which indicated that students had integrated theory with practice were needed; effective midwifery practice; professional and ethical practice; developing the individual

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midwife and others; and achieving quality care through evaluation and research (NMC, 2009:23).

2.4.4 Standards of Midwifery Education and Training in the Eastern Mediterranean Region

2.4.4.1 Educational Institutions

The institution can be public or private, and governed by the council or board formed by the community, government agencies and nursing bodies. The qualified nurse educator administers the institution. The line of management is clear and system of communication is well established. Administrative functions support the development of teaching staff and promote a conducive working and learning environment (Eastern Mediterranean Region (EMRO), 1998:19).

2.4.4.2 Teaching Staff

Teaching staff should hold a minimum of the Bachelor of Nursing Science degree or equivalent qualifications have appropriate clinical experience and trained in teaching. Must be a lifelong learner and actively involved in community development. Both clinical and teaching staff must be registered with the quality assurance body. The overall ratio of students to teaching staff is at least 15:1; these requirements were to make sure that both clinical and teaching staff was competent enough in assisting nursing student to integrate theory with clinical practice (EMRO, 1998:20).

2.4.4.3 Administrative and Educational Support

For the purpose of proper integration of nursing theory with clinical practice there was a need to have administrative staff adequate to support the institution's function and

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ensure that teaching staff potential and talent and time is efficiently used. The institution has a well-equipped library, laboratories and media resources that enabled lecturers and students retrieve relevant information that supports training. The institution staff included trained technicians to handle maintenances (EMRO, 1998:20).

2.4.4.4 Physical Facilities

There is sufficient number of classrooms, which are appropriate in size, equipment, supports learning and teaching like group lectures, etc. Conveniently located offices for teaching staff, administrators and support staff. Learning laboratories are well-equipped and spacious enough to meet students' needs without crowding and is run by qualified staff. Facilities for clinical training include hospitals, clinics and other agencies, industries and homes that made it possible for students to be allocated adequately without overcrowding, hence promoting the integration of theory and practice. Transport to clinical agencies is available and residential accommodation is similar to that provided for other institutions of higher education, transport assisted the lecturers and students to reach clinical placement in time and assist students to correlate theory with practice (EMRO, 1998:20).

2.4.4.5 Curriculum

The curriculum that was to promote the integration of theory and addresses the need of the population within the context of the health system in the country practice was developed by teaching staff in collaboration with the community. It combined both theory and practice. The curriculum was evaluated every 5 years to make sure that there is no gap between theory in practice, and this includes graduates, employers and

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consumers. The process gave opportunity to include teaching, assessment strategies that encouraged integration of theory with clinical practice (EMRO, 1998:25).

2.4.4.6 Teaching-Learning Process

A variety of teaching and learning methods that promoted integration of theory with clinical practice were used, for example, self-learning, participatory seminars, and journal clubs. Faculties are responsive to individual learning needs and provide students with opportunities to attain educational objectives. Clinical and fieldwork settings have written objectives and guidelines for orientation, teaching and evaluation of students at various levels (EMRO, 1998:26).

2.4.4.7 Evaluation

Student's progress in developing clinical skills is continuously assessed, student satisfaction is assessed by semester examinations and achievement is assessed by national examinations, and the progress possible if the results included both theory and practice (EMRO, 1998:27).

2.4.5 Standards of Midwifery Education and Training in South Africa

The SANC set standards for establishment and outcomes of the nursing education and training programmes, including midwifery. SANC sets and maintains standards, and ensures that nurses and midwives keep their skill and knowledge up-to-date, and upholds the standards of their professional code and is within the legal and ethical frame work of the practice.

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2.4.5.1 Curricula and Clinical Learning

Different universities, colleges and nursing schools developed the curriculum and submitted it to SANC for approval. SANC provides internal and external moderation. The programmes are aligned with the National Qualifications Framework (NQF). The SANC ensures facilitation and mentoring by experts. The curricula provide core content that will enable graduates to meet the established competencies (SANC, 2005:37).

2.4.5.2 Clinical Lecturer

Should be an expert in clinical and educational areas or have a speciality qualification in midwifery so that she would be able to assist students to integrate theory with practice. The lecturer should be excellent in education or have 3 years of experience in clinical teaching, clinical practice and research. The lecturer should have good communication skills, electronic competence, and a valid driver's licence, be accessible to students and act as a role model (SANC, 2005:97).

2.4.5.3 Nursing Education Institution (NEI)

SANC should be accrediting the NEI, and the NEI registers with the quality assurance body. The NEI should be equipped with classrooms, a library, and laboratories or simulation rooms (SANC, 2005:103).

2.4.5.4 Clinical Facilities

The SANC assesses hospitals and clinics for approval and accreditation. The NEI places students to the approved facilities and needs to conduct regular situational

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analyses of the clinical placement to ensure that the facilities are still fit for training. The SANC also do regular inspections to maintain fitness.

2.5 Integration of Theory and Practice in Nursing and Midwifery Training in Other Countries

This section outlines the integration of nursing theory with clinical practice in European countries and South Africa.

2.5.1 Integration of Nursing Science Theory with Clinical Practice in European Countries

2.5.1.1 Importance of Theory before Practice

In Australia, a study conducted by Grealish and Smale (2011:51) emphasized theory before practice and identified factors like transfer of nursing education into the higher education sector, increased number of students and the need for critical learning requirements of tertiary-based students. The other factors included students coming from different universities with different curriculum expectations. The increased number of students led to increased tension in the clinical placements that interfered with learning in practice. The other challenge that arose was shortage of qualified personnel in the units to supervise practical learning, hence it interfered with integration of theory with practice. Increased numbers of students also make it difficult to negotiate student access to workplace experience. During the early stages of midwifery education, the above challenges were not there as the curriculum was developed from within the local training hospitals, with more emphasis on practice supplemented with theoretical lectures and validated by a government regulatory authority (Grealish & Smale, 2011:51).This led to some experts advocating theory before practice and a call to professionals to consider putting some emphasis in

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practice. This idea was strongly supported by those who suggested that nurse should make scientific contributions to health outcomes of individual patients (Grealish & Smale, 2011:51).

2.5.1.2 Integration of Theory with Practice

A study done in the USA on how best theory and practice can be integrated in nursing, outlined the following factors that negatively affected integration of theory with clinical practice: shortage of qualified nursing staff affected integration as there was not enough mentors to assist students to put theory into practice in the units, reduced period of stay of patients and decreased acute-care admissions in the wards deprived students of opportunities to be exposed to nurse the patents, and limited clinical facilities led to overcrowding of students and less opportunities to learn (Lisko & O'Dell, 2010:106).

The authors recommended that students should be exposed to simulation using manikins and other models. Other approaches that could be used to educate students were to present nursing literature on scenario-based critical skills testing; this approach also accommodates individual learning styles. The clinical learning took place on a campus, in the laboratory. The method used to review previously taught skills and to familiarize students with the process were procedural skill demonstration with return, scenario-based presentation and reflection. Students also had opportunities to utilize interactive skill videos, participate in supervised skill demonstrations and use the nursing library. They also had an opportunity to experience all aspects of learning cycles, including concrete experience, reflective observations, abstract conceptualization and active experimentation (Lisko & O'Dell, 2010:106).

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The students' evaluation was positive as objectives of integrating theory and practice were met. The students mostly rated the scenario-based learning and evaluation as the best form of integration as it brings together theoretical knowledge obtained in the classroom and psychomotor skills learned in laboratory and clinical practice. Many students, as a result preferred, to practice in the nursing laboratory prior to testing (Lisko & O'Dell, 2010:106). In this curriculum, human patient simulators were also preferred. This was also useful as it offered important alternatives to contextual learning and a means to facilitate the development of nursing students' critical thinking abilities (Lisko & O'Dell, 2010:106).

2.5.1.3 Making Practice Perfect

In Scotland, a study done by Paterson & Burns indicated that mentoring is of benefit to students. Mentoring ensures support by practicing nurses who are up-to-date. The mentors also created conducive learning environments while ensuring supervision and guidance. The other factor outlined was students' participation. Students were offered an opportunity to identify their learning needs as well as an evaluation of integration of theory with practice during their placement (Paterson & Burns, 2005:12).

The nurse educators had the responsibility to evaluate the practice placement to ensure that the students benefited during the placement. The evaluation helped the institution to achieve the required proficiency needed for registration. Educators also needed to provide the health professional with relevant indicators of the theory covered in class to enable them to help students starting from the known to unknown. The theory covered helped the mentors to understand what the students could do and what they could not. With this response, nursing schools were able to ensure that each

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placement received the document or booklet that indicated the theoretical work done in class and incorporated the clinical skills list into each competency booklet that allowed mentors to see at a glance the skill level attained by a student in specific parts of their theoretical programmes (Paterson & Burns, 2007:14).

The support of mentors in nursing schools/colleges yielded good results, especially if the students remained in the same geographical place throughout their period of training. Theory, when taught to students properly also prepared them for integration of theory with practice (Paterson & Burns, 2005:15).

2.5.1.4 Learning for Reality

In a study done by Bendall in England, learning for reality indicated that students started by leaning theory in class; then they applied the theory in practice. The study outlined shortage of staff in the placement, increased workload and management jargon as some of the obstacles. These gave rise to problems, as students were unable to apply learned theory to practice (Bendall, 2006:14).

From the above studies factors affecting integration of theory with clinical practice were: shortage of staff, reduced period of hospital stay of patients, movement of nursing training from hospitals to institutions of higher learning, diverse students from different cultures and ethnic groups, and increased workload and incomprehensible management jargon. In the Vhembe district of Limpopo Province, the above factors have not been scientifically proven or documented.

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2.5.1.5 Factors Affecting Integration of Theory with Clinical Practice

In the study done in Ireland revealed that, lecturers played an important role in facilitating both classroom and clinical learning (Landers, 2000:154). Landers argued that lecturers need to have sufficient clinical competency to support students during clinical practice, and they need to identify the appropriate method or strategy to integrate theory with practice (Landers, 2000:155). In a study done in Dundee, UK, by Corlett, good sequencing of theory and practice and length of placement practice as the factors affecting bridging the gap between theory and clinical practice were identified (Corlett, 200:504).

Jerlock and Severinsson (2003:227) did a study in Sweden and Norway, which had outlined factors like decision-making and moral judgment of the students as well as creativity, open-mindedness and flexibility as other factors that can affect integration of theory and clinical practice. They further argued that the ability for self-directed learning through formulating own goals and choosing of a learning strategy play a role in facilitating of integration of theory and clinical practice.

In Finland, Saarikoski,Warne, Kaila and Leion-Kilpi (2009:599) did a study that identified the challenge of inability to use new technology like CCTV by both lectures and preceptors to integrate theory with clinical practice. They asserted that the use of CCTV enabled the mentors and lectures to learn differently in providing more effective and blended-learning opportunities for students. The above studies also outlined different factors that affected integration of nursing science theory with clinical practice in other countries. Such factors lack documented evidence in the Vhembe district of Limpopo Province.

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2.5.2 Integration of Nursing Science Theory with Clinical Practice in South Africa

In a study done by Lekalakala and du Rand (2005:22), a model for nursing education sought to find an effective model for facilitation that will enable the student to integrate theory and practice in nursing. Models like outcome-based learning, community-based learning and inquiry-based learning were discussed. The preferred teaching and learning strategy was small group discussion, which provided opportunity for expertise from the members and encourages diversity. The challenge of these models was that they were problematic for students and lecturers. The students were not exposed to programmes that stimulated self-directed learning, although these models, if well executed, may enhance correlation between theory and practice.

Maunye, Meres and van Velden (2009) assessed teaching strategies used by lecturers at Mpumalanga College of Nursing, and discussed different strategies that enhanced learning. The most effective strategies were, amongst others, formal lectures and clinical rounds with a portfolio of evidence at the end of the list. Most of the common strategies were used, but not fully due to lack of facilities, materials and shortage of staff. For the strategies to be effective, the facilitation needed more staff, enough materials and updated lecturers. If the above challenges could be addressed, there will be a good integration of theory and practice.

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2.6 Core Competencies for Basic Midwifery Practice

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2.6.1 Introduction

Competency is the combination of knowledge, psychomotor, communication and decision-making skills that enable an individual to perform a specific task to a defined level of proficiency (ICM, 2008:09). The core competencies for basic midwifery practice describe the essential or elementary knowledge, skills, and behaviours expected of a practitioner. They guide policy makers, lecturers, midwife practitioners, students and consumers. The competencies also constitute the basic prerequisites for graduates of midwifery education programmes (American College Nurse-Midwife (ACNM), 2008:1). In this study, this section of literature review describes core competencies that were considered essential in guiding midwifery training. These were the competencies that were to be included in the learning package of midwives in various countries to ensure that the relevant theory of basic midwifery was covered before the students were placed in different clinical settings, and before the completion of their training, to enhance integration of theory with clinical practice.

2.6.2 Core Competencies for Basic Midwifery in America

These were the essentials or elementary knowledge that guided basic midwifery training and practice in the US, and expanded the scope of midwifery beyond the core competencies to incorporate additional skills and procedure that had improved integration of theory with clinical practice and improved the care of women and their families (ACNM, 2008:1). The core competencies were:

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2.6.2.1 Hallmarks

The hallmarks include the following, but not limited to these only: for proper integration of midwifery theory and clinical practice, midwifery training should include recognition of pregnancy; birth and menopause; advocacy; scientific evidence; family-centred; continuity; promotion, preventive and curative aspects. The other aspects are therapeutic communication, value of culture and collaboration with other health team members, etc. (ACNM, 2008:2).

2.6.2.2 Professional Responsibilities

Students need to be taught the above midwifery hallmarks; knowledge of history and ethical or legal or policies and systems aspects; knowledge of national and international issues during midwifery training to instil them with expected professional responsibilities. The knowledge of the structure and function of licensures, clinical privileges and accreditation should form part of their learning package as well as knowledge of philosophy; standards and code of ethics and, as such, assist them to assume responsibilities to improve their competency (ACNM, 2008:2).

2.6.2.3 Midwifery Management Process

The training modules should include aspects of investigation and evaluation; identifying of problems and making a diagnosis; anticipating other potential problems; identifying those patients that will need a midwife and those that need a doctor; intervening; evaluating the intervention; involving other team members, developing a partnership with the woman; evaluating the effectiveness of the care given so that

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students can learn the skills theoretically and then assisting them to integrate the skills with clinical practice (ACNM, 2008:3).

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2.6.2.4 Midwifery Care: Fundamental

The fundamentals of midwifery training such as anatomy and physiology; normal growth and development; clinical genetics; psychosocial, sexual and behavioural development; basic epidemiology; nutrition; pharmacokinetics and pharmaco-therapeutics; bioethics related to the care of women, newborn and families should form part of midwifery training curricula to assist students to relate theory with clinical practice, for example, student who have knowledge of the anatomy of the pelvis will learn easy how to perform pelvic assessment as they know the important landmarks (ACNM, 2008:3).

2.6.2.5 Child Bearing Family Antepartum (Prepartum)

Students need to be taught the positive signs that assist them in the confirmation of a pregnancy; sign to detect genetics problems; epidemiology; promotion of breast-feeding; comprehensive antenatal care; identify deviation from normal (ACNM, 2008:4).

2.6.2.6 Intrapartum Care

Confirm true labour; assessment of maternal and foetal status; pick up deviation from normal, including obstetric emergencies; psychological and emotional support; pain relief techniques; management of second, third and fourth stages of labour; performance and repair of episiotomy and lacerations; techniques to manage emergencies and complications during intrapartum (ACNM, 2008:5).

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2.6.2.7 Postpartum Care

Postpartum self-care, newborn care, feeding and family planning; facilitation, initiation and establishment of lactation; identify deviation from normal and manage any discomfort (ACNM, 2008:5).

2.6.2.8 Newborn Care

Facilitate bonding; assess foetal risk factors; assess and evaluate gestational age; facilitate adaptation to extra uterine life; promote and assess growth; facilitate and establish continuous lactation; identify deviation from normal and manage (ACNM, 2008:5).

2.6.3 Core Competencies for Basic Midwifery in Australia

To provide family planning; diagnose pregnancies; recognize abnormalities in time and cooperate with doctors; to prepare women/couples for parenthood; to conduct spontaneous deliveries (including episiotomy and breech delivery in urgent cases) (European Midwife Liaison Committee; EMLC, 2001:17).

2.6.4 Core Competencies for Basic Midwifery in Finland

Provide antenatal classes; antenatal check-ups; normal delivery, including episiotomy and suture; assistance in case of abnormalities; postnatal (home) visits and parental education, e.g., breast-feeding and parenting skills (EMLC, 2001:36).

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2.6.5 Core Competencies for Basic Midwifery in Germany

To provide antenatal examination and monitoring; antenatal classes and counselling; treatment of disorders during pregnancy such as diabetes, hypertension and anaemia in consultation with the woman and the physician; normal deliveries, including episiotomies; complete postnatal care for at least ten days, including nutrition and follow-up (EMLC, 2001:54).

2.6.6 Core Competencies for Basic Midwifery in Portugal

Provide counselling on conception, fertility and adolescence; preparation for different stages of labour; normal delivery, including analgesia and perineal repair; postnatal care; prenatal education, e.g., breast-feeding and family planning (EMLC, 2001:99).

2.6.7 Core Competencies for Basic Midwifery in South Africa

Apply specific knowledge of bio-natural, pharmacology and social sciences in midwifery using an integrated approach; provide safe and quality midwifery and neonatal care in a scientific, integrated and evidence-based approach in all health care settings; practice independently and professionally within an appropriate ethical-legal framework; improve quality of midwifery and neonatal care through an analytical, reflective and problem-solving approach; and effectively manage a midwifery unit through appropriate clinical governance strategy (SANC,1985).

2.7 WHO Report on Improvement of Health-Care Provider Training

2.7.1 Introduction

The WHO advocated for the establishment of correct and proper institutions for

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training and practice that will produce right workers who are fit for practice. It further stressed that the world health needs are changing and will need modern, up-to-date institutions that are up to standard. This has led to the closing down of many institutions in the USA during the 21st century in organizational efforts to adapt to new challenges.

Worldwide prevalence of chronic diseases, unanticipated outbreaks and the need to meet the MDGs placed enormous expectations and responsibility on the role of health training institutions. A clear understanding of the institutional landscape is required to produce a matured fit-to-practice worker. WHO continues to advocate for the accreditation of institutions as this is an essential mechanism for assessing and securing public trust.

This requires institutions to generate support for their performance and objectives related to training. WHO also advocates for policies that will select students with personality traits that will make them well-suited for health services training. In short, WHO has identified the following factors that would influence proper integration of theory with clinical practice (WHO, 2006:43).

2.7.2 Proper Training Facilities

The WHO advocated for the establishment of proper training schools for both medical staff and nurses. This was because of the African and the Eastern Mediterranean region where health school were not meeting the criterion to train doctors and nurses. Then WHO advocated for the accreditation of schools to secure public trust and to

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promote proper integration of theory with clinical practice during training of health workers and to assure competency of their products (WHO, 2006:43).

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2.7.3 Skilled Facilitators

The WHO was also concerned about the lack of skilled personnel as most poor countries, due to financial reasons, are unable to produce, hire and sustain skilled teachers in medical and nursing schools. This led to a limited pool of teachers who could guide the health training staff. On the other hand, in poor African countries with an increased dropout rate in secondary schools, it becomes impossible to have more students registering in health service training schools. This makes it difficult to have skilled personnel who can assist health trainees to integrate theory with clinical practice (WHO, 2006:43).

2.7.4 Proper Policies

The growing diversity of patient populations and awareness of socio-cultural and linguistic issues pose a problem in policy development. The training institutions are unable to come up with proper selection criteria that will select students with needed attributes for health trainee. This poses a challenge to admit all students even those who may have considered health professional training as an option. The situation has resulted in having students who would not go the extra mile to try to correlate theory with clinical practice because health profession was not their first choice career (WHO, 2006:43).

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2.8 Problems that Occur Due to Poor Maternal Quality Health Care in South Africa

2.8.1 Introduction

The poor maternal care results in many problems, including illness, death of mothers and babies as well as litigations. The effects and problems of poor maternal care are outlined below.

2.8.2 Effects of Incompetence on Maternal Care in African Countries

According to a study done in Uganda, by Konde, Dolamo& Monareng (2011:3), a woman dies from birth complications every minute, with a total estimated to about 529,000 per year. In 2001, about 147 heads of state met to collectively endorse the MDGs. Goal #5 is intended to reduce maternal mortality ratio by 75% (Konde et al., 2011:3). Safe motherhood depends on the availability of a competent provider of midwifery skills at every birth (Konde et al., 2011:4). The proportion of births attended to by trained health personnel is one of the indicators of monitoring progress towards achieving Goal #5 (Konde et al., 2011:4).

Konde et al (2011:5) further indicated that the Safe Motherhood Movement marked its 20th anniversary in 2007, yet only half of the world's women have access to skilled professional care during childbirth. The whole world requires 700,000 midwives to provide universal access to skilled midwifery care (Konde et al., 2011:5). The proper integration of midwifery science theory and clinical practice can be a good vehicle to produce competent midwives instead of producing only the required quantity of midwives.

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Proper integration of classroom midwifery science theory with actual clinical practice in the maternity units will improve training, and improved training produces competent midwives who would bring change in maternal care. This is why the researcher became interested in the identification of factors affecting integration of midwifery science theory with clinical practice in training hospitals.

2.8.3 Increased Maternal Mortality in South Africa

According to the DoH Saving Mothers Tri-Annual Report (2005-2007:6), there is increased maternal and neonatal mortality in South Africa and in the world at large. Maternal deaths from 1999-2001 was 2445; in 2002-2004 it was 3296; in 2005-2007 it was 3959. Perinatal deaths in 2006-2007 were 62,234; in 2008-2009, they were 64 883 (DoH: Saving Babies, 2008-2009:4). These statistics alone indicate that there is a problem in the provision of maternal care and that there is a gap between theory and practice as practicing midwives had passed the classroom examination, but had failed to provide the requisite quality midwifery care that will reduce the maternal and perinatal death rates.

This may be an indication that there is poor integration of theory with practice in the midwifery curriculum. The big five killer diseases are human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), hypertensive disorders, postpartum haemorrhage, antepartum haemorrhage and ectopic pregnancy, as well as killer diseases for the newborns like prematurity, asphyxia and neonatal sepsis (DoH, 2005-2007:6). It is alleged that a competent maternal health care provider can reduce diseases causing maternal and neonatal mortality.

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2.8.4 Litigations

Sellers (2012:19) pointed out the increased litigations in midwifery compared to other categories of nursing in the year 2007 in the USA. She indicated that about 600 midwives in USA have been involved in litigation. The increased litigation may be due to incompetency of midwives, which can in turn be associated with poor integration of midwifery science theory with clinical practice during training.

2.9 Role of Preceptors in Facilitation of Nursing Science Theory with Clinical Practice in the Clinical Setting

A preceptor is a teacher or instructor accompanying inexperienced health workers in order to help them to become knowledgeable and experienced in clinical practice (Booyens, 2008:292). Authors used the word preceptor or mentors interchangeably (Quinn, 2007:377). From the beginning of nurse training, which is from the early 1800s, mentors were the most reliable vehicle to assist students to apply theory to practice, and this practice was possible because nurse training occurred in hospitals at the bedside. The tradition was to teach knowledge and skills that would enable the nurse to practice competently in a hospital setting (Berman et al., 2008:9).

During the 1960s, nursing took the form of apprenticeship with little formal classroom instruction wherein students learned by doing, by providing care to the patients in hospitals. These programmes provided rich clinical experience for nursing students as these nurses leaned through mentoring by professionals in the units. During this time, there were lectures in the classroom who were close to preceptors in the unit, and a preceptor or link nurse made communication possible. The preceptor was acting as a liaison between the clinical department and the classroom (Berman et al., 2008:9).

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Mulaudzi, Libster and Phiri (2009:45) argued that mentoring enables smooth transition from novice nurse to knowledgeable practitioner who is self-reflective and self-confident, and able to negotiate professional and patient relationship well.

Mentors act as resources for students, they made sure that the students received maximum benefit from their allocation to the unit while caring for the mother and her newborn baby during midwifery training (Quinn, 2007:377). The preceptor or link nurses kept the mentors in the units up-to-date (Berman et al., 2008:9). Quinn (2007:356) indicated that some authors argued that mentorship is not well-defined; instead, they opted to use the concept preceptor as they see mentorship as a long-term relationship that extends throughout the students programme, whereas others limit the concept relationship within a specific clinical placement.

A preceptor is appropriately qualified and experienced first-level nurse/midwife/health visitors who, by example and facilitation, guides, assists and supports the students in learning new skills, adopting new behaviours and acquiring new attitudes (Quinn, 2007:356). Mellish, Brink and Paton (2000:217) maintained that preceptors need to know what students have learned in class (theory) to enhance integration of theory with practice. The lectures submits the clinical learning outcomes to the units together with the theoretical aspects covered in the classroom whenever the students are allocated to the unit to make sure that mentors are abreast with what students need to be exposed to during clinical placement. The preceptor's expertise was kept up-to-date through in-service training offered by the training institution.

The preceptors need to know that support is available to boost their morale and motivate them to continue to help students to integrate theory with practice. The

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support can be maintained through established preceptor committees that always liaise with the training college/institution. Preceptors thus serve as role models for the students until they can practice and utilize the same skills themselves (Mellish, Brink & Paton, 2000:217).The above discussion indicates that during the time when there were preceptors in the units of training hospitals there was good integration of nursing science theory with clinical practice.

2.10 Role of the Professional Nurse in Integration of Theory with Practice

2.10.1 Introduction

Professional nurses have an important role in midwifery training. According to the social learning theory by Albert Bandura (Bandura, 2004), as explained in this study, professional nurses act as role models. Students allocated in the training hospitals will have the opportunity to observe the well-trained skilled and experience of professional nurses. The whole process will enable students to integrate theory with practice and they will become competent. Below are the attributes of a professional nurse who is a good role model (Quinn, 2007:100).

2.10.2 Creation of Conducive Learning Environment

The professional nurse has the responsibility to create a psychological climate conducive to learning and this will automatically create a safe physical environment for learning. The safe learning environment will be benefiting both the student and patient, and will enhance the development of a student to become a safe and accountable practitioner, who will add value to the health care service delivery (Meyer, Naudé, Shangase & van Niekerk, 2009:100). A conducive environment is an

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ideal environment that would assist students to practice what they were taught in class at ease, therefore integrating theory with clinical practice.

2.10.3 Characteristics of a Good Learning Environment

For the purpose of this study, a good learning environment is one where there is mutual respect between the nurses and between the nurses and students, where students are also recognized as part of the staff and not taken as irresponsible, and where students are supported and allowed opportunity to perform skills as demonstrated in class. The professional nurse would act as a bridge that assists students to integrate theory with clinical practice. The factors that would help to create a psychological environment conducive to clinical learning, and assist students to integrate theory with clinical practice are:

2.10.3.1 Mutual Respect

A student should be treated as a person in totality, as should the patient. Students are developing professionals and the professional nurse needs to create an environment where they feel free to ask questions and for explanation or discuss problems and to participate in all activities in the unit. The professional nurse should create opportunities in the unit that emphasize respect for the developmental ability of the student and willingness to support the leaner (Meyer et al., 2009:100).

2.10.3.2 Collaboration

The professional nurse has the responsibility to assist students to become skilled and knowledgeable, and it can be achieved by creating an environment where students are part of a group of professionals who are rendering patient care according to the

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philosophy of team work. The learners should be exposed to an environment where all health team members are providing the care, e.g., dieticians, doctors, social workers and so on (Meyer et al., 2009:100).

2.10.3.3 Mutual Trust

The professional nurse needs to allow students to participate actively and enhance professional socialization, and delegate the students some responsibilities under supervision and not take all students as irresponsible. They should stop to give learners routine tasks like bed making or bed bathing and allow them to do the tasks that will unleash their potential. They need to believe in students and not draft them because they may help to bring current knowledge and experience (Meyer et al., 2009:101).

2.10.3.4 Support

The professional nurse needs to guide learners on the procedures that they are not yet competent in; this support will help students to move from the attitude of not knowing that of knowing, from not being able to do, to being able to do. At first, students may need support to a greater extent, but later they will need less support (Meyer et al., 2009:106).

2.10.3.5 Coaching

Coaching is to train or teach a pupil or to give a hint (The Concise Oxford Dictionary, 1990:175). Neary (2000:29) explained coaching as helping the next person to better understand a point and to improve their abilities. Coaching encourages students to

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suspend their judgment and listen with open minds, see issues from another's perspective, and receive of constructive feedback from others.

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2.10.3.6 Communication

The professional nurse needs to have good communication and listening skills, in such an environment, a learner will feel free to communicate issues related to patient care with the other multidisciplinary team members. The learner may also confide in the professional nurse and discuss more professional issues. The professional nurse needs to communicate clearly to make sure that learners understand what is expected from them. Effective communication, therefore, forms an important part of student development in the clinical setting. Learners will also become involved in their own learning and will make use of clinical learning opportunities offered to them (Meyer et al., 2009:106).

2.10.3.7 Catalyst

A catalyst is a person or a thing that precipitates change (The Concise Oxford Dictionary, 1990:215). The professional nurse acts as a change agent that speeds up the reaction between two discourses. In this case, she assists students to integrate theory with practice and motivates them to develop intellectual commitment, understanding and emotional attachment. This process also goes hand in hand with motivation (Nicklin & Kenworth, 2000:79).

2.10.3.8 Counselling

Counselling is a process of giving advice (The Concise Oxford Dictionary, 1990:262). The professional nurse helps students to work through their own motivation and

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intention with a view of resolving a problems or making an important choice. S/he helps to put the student at ease and has good listening skills (Neary, 2000:29).

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2.10.3.9 Pleasure and Humanness

The professional nurse treats students with kindness and understanding, and shows interest in students as people. The professional nurse should take students as learners and not as extra pairs of hands and foster students' self-esteem and make them feel part of the team (Neary, 2000:21).

2.10.3.10 Facilitating

Is a process in which a person who makes a task easy, less difficult or more achievable (The Concise Oxford Dictionary, 1990:419). The professional nurse helps students to make things happen and helps them to diagnose, plan, implement and evaluate systematically. S/he smoothens encountered problems by calling upon experience, contacts and extra resources. S/he sets standards and criteria that are to be maintained to help the student to focus within each topic or subject. S/he sets outcomes that are measurable, and assessment tools which will help the student to meet such needs (Neary, 2000:31).

The above information describes the attributes that makes a midwife who will enhance integration of midwifery theory to practice. Attributes of a midwife can be one of the factors that can affect integration of midwifery science theory with practice.

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2.11 Role of the Lecturer Practitioner in Integration of Theory with Practice

2.11.1 Introduction

A lecturer practitioner is a qualified teacher who has retained clinical competence and whose responsibilities include teaching, supervision and assessment of students. In addition, s/he acts as a link teacher who establishes relationships with clinical areas with the purpose of liaison, troubleshooting and staff development (Quinn, 2007:358).

2.11.2 Characteristics of a Lecturer

The attributes of a good lecturer include being an expert in own subject; well-organized and prepared; confident and open to suggestions and others viewpoints; fair, even-tempered and friendly; flexible and willing to change; know students as individuals with their strength and weaknesses; leads well with appropriate pace; gives feedback within an appropriate timescale (Quinn, 2007:422).

2.11.3 Key Roles of the Lecturer Practitioner

- **Educational role for practice-based staff**

This includes dealing with supernumerary students on pre-registration programmes, and support staff acting as mentors to students (Quinn, 2007:358).

- **Tutoring students**

This includes facilitating the development of student autonomy and their skills with regard to reflective practice (Quinn, 2007:358).

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- **Facilitating good practice**

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This includes awareness of current practice, providing a resource to unit staff, promotion of research-mindedness, and fostering critical approach to practice (Quinn, 2007:358).

2.12 Role of the Student Practitioner in Integration of Theory with Practice

In this study, student practitioner is a learner registered for the training of Midwifery Nursing Science. This student is an adult who is willing to learn and work under the supervision of professional nurses in maternity units and take part in his/her learning. A student practitioner is a student who would utilize the learning opportunity available in the clinical placement and try to integrate the theory s/he had learned in class with the care provided in the clinical practice. The nursing and midwifery education and training has adopted the principle of adult learning. Nursing students are no longer passive, but are actively involved in learning. They are encouraged to ask questions and to feel part and given opportunity to practice and experience the reality of learning and practice (WHO EURO, 2001:127). The strategies used also encourage students to seek information and to work in groups. Lecturers are not the only sources of information, students can use the internet to search for information and do self-learner presentations. The whole process encourages lifelong learning and research (WHO EURO, 2001:127).

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2.13 Teaching Strategies that Promote Integration of Theory with Practice

2.13.1 Introduction

Nursing education takes place in two locations, a nursing school (theory) and clinical placement (practice). Therefore, learning and teaching strategies should be diverse based on theories of teaching and learning, including adult learning, the role of a teacher is that of the facilitator. The facilitator would use various strategies that are of more assistance and would assist students to merge theory with practice. Few strategies that which are useful and can assist students to bridge the gap between theory and practice were discussed as follows:

2.13.2 Teaching and Learning Strategies

2.13.2.1 Classroom-Based Teaching and Learning Strategies

Problem-based learning depicts the real-life scenario of practice and encourages students to seek out information, and further assists them to develop analytical, critical thinking and problem-solving skills (WHO EURO, 2001:128).

- **Group work**

Group work encourages student interaction; cooperation; active seeking of information and preparing students to be able to work in a team (WHO EURO, 2001:128).

- **Simulation (Role-play a real situation)**

Simulation is useful in rehearsing the real situation in a safe environment that helps students to develop self-confidence (WHO EURO, 2001:128).

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- **Self learning study packs**

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Self-learning study packs help students to work at their own pace, encourages active seeking of information (WHO EURO, 2001:128).

- **Lectures**

Lectures are useful in introducing the topic and provide baseline care (WHO EURO, 2001:128).

- **Demonstration**

Demonstration is used in practicing psychomotor and communication skills, and developing competency in a safe environment. It is used for microscope work, for example, in biological sciences and for practicing accurate observations and concise detailed report writing (WHO EURO, 2001:128).

2.13.2.2 Practice Based (Placement) Teaching and Learning

- **Teaching on one-to-one basis**

This is opportunistic; the teacher who is accompanying the students uses the available conditions to teach the student. This may come when the teacher has identified that the student or a nurse is having trouble in performing a procedure. The teacher will use the opportunity to demonstrate the procedure to the student. The other opportunity may be that of concepts in the workplace, it is difficult for the students to become acquainted with midwifery concepts at once, it needs a teacher to explain repeatedly to new students as they come to the unit, this will helps students to conceptualize the concepts (Quinn, 2007:363).

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- **Case conferences**

This is ideal for learning in clinical placement because it involves all members of the nursing team discussing and evaluating the care of a particular patient. One member presents the case and the other team members become involved in the discussion of the case. This helps the students to feel part of the team and acquire the skills of presenting to the public. It is useful because it provides a holistic view of the patients and their problems. The critical analysis of the case makes the students and the members to benefit; patient care become improved as the members will manage to pick up good and bad care. After the whole process, they come up with the way forward to avoid repeating the same mistakes (Quinn, 2007:364).

- **Clinical rounds**

In this strategy, the students get the opportunity to rotate, accompanying the doctor or nurse doing clinical rounds. This makes students to gain insight into the role of a nurse and that of the doctor during clinical rounds. Students use the opportunity to discuss the patient's treatment and progress. This helps the students to be able to interact with the team and the patients. The student will be able to utilize the knowledge in helping other patients who may have the same condition (Quinn, 2007:365).

2.14 The Inclusive Educational Environment

2.14.1 Introduction

An inclusive educational environment influences the students' performance and progress. The physical organization as well as instructions and useful material needto

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be well organized (Sabornie, 2010:6).

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2.14.2 Physical Organization

The physical organization of the classroom is of importance as it influences student behaviour and affects learning positively or negatively. Well-organized classrooms which are spacious influence learning positively while an unorganized small classroom affects learning negatively. The physical organization ensures that all materials are ready to be used and all mechanical and electronic devices are in good working condition. The facilitator should avoid congestion or overcrowding in the classroom as this is distractive and disrupt learning (Sabornie, 2010:6).

2.14.3 Instructional Environment

Everyday instructional materials should be ready for all to use at all times; assign task that are meaningful to the students and at their level of learning. Start from what the students knows and what is not kwon next (Sabornie, 2010:6).

2.15 Summary

There is a challenge in bridging the gap between midwifery science theory and clinical practice in nurse training. It is the cause of increased maternal and perinatal morbidities and mortalities worldwide. The researcher has tried to review the literature that maps the development of nursing and midwifery educating and training as well as training and education standards, to identify factors affecting integration of midwifery science theory and practice, and strategies to bridge the gap. Some schools of thought recommend theory before practice while others recommended supervision by professional nurses. Several researchers regard preceptors as the main group that

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will enhance integration of theory with practice. Hence, the purpose of this study was to identify and describe factors affecting integration of midwifery science theory with clinical practice in training hospitals in the Vhembe district of Limpopo Province.

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RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

The previous chapter reviewed and discussed literature related to the integration of midwifery nursing science with clinical practice. This chapter will deal with the research methodology in detail. This chapter outlines the methodological approaches used to investigate the factors affecting the midwifery nursing science theory with clinical practice in training hospitals of the Vhembe district in Limpopo Province. The sections include; approach, design, population, sampling procedure and technique, sample size, data collection methods, data processing and analysis. The researcher used a qualitative approach to determine the factors affecting integration of midwifery science theory and clinical practice.

3.2 Research Design

A research design is a blueprint that guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal (Burns & Grove, 2005:211). According to Mouton (2001), it is a plan of how to conduct the study, which includes methods and techniques used to collect, analyze and interpret data. It is thus the overall plan for addressing a research question, including specifications for enhancing the study's integrity (Polit & Beck, 2008:219).

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In this study, an explorative and descriptive research design was chosen because of the following reasons: The type of design is flexible and unique and evolves throughout the research process. The design has no fixed steps to be followed that cannot be easily replicated. It allows for a merge of various data collection strategies (triangulation) and may require the researcher to be intensively involved, or remain in the field for a long period, and become a research instrument.

The unit of analysis in this design is holistic, striving for an understanding of the whole. The design ensures that the study is done in natural settings and respondents narrate their lived experiences. In this study, research analysis is ongoing and formulates subsequent strategies to determine when to do fieldwork. Data sources were determined by information richness, observations were modified to enrich understanding (De Vos, Strydom, Fouche & Delport, and 2005:75).

3.2.1 Explorative Research Design

This design begins with a phenomenon of interest; it investigates the full nature of the phenomena under study and other related factors (Polit & Beck, 2008:20). According to Burns and Grove (2005:482), explorative studies examine relatively unknown phenomena in order to gain new insights to understand the phenomena with the aim to determine priorities for further research.

In this study, the researcher was explored the factors affecting integration of midwifery nursing science theory with clinical practice in selected training hospitals of Vhembe District, Limpopo Province. Through exploration, the researcher gained new insights, discovered new ideas and increased the knowledge on the factors affecting

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integration of midwifery nursing science theory with clinical practice in Vhembe district.

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3.2.2 Descriptive Research Design

A descriptive study is a way of discovering new meaning as it describes what exists to determine the frequency at which something occurs, and categorize information (Burns & Grove, 2005:232). According to Polit & Beck (2008:274), descriptive studies describe and document aspects of the situation as it naturally occurs and may serve as a starting point to generate or develop theory. In this study, a descriptive research design was used to give the respondents opportunity to present and describe the factors affecting the integration of midwifery nursing science theory with clinical practice in Vhembe District. The respondents described the factors as they naturally occurred in classrooms and in the clinical practice.

3.3 Research Setting

The study was conducted the Vhembe district of the Limpopo Province in South Africa. Limpopo Province has one nursing college called Limpopo College of Nursing, which is composed of five campuses, namely, Thohoyandou at Vhembe district, Giyani at Mopani district and Sovenga at Capricorn district, Sekhukhune campus at Sekhukhune District and Waterberg campus at Waterberg District. Vhembe District is located in the rural northern part of the Limpopo Province. It shares borders with Botswana, Zimbabwe and Mozambique and it is composed of four municipalities; Makhado, Mutale, Musina and Thulamela. Thohoyandou campus is the only public nursing college were students are placed through block system to be taught or learn theory. Vhembe district is composed of seven hospitals of which five are

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training hospitals. Training hospitals are Tshilidzini, Siloam, Donald Fraser, Elim and Malamulele. The five training hospitals act as clinical placements were students are placed to integrate theory with clinical practice

The actual setting for this study was in 3 training hospitals selected from the above-mentioned 5 and Thohoyandou campus, which is the only nursing campus in the Vhembe district. The selected hospitals were Donald Fraser, which is 35km from the campus, Siloam, which is 45km from the campus and Tshilidzini, which is 2km from the campus. The campus has a total number of level 4 students ranging between 40 and 80 students per academic year; the ratio of midwifery lecturers to students at the time of the study was between 3:40 and 3:80.

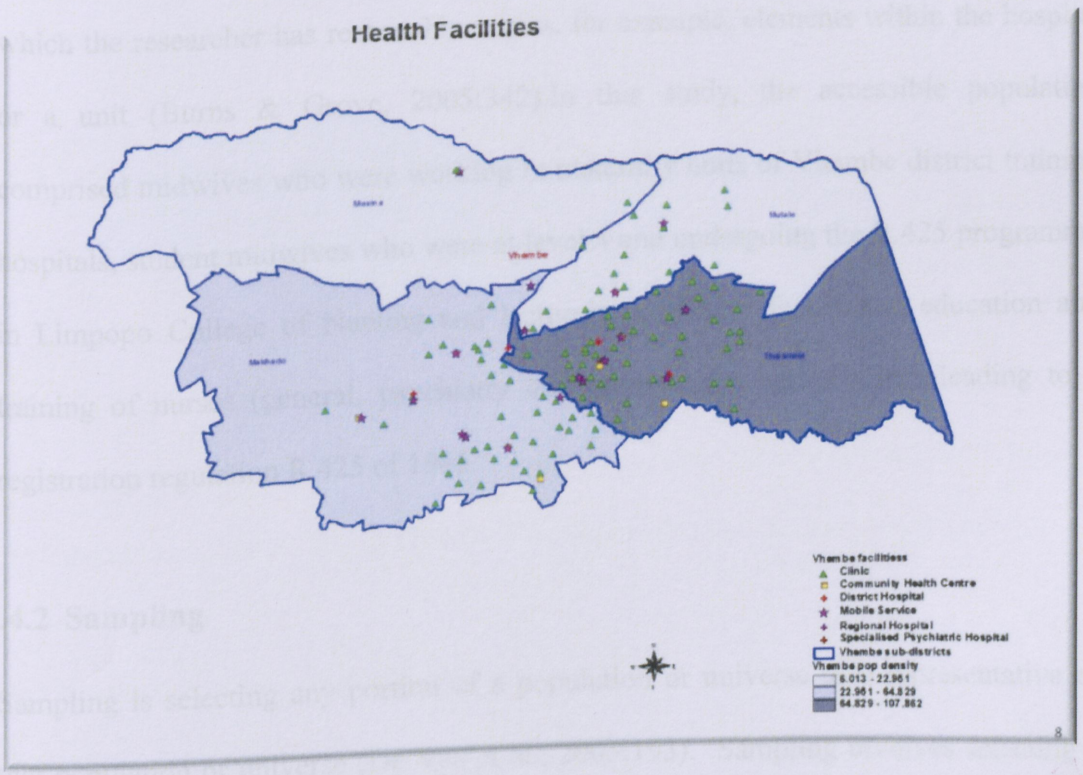


Figure 3.1: Map of the Vhembe district municipalities with clinical health facilities.

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3.4 Study Population and Sampling

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3.4.1 Population

A population is the entire set of individual or elements who meet the sampling criteria (Burns & Grove, 2005:342). Population is a term that sets boundaries on the study unit and refers to individuals in the universe who possess specific characteristics (De Vos et al., 2005:192). Target population is the entire set or aggregation of objects, persons, behaviour or events or any other single unit of a study sometimes called elements or sampling units that meet the sampling criteria (Botma et al., 2010:124). In this study, the target population were all midwives in the training hospitals, lecturers in Limpopo College of Nursing and all students doing the 4-year comprehensive course, the (R.425) programme. Accessible population is the portion of the target population to which the researcher has reasonable access, for example, elements within the hospital or a unit (Burns & Grove, 2005:342).In this study, the accessible population comprised midwives who were working in maternity units of Vhembe district training hospitals, student midwives who were at level 4 and undergoing the R.425 programme in Limpopo College of Nursing and lecturers who were facilitating education and training of nurses (general, psychiatry and community) and midwife leading to a registration regulation R.425 of 1985.

3.4.2 Sampling

Sampling is selecting any portion of a population or universe as a representative of that population or universe (De Vos et al., 2005:193). Sampling involves selecting a group of people, events, behaviour or other elements with which to conduct a study (Burns & Grove 2005:34).

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3.4.3 Sampling Method and Procedure

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In qualitative research, the non-probability sampling method is used. In non-probability sampling, the researcher does not know the members of the population (De Vos et al., 2005:201). This sampling approach also involves non-random sampling, since each element has no equal chance to be selected (Polit & Beck, 2008:340). Non-probability sampling has types including purposive, snowball, theoretical, and volunteers. In this study, purposive sampling was used. Purposive sampling is often referred to as judgemental as it is based entirely on the judgement of the researcher and is composed of characteristics representative of the population (De Vos et al., 2005:202). The researcher purposively selected the training hospitals and participants based on the features needed for the study. In this study, sampling was completed in four stages as follows:

3.4.3.1 Stage 1: Sampling of Training Hospitals

Three training hospitals had been purposively selected from the five training hospitals in Vhembe district. Donald Fraser, Siloam and Tshilidzini hospitals were selected because they were the most frequently used hospitals for clinical placement for the R.425 programme from Thohoyandou Nursing Campus. The researcher accompanied students to the hospitals during their clinical exposure and thus had to access them.

3.4.3.2 Stage 2: Sampling of Lecturers

Lecturers facilitating education and training of nurse (general, psychiatric, community) and midwife leading to registration R.425 training programme from training college that was Thohoyandou Campus in Vhembe district of Limpopo

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Province had been purposively selected. Only the lecturers who had been facilitating Midwifery Nursing Science for a period of 4 years and above had been selected. Their teaching experience added to the theoretical information.

3.4.3.3 Stage 3: Sampling of Students

Students following education and training of nurse (general, psychiatric, community) and midwife leading to registration R.425 programme and who were in level 4 doing Midwifery II, allocated at Donald Fraser, Siloam and Tshilidzini hospitals had been selected because they already had a midwifery background.

3.4.3.4 Stage 4: Sampling of Professional Midwives

The researcher had purposely selected professional midwives who were working in maternity units of training hospitals in Vhembe district of Limpopo Province, which were Donald Fraser, Siloam and Tshilidzini hospitals as these facilities were easily accessible to the researcher. The midwives had at least 4 years of experience in midwifery practice. Their years of experience in the unit enabled them to provide the researcher with rich data.

3.4.4 Sample Size

Data saturation and purpose of the study and depth of information needed to gain insight into a phenomenon determined the sample size (Burns & Grove, 2005:358). In qualitative research, sample size can be determined by data saturation. Data saturation is sampling to the point at which no new information is obtained and redundancy is achieved if more respondents are added (Polit & Beck, 2004:308). In this study, the researcher interviewed 26 respondents. The respondents included 4 lecturers, 18 level

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IV students who were further dived into focus group comprised of 6 students in each focus group and 3 midwives from the three training hospitals. The size of the sample was considered satisfactory when data saturation was reached, this was indicated by the repetition of themes (Burns & Grove, 2005:358). Predetermination of the number of respondent was not possible.

3.4.5 Preparation for Data Collection and Recruiting Study Participants

Recruiting the respondents to participate in a study include identifying the eligible candidates and pursuing them to participate in the study (Polit & Beck, 2008:352).The following factors as described by Polit and Beck (2008:352) that influenced the cooperation of respondents were employed:

Recruitment Method: the researcher approached the respondents face-to-face and asked them to participate, as this method is more effective than phoning them.

Convenience: arrangements were made with the participants to interview them during the time most convenient to them; some participants were interviewed at their own homes when they were off-duty, some were interviewed during lunch time, students were interviewed after 16h00.

Endorsement: permission to interview them was sought and granted by the University of Venda Health, Safety and Research Ethics Committee and the Limpopo Province Department of Health.

Assurance: the respondents were told that the researcher would be the main data collector and that the supervisor may contact them for quality assurance purposes to

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make sure that data were from the respondent and not researcher's ideas. The students in the focus groups were advised that there would be another person who was their lecturer, who will act as a focus group moderator who would assist with field notes and would operate the tape recorder.

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The researcher initially visited to the hospitals to contact the hospital management to inform them that their employees who were midwives in the maternity section would be requested to participate in the study titled integration of midwifery nursing science theory with clinical practice. The purpose of the study and how the institution will benefit from the results of the study was also explained. The researcher is a lecturer at Thohoyandou Nursing Campus and was not a stranger or a threat to the campus and therefore it was easy to request permission to sample students and lecturers as participants in this study. The researcher had good cooperation from all groups of participant.

3.5. Data Collection

Data collection is the precise, systematic gathering of information relevant to the research purpose or specific objectives, question, or hypothesis of the study (Burns & Grove, 2005:733). In qualitative research, interviewing is the predominant mode for data or information collection. De Vos et al (2005:287) stated: "You interview because you are interested in other people stories." Telling stories is a meaning-making process and stories that people tell is the microcosm of their consciousness. The researcher had used more than one data collection method, that is, interviews, focus groups as well as field notes. The researcher was the main data collector and conducted the interviews to collect data from professional midwives and lecturer. The

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researcher had appointed the research assistant/focus group moderator who acted as co-facilitator during focus group sessions. The research assistant was a lecturer in midwifery with less than 4 years facilitating experience in Midwifery Nursing Science, but was a lecturer for more than 20-year in General Nursing Science. The research assistant's role during the focus group interviews was to handle logistics and distractions, operate the tape recorder and take preliminary field notes (Botma et al., 2010:212). The research assistant was orientated to the aim and purpose of the research, interview guide, and focus group members', plan of action, venue transport and incentives, if any.

3.5.1 Data Collection Methods

3.5.1.1 Interview

Types of interview are unstructured or semi-structured. An unstructured interview is referred to as an in-depth interview; this is a conversation with a purpose (De Vos et al., 2005:292). In this study, the researcher used unstructured interviews to collect data from participant midwives and lectures because of the same advantages. This includes the fact that during an unstructured interview a researcher is interested in understanding the experiences of other people and the meaning they make of that experience. It is focused and discursive, and allows the respondents and researcher to explore the phenomenon. It also allows the researcher to note non-verbal gestures or cues that add meaning to the study, and to clarify any ambiguous questions. It allows the respondents to have 90% chance of talking, while the researcher is listening (De Vos et al., 2005:287). The weak point of an unstructured interview, however, is that the data collected is subjective and cannot be generalized.

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The central question was: **"What are the factors affecting integration of midwifery science theory with midwifery clinical practice?"** (Annexure 3A). The interview with professional midwives had been conducted at the training hospitals while lecturers had been interviewed at Thohoyandou Nursing campus. The first encounter between the researcher and respondents took place during lunchtime, following arrangements made with respondents to be interviewed after work from 16h00 to 17h00 to avoid interfering with their work. Some were interviewed at their homes during their times off from work.

During the interview, paraphrasing had been used wherein the researcher stated the respondents' words in another form to convey the message that the researcher understood the situation and to confirm what was said. Then the researcher summarized the responses to condense and crystallize the essence of the respondents' statements. While interviewing, the researcher probed to get more information and had picked up on comments made by the respondents and began to ask questions to obtain further meaning (De Vos et al., 2005:288). A voice recorder/audiotape had been used to record the information from the respondents, which was then transcribed verbatim. In the process of the interview, the researcher also looked for non-verbal cues and took some notes (De Vos et al., 2005:289). The other respondents, mostly midwives, requested the researcher to switch off the tape recorder when they were giving information which they said was regarded as sensitive.

3.5.1.2 Focus Groups

De Vos et al (2005:300) defined a focus group as a carefully planned discussion designed to obtain perception on a defined area of interest in a permissive, non-

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threatening environment. A focus group also involves a number of people who often have common experiences or characteristics, who are interviewed by the researcher for the purpose of eliciting ideas, thoughts and perceptions about a specific topic or issues of interest (Holloway & Wheeler, 2002:110).

In this study, focus group interview sessions were conducted to collect data from the R.425 programme students who were in level IV as they already have a background of midwifery, 6 students were selected to form a focus group, and 3 focus groups were formulated as follows:

- **Focus group 1**

These were students placed in Donald Fraser Hospital. Six level IV students volunteered to participate in the study and all honoured the appointment, all students were females. This group was interviewed on Monday the 10th of September 2013 from 13h00 to 13h45; the session lasted for 45 minutes.

- **Focus group 2**

This group comprised of level 4 students placed in Tshilidzini hospital. Eight students volunteered, but 6 students honoured the appointment; 4 females and 2 males; their session was on Tuesday 11th September 2013 from 13h00 to 14h30, the session lasted 1hour and 30 minutes. For this group the data were more and it was thus easy to reach data saturation.

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- **Focus group 3**

This was the last group of level IV students placed at Siloam Hospital. Seven students volunteered to participate, 6 honoured the appointment; 2 males and four 4 females. Their session was on the 12th of September 2013 from 13h00 to 13h30, lasting for approximately 30 minutes.

The researcher had one session with each group and data was saturated within a session, and all groups were interviewed to have the picture of all three sampled hospitals. Focus group interview was conducted similar to one-to-one interview; however one major difference from one-to-one interview was that it was done with a group of people, exploring and stimulating ideas based on shared perceptions of the world rather than individual. The group is usually composed of 6 respondents (De Vos et al., 2005:287). The interview guide was developed based on the selected learning theory (Annexure 3B). The researcher arranged with the students to conduct focus group interviews after class, from 17h00 to18h00, to a void interference with their classes. Focus groups were selected to collect data from the students because of some strength. This included the fact that discussions would allow multiple viewpoints or responses on the integration of midwifery theory with practice and produce significant amounts of information which is concentrated data in a short period of time. It will also allow the use of group discussion to generate data. It is one of the best tools to explore, for example, students' perspectives towards their education and training. The findings from the focus group interviews will be used as a basis for action. However, the weak point of a focus group is that sensitive issues may not be revealed in a group; one member may dominate and influence the results; some

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may conform to the group and some may give divergent answers, making it difficult to obtain definite answers (Holloway & Wheeler, 2002:118).

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3.5.1.3 Field Notes

According to De Vos et al. (2011:359), it is vital for a researcher to take field notes and not rely entirely on memory to recall everything. The researcher needs to sit down immediately after the interview and jot down what transpired during the interview, this would help the researcher to remember and explore the process of the interview and minimize loss of data. In this study, the researcher jotted down all that happened during the in-depth one-on-one interviews with lecturers and midwives as well as during focus group meetings with the students.

3.6 Data Analysis

3.6.1 Data Preparation and Organization

This is a process of bringing order, structure and meaning to the mass of collected data. In the qualitative method, data analysis is not linear (De Vos et al., 2005:333). Polit & Beck (2008:751) defined data analysis as a systematic organization and syntheses of research data. In this study, data were analyzed as follows:

- The interviews were transcribed verbatim from audiotapes and field notes.
- Codes were assigned to the transcribed data, which is open-coded.
- The related codes were grouped together or categorized.
- The categories were merged to form themes.
- Each theme formed a basis of an argument in the entire report.

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- To make sure that the data were enriched, the researcher read the report starting from themes back to transcription, that is moving backwards through the process of thematic patterns to categories, to codes and then to raw data (Henning et al., 2004:105).
- The researcher evaluated the data for its usefulness and carefully evaluated if the data had answered the explored questions, and how true it was to unfold data about the topic under study.
- The researcher searched for alternative explanations and for the identity and then translated until the explanation offered was most appropriate.

3.6.2 Data Analysis Using Tesch's Open-Coding Method

In this study, data were analyzed through open-coding (Botma et al., 2010:223). Data was broken down carefully from audiotape recordings, closely examined, compared for similarities and differences as reflected in the data (Polit & Beck, 2008:526). A theme and categories were developed using Tesch's Open-Coding Method, following the steps as described in Botma et al (2010:223).

- **Step 1: Getting sense of the whole**

The researcher read the transcriptions to understand the information and became immersed in details in order to get the sense of whole before breaking it into parts.

- **Step 2: Picking one document**

The researcher had selected the shortest interview and read it analyzing the highlighted meaning.

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- **Step 3: Making a list of topics**

The data were arranged into categories, labelled with a term based in the actual language of the respondents. A list of topics derived from the interview was made. Similar topics were grouped together in a column and arranged as major topics.

- **Step 4: Involve the coding process**

The researcher took the list topics, referred back to the data, abbreviated topics as codes and codes were written next to the appropriate segments of the text. The researcher then studied the organization of the data to check if new categories or codes emerged.

- **Step 5: Turn topics into categories**

The researcher developed one theme and four categories and developed a column between categories to show how they were interrelated.

- **Step 6: Making a final decision**

The researcher made a final decision on the abbreviations of each category and the codes were arranged according to their priority of occurrences.

- **Step 7: Preliminary analysis**

The data material belonging to each category was assembled in one place and a preliminary analysis done.

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- **Step 8: Re-coding**

Re-coding of existing data was done as it was found necessary during the process of analysis; a theme, categories and subcategories were generated from the collected data (Polit & Beck, 2008:526).

3.7 Measures to Ensure Trustworthiness

Trustworthiness means methodological soundness and adequacy (Holloway & Wheeler, 2002:254). Trustworthiness includes strategies for enhancing the integrity of qualitative study flow throughout the research project. Lincoln & Guba's framework (1985), as cited in Polit and Beck (2008:539) as well as in De Vos et al (2005:347), outlines 4 criteria for developing trustworthiness and representing parallels to positivists' criteria of internal validity, reliability, objectivity and external validity.

3.7.1 Credibility

This ensures confidence in the truth of the data and interpretation of thereof. Lincoln and Guba (1985), as cited in Polit & Beck (2008:539), pointed out two aspects: first, carrying out the study in a way that enhances the believability of findings and, second, taking steps to demonstrate credibility to external readers. In this study, credibility was established by prolonged engagement, which is an investment of sufficient time in data collection. The researcher ensured that there was adequate time and resources to stay engaged in the field to establish trust and rapport with informants. This, in turn, made it more likely that they would provide useful, accurate and rich information (Polit & Beck, 2008:539). In addition, the researcher used a multiple data collection method (triangulation), that is interview and focus group discussions. During data

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collection, a tape recorder was used to record the interviews. Field notes were taken to capture rich descriptions of what had transpired in the field, including the demeanour and behaviour during interaction with the respondents. The researcher also acknowledged other people's ideas by adequate referencing throughout the study and performed member checks throughout by allowing respondents to give feedback to the researcher.

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3.7.2 Dependability

It is the stability or reliability of data over time and over conditions. The primary question is: "Will the findings of the study be repeated if it were replicated with the same participants in the same context?" (Polit & Beck, 2008:539). Botma et al (2010:233) explained dependability as consistency of the findings which implies that audit trail was done (a detailed description of how the researcher collected data and the kind of data collected). In this study, the researcher did an audit trail, meaning that a detailed record and description of the decisions made before and during the research. The researcher documented non-verbal communication during one-to-one interviews to enrich the data and concretize the data for the reader.

3.7.3 Transferability

This principle refers essentially to the generalizability of the data and the extent to which the findings can be transferred to other settings or groups (Polit & Beck, 2008:539). In this study, the researcher provided a detailed description of the methodology selected and provided sufficient descriptive data, context and report so that consumers can evaluate the applicability of data to other contexts. The researcher also performed triangulation of the data collection method, namely, focus groups and

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in-depth interview to enhance transferability. The researcher collected data from different sources to collaborate, elaborate and shed more light on the research in question (De Vos et al., 2005:347).

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3.7.4 Confirmability

This refers to the objectivity or the potential for congruency between two or more independent people about the data accuracy, relevance or meaning and is concerned with establishing that the data represent the information provided by participants and not the researcher's imaginations (Polit & Beck, 2008:539). In this study, the researcher did the following to enhance confirmability:

- Carefully planned the research process, design, sampling and data collection;
- Recorded the participants during interviews;
- Transcribed the raw data from the tape;
- Analyzed raw data and findings through contextualization;
- The independent coder analyzed transcripts, reviewed raw data, transcribed data from the tape recorder as well as written field notes and documented the results independently;
- In addition, the independent coder checked the representativeness of data, i.e., whether the researcher had indeed interviewed all categories of participants needed to get a complete picture of the topic;
- The draft proposal was presented to the University of Venda School of Health Sciences for corrections to establish truth-value of the data; and

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- The supervisor checked the work with the co-supervisor to validate the study.

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3.8 Ethical Considerations

It is the principle of respect for person, beneficence, and justice (Burns & Grove, 2005:181). Polit and Beck (2008:170) define ethics as a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations of the study. In this study, the researcher observed the following major ethical principles:

3.8.1 Permission to Conduct the Study

The researcher requested permission to conduct the study from the Limpopo Province Department of Health (Annexure 1A), Vhembe district (Annexure 1B) and the 3 training hospitals and a nursing campus of Vhembe district (Annexure 1C) and the University of Venda Health, Safety and Research Ethics Committee. The researcher obtained informed consent (Annexure 2A) from the respondents and requested them to sign a consent form to give information and for recoding (Annexure 2B &2C).

3.8.2 Anonymity and Confidentiality

Anonymity occurs when the researcher cannot link the respondents to their data (Polit & Beck, 2008:1180). Confidentiality is a pledge that any information provided by the respondents would not be publicly reported in a manner that identifies them and will not be accessible to others (Polit & Beck, 2008:180). Though not easy to maintain, anonymity and confidentiality in one-to-one interviews was ensured by the researcher in that data from the respondents were not linked to them, no names were used as codes to identify the respondents, e.g., professional nurse 1, lecturer 1, etc. The

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researcher made sure that the supervisors from the university and the researcher only had access to information from the respondents.

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3.8.3 Informed Consent (Right to Full Disclosure)

Informed consent encompasses people's right to make informed, voluntary decision to participate, which requires full disclosure, no deception or concealment (Polit & Beck, 2008:176). In this study, the researcher asked the respondents to sign the consent forms, and to disclose the use of equipment like video tape or tape recorder. The researcher explained in full what the study entailed, including risks and benefits (Annexure 2A).

3.8.4 Voluntary Participation and Respect for Human Rights

This encompasses the principle of self-determination, which means that the prospective respondents have the right to decide voluntarily to participate in the study without risk or penalty and they have the right to question, to refuse to give information, or withdraw from the study without risk or prejudiced treatment (Polit & Beck, 2008:171). In this study, the respondents had the right to participate voluntarily and to withdraw anytime they feel to do so with no incurred risks.

3.8.5 Freedom from Harm (Protection from Exploitation)

The researcher has an obligation to avoid, prevent or minimize harm, and not subject respondents to unnecessary risks of harm or discomfort. The researcher needs to prevent physical and psychological harm. The study needs to be scientifically and socially safe (Polit & Beck, 2008:171). In this study, the researcher did not harm the participants physically or emotionally. There were no risks incurred if they

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participated. The researcher disclosed that there was no direct benefit in the form of money or reward to the respondents.

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3.9 Limitation of the Study

In this study, transferability of research findings may not possible, i.e., like most qualitative studies where transferability is not feasible. The researcher had conducted the study in one district and a Nursing College in Vhembe district of Limpopo Province and because the sample size is limited, this cannot lead to transferability of the results.

3.10 Dissemination of the Study Findings

Dissemination of the study findings means to share the results to the scientific community and public (Botma et al., 2010:27). The researchers' report of the study had been submitted to the Limpopo Province Department of Health, Vhembe district training hospitals and the nursing campus. The results of this study will be submitted to journals and a website for publication. Oral presentation or posters may also be presented at organized conferences (Botma et al., 2010:314).

3.11 Summary

This chapter described the research methodology followed in this study, i.e., the research design, research setting, population and sampling, data collection analysis and ethical considerations. Chapter 4 presents the data analysis, discussion and literature-control.

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DATA ANALYSIS, DISCUSSION AND LITERATURE CONTROL

4.1 Introduction

The previous chapter presented the research design and methods. This chapter covers the analysis and discussion of the data. The following question directed the study: "***What were the factors that affected integration of midwifery nursing science theory with clinical practice in training hospitals in Vhembe district?***"

This question sought answers from 4 lecturers and 3 midwives through in-depth one-to-one interviews.

The focus group interview guide was derived in relation to the theoretical framework based on the theory of Albert Bandura (Bandura, 2004) to seek answers from the students. Three focus groups of 6 students each to yield a total number of 18 students were formulated, each group represented each training hospital. The questions included in the interview guide were developed as follows:

- What do you think can be the factors that affect your attention in class and in the unit as you are observing the midwives?
- What do you think can be the factors that affect your remembering of observed midwifery nursing-science skills?

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- What do you think can be the factors that affect your ability to perform the observed midwifery nursing-science skills?

- What do you think can be the factors affecting your motivation to imitate the observed midwifery-nursing science skills?

- Can you explain any other factors that might affect your ability to integrate midwifery nursing-science theory with practice?

The interview sessions were conducted in English as it was also their medium of instruction therefore; there was no need to translate the questions. In order to promote quality in the process of obtaining data from the respondents, the researcher utilized the following techniques to collect data carefully: in-depth one-to-one interviews and focus group interviews.

- **In-depth one-to-one interviews**

This is a conversation with a purpose (De Vos et al., 2005:292). It allows the respondents to have 90% chance of talking, while the researcher is listening (De Vos et al., 2005:287). An in-depth one-to-one interview was conducted with 7 respondents. Of the 7 respondents, 4 were lecturers from Thohoyandou Campus (Table 4.1), 3 were midwives from the three selected training hospitals, which were Donald Frazer, Tshilidzini and Siloam (Table 4.2).

- **Focus group interviews**

Focus group interviews involve a number of people who often have common experiences or characteristics, who are interviewed by the researcher for the purpose of eliciting ideas, thoughts and perceptions about a specific topic or issues of interest

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(Holloway & Wheeler, 2002:110). The 18 finalists (level IV) students from Thohoyandou Campus were interviewed in focus groups of 6 students per group. The students were further grouped according to their clinical practice in the selected training hospitals, which were Donald Frazer, Tshilidzini and Siloam. There were 3 groups of which the researcher conducted 1 session per focus group to give a total of 3 sessions (Table 4.3).

4.2 Demographic Profiles of the Respondents

4.2.1 Demographic Profile of Lecturers

Four female lecturers from Thohoyandou Campus with age ranging between 40-65 years and lecturing experience between 4-20 years participated in this study (Table 4.1).

Table 4.1: Demographic profile of lecturers

Lecturers	Age Range	Teaching Experience (Years)	Male	Female
1	40-50	4	0	1
2	50-60	≥20	0	1
3	60-65	≥20	0	1
4	40-50	≥10	0	1
Total			0	4

4.2.2 Demographic Profile of Midwives

Three female midwives one from Tshilidzini, one from Donald Fraser and one from Siloam with the age ranging between 30-60 years and midwifery experience between 8-20 years participated in this study (Table 4.2).

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Table 4.2: Demographic profile of midwives

Midwives	Age Range	Service Experience (Years)	Male	Female
1	30-40	8	0	1
2	50- 60	≥20	0	1
3	50-60	≥20	0	1
Total			0	3

4.2.3 Demographic Profile of Students

Eighteen level 4 students participated in this study, 4 males and 14 females (Table 4.3). The students were divided into 3 focus groups of 6 each, Focus Group 1 was from Donald Frazer Hospital, Focus Group 2 was from Tshilidzini Hospital and Focus Group 3 was from Siloam Hospital.

Table 4.3: Demographic profile of students

Focus Group	Number in Group	Level of Study	Male	Female
1	6	4	2	4
2	6	4	2	4
3	6	4	0	6
Total	**18**		**4**	**14**

4.3 Presentation of the Findings

One major theme emerged from the collected data, and the researcher coded four themes, and sub-themes under each theme were deduced (Table 4.4). The major theme was poor integration of midwifery nursing science theory with clinical practice. From the major theme, 4 themes emerged, namely, factors related to teaching and

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facilitation by lecturer; factors related to learning by students; factors related to midwives in the clinical areas and factors related to systems in the organization. The responses extracted from the data recordings were enclosed in quotation marks and placed into context by a literature support. Table 4.4 presents the major theme, themes and sub-themes.

Table 4.4: Major theme, themes and sub-themes that emerged from the data analysis

Major theme: Poor integration of midwifery nursing science theory with clinical practice		
Themes	**Sub-Themes**	
Factors related to teaching and facilitation by lecturers	1.1	Shortage of lecturers
	1.2	Systems of teaching
	1.3	Lack of accompaniment
Factors related to learning by students	2.1	Students' lack of interest towards learning and/or midwifery practice
	2.2	Student absenteeism
	2.3	Ability to understand the theory as taught in class
	2.4	Attitude of students towards midwifery practice
Factors related to midwives in the clinical areas	3.1	Shortage of midwives
	3.2	Attitude towards student midwives
	3.3	Reluctance of midwives to perform teaching function
	3.4	Language barrier
	3.5	Declining midwifery practice standards
Factors related to systems in the organization	4.1	Shortage of student accommodation next to clinical placements
	4.2	Shortage of material resources and physical structures, e.g., classrooms and hospitals

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4.3 Short periods of learning and clinical exposure

4.4 Student selection criteria

The lecturers, midwives and students indicated various factors that led to the major theme, poor integration of midwifery nursing science with clinical practice. They indicated factors related to teaching and facilitation by lectures wherein they identified that shortage of lecturers led to lack of student accompaniment that resulted in students being left alone most of the time without a mentor or supervisor assisted them to merge theory with practice.

> **Lecturer #2 said:** *"Mmm, I think that they are some few problems that we can highlight, for example, we've got shortage of staff,i.e., lecturers that can be able to teach the learners at the theoretical areas and that are supposed to teach them in the clinical areas. You will find that it will be very much difficult to integrate the information that they have learned in class because you may find that the lecturer who is supposed to help them is still attending other things here at the school, but in reality she was supposed to be accompanying them."*

Respondents indicated other factors were related to learning by students wherein they raised factors like absenteeism, attitude towards midwifery training and midwives. Absenteeism deprived students of the opportunity to practice skills repeatedly to gain competence. Attitude towards midwifery practice made students to lose interest in midwifery practice and they tended to memorize theory and passed, but were unable to put that theory to practice.

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In support of the findings, Meyer et al (2009: 245) indicated that students miss golden opportunities to merge theory with practice due to unauthorised absence from class or clinical placements.

> **Lecturer #4 said:** *"Another thing is being the attitude for midwifery practice, especially for our male students, you will find that mostly they will hide behind others for anything that is related to midwifery practice. When time is right for them to complete they think they can fill the midwifery register within a month, something that they have been exposed to for the whole year and as a result integration is not taking place as it should be, because when procedures are demonstrated to them, they should directly go and implement it on their own under the supervision of the midwives in the ward."*

Other factors mentioned included declining midwifery standards of practice wherein midwives were not performing their procedures properly, they were taking shortcuts in most of the procedures, not observing proper midwifery principles, this made students to repeat wrong procedures and not being able to visualize the theory and merge it with clinical practice, for example, midwives were no more setting trolleys for swabbing or giving injections.

In support of the findings, Meyer et al (2009: 106) argued that there is a need of availability of professional midwives to facilitate proper integration of midwifery theory with clinical practice whilst Singingtree (2006:1) indicated that competent midwives will employ their basic skills together with clear written objectives and skills and assists students to learn and execute midwifery procedures.

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Student #5 said: *"Also, the way you have taught us, the theory that we have been taught here are more different than that we do practically, because how you teach us the procedure to be done this way, then when we arrive there they like us to do it in their way, so there is no any means that it will make us to practice."*

Factors related to systems in the organization alluded to by respondents included shortage of materials and medical supplies in the maternity units of all three selected training hospitals. The shortage of materials and supplies made it difficult for students to carry out procedures as there were no gloves to protect themselves during procedures, like per vaginal examination. There were also shortage of equipment like blood pressure taking machines and many more.

Midwife #1 said: *"Hi, no proceduray we can't say we are doing procedures accodingly, because you just find that, for example, maybe you want to do the PV (per vaginal examination) they just put on gloves without a trolley or pack and not mantain sterility, but we use to tell them that you must do the correct things, but later when they are to do the PV they do the same as we are doing."*

Lecturer #2 said: *"The other thing is shortage of equipment, of which that this one is very much serious, that is why nowadays we are producing the midwives who are not skilled. We are running short of gloves, you can imagine if we do not have gloves how are we going to teach per vaginal examination, etc."*

Literature supported that poor integration of Midwifery Nursing Science theory with clinical practice was indicated by increased perinatal and maternal deaths. The

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National Department of Health reports indicated that there was an increased maternal and neonatal morbidity and mortality in South Africa. Most of the causes of illness and deaths were avoidable. The major contributory factor was that there was lack of skilled personnel in most of the maternity units. The poor integration of midwifery theory and practice was further linked to incompetency products of both nurses and doctors. The incompetent products of health care providers were further linked to lack of resources and commitment of students during their training (Saving Mothers Report, 2008-2010: IV).

The following themes have emerged from this major theme as indicated in Table 4.4 and are discussed individually with their sub-themes in sequence.

4.3.1 Theme 1: Factors Related to Teaching and Facilitation by Lecturers

Table 4.4representsTheme 1: Factors related to teaching and facilitation by lecturers and its Sub-Themes: shortage of lecturers; systems of teaching and lack of accompaniment. The respondents described this factor as relating to shortage of lecturers at the Thohoyandou Campus, there were not an adequate number of lecturers needed to teach and facilitate learning of students.

The shortage affected the support of students by lecturers (accompaniment) at the clinical areas. Since the lecturers were unable to implement other strategies to facilitate learning, they resorted to lecture methods that helped them to cover large groups of students at the same time. The students sit in class for longer hours and, after hours,no lecturers were available whom the students could consult if they encountered problems as they were revising the theory taught in the morning.

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Lecturer #1 stated: *"Hey, both the lecturers and the nursing midwives, cause now as I am saying we are only 3 lecturers in the midwifery component , who are supposed to teach Midwifery1 at level III and Midwifery II at level IV."*

In support of what the respondent said, the WHO report indicated that it is now widely accepted that there is a dire need for health workers in many parts of the country. The health worker shortage is due to less production by the colleges and the increasing burden of diseases as well as the demand to meet the three health-related MDGs reduction of child mortality, improving maternal health and combating infections.

Globally, there is a shortage of skilled health workers, including nurse educators who are needed to assist students to correlate theory with clinical practice and to become competent to meet the MDGs (WHO, 2006:19).

4.3.1.1 Sub-Theme 1.1: Shortage of Lecturers

The respondents, lecturers and midwives came up with shortage of staff as a factor that affected the training and learning by student midwives in class and integration of theory with clinical practice in the training hospitals. For learning to take place there is a need to have sufficient numbers of lecturers in the nursing colleges, and enough midwives in the clinical units who can act as mentors to undergraduates students.

Lecturer #1 stated: *"Hey, both the lecturers and the nursing midwives, cause now as I am saying we are only 3 lecturers in the midwifery component, who are supposed to teach Midwifery I at level III and Midwifery II at level IV."*

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Lecturers #2 said: *"Mmm, I think that there are some few problems that we can highlight, for example, we've got shortage of staff, which is lecturers that can be able to teach the learners at the theoretical areas and that are supposed to teach them in the clinical areas. You will find that it will be very much difficult to integrate the information that they have learned in class because you may find that the lecturer who is supposed to help them is still attending other things here at the school, but in reality she was supposed to be accompanying them."*

Midwife #2 stated: *"Ok, shortage of staff, we have got few midwives who need to attend to students as well as patients. Lack of accompaniment, sometimes you find that students need to be taught certain procedures and due to this shortage of staff we do not manage to teach them,we will just do a summary."*

Midwife #3 said: *"The other thing is that we do not have enough staff, there is shortage of staff and patients are many, we are needed also to pay attention to students so we cannot attend both students and patients. Sometimes the number of students outnumbers us,so they will just come and sit we will attend to those who are fast to learn and those who are slow will be left behind,some because they will be many hide behind others and we will only reach those who are interested and always we will call those who cooperate."*

According to the social learning theory employed in this study (Bandura, 2004), the lecturers act as role models who ensure vicarious reinforcement. Vicarious learning involves learning though observing the more experienced practitioner, the lecturers who are experienced practitioners need to be adequate enough so that they can do

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student accompaniment. Shortage of lecturers will affect learning and result in poor integration of theory and practice (Quinn, 2007:100).

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In support of what the respondents said, the nursing strategic plan for the state of Texas to meet nursing workforce 2013, indicated that there is a shortage of nurse educators as baby boomers are leaving the job due to retirements, and there is less production of graduates. They had seven meetings in 2008 from June to December to come up with a strategy to overcome the bottle-neck. They accelerated the programmes that led to the production of nurses, especially nurse educators. They acquired financial assistance in the training of nurse educators who would assist in teaching and facilitation of nurse training.

Student nurse training demands an adequate number of educators who will teach theory in the classroom and go to clinical areas with the students and assist students to bridge the gap between theory and practice. The strategies included the following; to double the number of graduate by 2013; developing regional partnerships; establish new relationship with health care systems, namely, hospitals. All this was done to overcome the problem of staff shortages in the health system to try to increase the number of nurse educators in training institutions (Texas Team, 2009:7).

Grealish and Smale (2011:51) supported the view of the respondents by indicating challenges like shortage of qualified personnel in the units to supervise practical learning; hence, it interfered with integration of theory with practice. Increased numbers of students also make it difficult to negotiate student access to workplace experience as there were fewer mentors to assist them implementing what they had been taught. During the early stages of midwifery education, the above challenges

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were not there as the curriculum was developed from within the local training hospitals, with more emphasis on practice and with supplemented theoretical lectures and validated by government regulatory authorities; the number of students was also determined by the hospital's need and fewer students were selected for training; there was no problem of overcrowding. Few lecturers were needed as they were only there as a supplement as most of the teaching occurred at bedside.

The respondents further indicated that shortage of staff was also due to remuneration and poor working conditions. Lecturers at colleges are receiving less remuneration compared to their counterparts who provide bedside service at the hospitals and clinics.

> **Lecturer #2 said:** *"We've got a lot of vacant posts here at the college, maybe because there is no rural allowance for lecturers. Whenever people think of coming this side and lose their rural allowance they feel it is better to stay at the hospital rather than joining the lecturers."*

This statement was supported by a study in USA that had proposed an increased budget for the teaching faculty at colleges and universities to retain and attract more nurse educators and providing training nursing schools with scholarships for continuing professional development (CPD). The increased number of lecturers will close the gap and make it possible to have lecturers who will teach theory and manage to go with students to clinical facilities and show them how to integrate theory with practice (United States Department of Health/USDoH, 2010:3).

In support of what the respondents said, a study done in South Africa revealed a lack

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of nursing lecturers at institutions of higher learning following the legacy of Apartheid—due to discrimination, nurses from white communities were privileged to advance to become lecturers; after the liberation there was a dire need for lecturers. Also, in response to the global call to move nursing to institutions of higher learning left a gap that would need more years to produce enough lecturers. For proper integration of theory with clinical practice there was a need for more lecturers who will be able to teach theory in the classroom and then go to clinical areas with the students for accompaniment to assist them how to put theory into practice (Council of Higher Education (CHE), 2010:19).

4.3.1.2 Sub-Theme 1.2: Systems of Teaching

The respondents' lecturers, midwives and students, raised the factor of the systems of teaching as another dynamic that would facilitate learning and help students to integrate theory with practice. The way that students were taught theory in class and the strategies used to present the lessons could help them to retain the basics to assist them to apply theory into practice. Midwives in clinical units wondered how nursing students were taught basics because they could hardly come up with a clue that indicated that they were indeed in class and some fundamental basics were given to them as foundation.

> **Lecturer #4 said:**"*I'm not sure of how it is done, whether the students are made aware of the theory they have done in class or what theory related. Students will be aware of what to bring. No memos to write or do registered midwives dish out information without letting them to come with theory.*"

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Midwife #2 said: *"I don't know—do you realy teach them basics there at school before they come to the ward, I mean those old nursing basics."*

Student #3, Focus Group1 said: *"Sometimes lecturing itself, if I may be a tutor comes and just read out like a newspaper that is system of teaching."*

In suport of what the respondents said, learning in adult education needs to change from traditonal concepts of lecturing and allow students to participate actively. This means that the teacher's role must change to be that of a facilitator. Learners become self-directed when they are provided with learning packages that require them to engage actively through a variety of exercises. When they are self-directed they become more responsible and will make sure that they donot absent themseves from work in order to learn more and achieve the competency required of them (WHO EURO, 2001:125).

Cashin (2010:10) indicated that lectures, despite the avilability of many methods of teaching, formal lecturesare still bieng used in most universities throughout the world.From the report, 58.6% of students surveyed voted in favour of the lecture method. The reseacher continued to argue that a lecture is a special form of communication in which gestures, eye contact and facial expresions can infuence students understanding; can describe and summerise scattered material or descibe latest issues of discoveries.Lectures assissted students with basics or fundamental theory that can later be aplied to practice to ehance integration of theory with practice.

At Thohoyandou Nursing Campus (formerly Venda Nursing College), the learners satisfactory survey for the end of May-June 2013 block, students opted for group

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discussions, self-learner presentation and demonstration as the top three strategies that had helped them to learn more effectively. The strategies promoted active participation by students, when students were involved in their learning they became more motivated and wanted to practice what they had explored and, by so doing, they got more chances to implement theory explored to see if it is applicable to real-life situations, thus integrating theory with clinical practice.

From the focus groups, students indicated that computer-aided learning and self-study had helped them. The students argued that it was easy to follow the lecturer if you were seeing, rather than listening to a monotonous voice that made them to sleep and lose the important information. Some students argued that they needed to be taken as adults who can learn on their own with minimal supervision from the facilitator.

> **Student #4, Focus Group 2 said:** "*My problem is on the audiovisual material where students manage to view/read while you are teaching I think it will be better if we are seeing something when you are teaching.*"

> **Student #3, Focus Group 2 said:** "*If the tutor can just do the facilitation work and give us more time to study. We spent a lot of time in class without doing things for ourselves like maybe in group work is better and the tutor just come and check "uri" where do we stuck, that is better because listening to the person talking is tiresome. The tutor needs to leave us and do things on ourselves and the tutor come just to evaluate if we have understood and correct us where we are going wrong, I think that can be good. Do the schedule that will give us more time for self-study like in the universities setting where people go to class maybe for an hour and the rest is for them to*

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read and learn, with us we attend the whole day 7-16 hours. The time to read is at night when there is no tutor if you stuck nowhere to go."

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In support of the respondents' views, Lisko and O'Dell (2010:106) indicated teaching strategies that gave students opportunities to utilize interactive skill videos participate in supervised skill demonstrations and use the nursing library. They also had an opportunity to experience all aspects of the learning cycle, including concrete experience, reflective observations, abstract conceptualization and active experimentation. Interactive skill videos improve student retention as retaining what you had seen is easier than memorizing things without understanding. Supervised skill demonstrations gave students opportunities to practice skills several times before final assessment; concrete experience assisted students to practice theory in real life which made it easier for them to correlate theory with practice.

The literature supports the point that strategies used for teaching assist in good integration of theory with practice. The use of computer-assisted learning, for example, Microsoft PowerPoint® for presentations and videos can assist students to learn (Quinn, 2007:215). Self-study helps students to work at their own pace as it encourages active seeking of information and increases critical analysis that assists students to integrate theory with clinical practice (WHO EURO, 2001:128).

4.3.1.3 Sub-Theme 1.3: Lack of Accompaniment

The inputs from the respondents' lecturers, students and midwives indicated the factor of lack of accompaniment by the teaching staff, this was because there were not enough lecturers to cover the classroom teaching and clinical reinforcement. This lack

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of accompaniment impeded learning as the learners could not manage to put theory to practice alone without the guidance of their lecturers. Lecturers need to be with the students to be able to assist them to correlate theory with practice, students also would understand a procedure better when it is performed by the same person who had taught them the theoretical component.

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According to the social-behavioural learning theory employed in this study, lecturers should act as role models in practical placement and ensure vicarious reinforcement. As asserted by Quinn (2007:99), lecturers must help students to practice what they were taught in class. During accompaniment, lecturers must use the teachable moment or sport teaching to assist students to implement theory with the practice. The way in which lecturers perform skills while students are observing, also motivates them as students would emulate lectures' diligence and competency. During accompaniment the lecturer should assess the students' competency and give them a chance to repeat the skills until they demonstrate competency. Lack of accompaniment would therefore interrupt this important function of a lecturer in clinical placement.

> **Lecturer #1 said:** *"Poor supervision in the sense that as a lecturer it is not always the case that you will be there with the students every day, and the days when you are not there you will find that registered midwives do not take over the function to teach and to supervise the students and then on how to do the procedures or daily routine because they feel it is not their responsibility."*

> **Student #4, Focus Group 2, said:** *"I do not know if it is allowed our tutors need to accompany us every day. We were taught pelvic assessment 3 months*

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ago, the overload that we were doing there makes us not to practice that. If "Mam" is there every day that thing will be better."

Midwife #1 said: *"Mmm, you will find that they are here at the hospital for the whole week and there is nobody comes for follow-up it makes them to dodge and just move around not concetrate on their learning. And the other issue is that you will find that students in certain procedures complaining that what we were taught by our lecturer is diferrent from the ones we are seeing here in the ward."*

Midwife #3 said: *"Another factor is accompaniment, we need someone to be with the students full-time for control purposes because students tend to take us professional nurses for granted and dodge. Some of them do not respect us nurses with bar one, so they need you as lecturer to supervise them. The accompanying lecturer would also help to bridge the gap of knowledge, will help to put students on board as far as midwifery practice is concerned,also act as a liason between college and the hospital to smoothen training. The preceptor will also help in drawing up a teaching programme, comes with clinical objectives to be covered or met acording to students level of training."*

In support of what respondents said, the Nursing and Midwifery Council (NMC, 2009:18) explained that students need to be supported both in academic and clinical practice; the teachers and mentors need to have knowledge, skills and expertise to support the students, and as such lectures would be able to identify clinical learning opportunities that would assist students to provide quality care and become competent. Teachers were expected to cover 20% of their teaching time in the clinical practice to

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enable students to apply theory to clinical practice.

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Bacon (2010:311) also supported the findings by indicating that midwifery lecturers must be more active in supporting mentors (midwives) throughout the process of referring students and being visible in the clinical area and meaningfully engage with students during assessment and clinical progression.

The lecturers mentioned transport as a contributing factor to lack of accompaniment as well as very long distances from the colleges to clinical areas. There were not enough cars for each discipline with a practical component to utilize on a daily basis; the college used fleet cars which were used by everyone in the campus. This became a problem if there were other activities that needed urgent attention, accompaniment would stop and the car would be sent to attend to such emergencies. The other problem was the distance between hospitals. The furthest hospital is 75 km to and from the campus, depending on the situation; sometimes the lecturers would be allocated one car to transport them to a different hospital, the lecturer to the furthest point arrived late at the hospital. Due to this problem, they would also depart early and shorten the time of accompaniment.

> **Lecturer #2 said:** *"The other problem, apart from shortage of staff, we've got shortage of transport, at some stage you may find that you are available and free, you want to go to accompany the students so that you reinforce the theoretical aspects taught in class in the clinical areas, but unfortunately you find that there is no transport to can take you to the clinical area."*

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Lecturer #4 said: *"This College has about 3-4 components with clinical practice, there is Community, General, Psychiatry and Midwifery—they use the same transport to go to clinical areas. Some clinical areas are far from each other, the transport spreads the lecturer to various areas; some arrive late and cannot do their work properly as they arrive late and suppose to leave early."*

The lecturers again mentioned the withdrawal of preceptors as a factor contributing to lack of accompaniment in the training hospitals. Before the relocation of training from hospital to colleges or institutions of higher learning, each hospital had a trained nurse tutor, called a preceptor, who was employed full-time to support or mentor the students at the clinical placement. Immediately after the process of moving to higher institutions, the hospitals withdrew their tutors to remain as hospital staff, leaving a lack of preceptors and thus nobody left in the units on a full-time basis to assist students to correlate theory with practice. Due to financial constraints, college were unable to hire enough staff to manage and alleviate the scarcity left by preceptors as discussed above.

Lecturer #2 said: *"Maybe the other thing that can relieve is to appoint clinical lecturers who are full-time with the students, it can assist students as far as imparting knowledge is concerned, because lecturers from the college are short. They can be mentors, but I want to further explain that it can be any person who will be with the students most part of the day. If this person is at the clinical area, students will report on duty to her and she will monitor their absence. It will be much better they will not wait for someone who is stuck by*

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transport. It just stopped, the nursing colleges become independent, and the hospitals withdraw their nurses who were preceptors as they were belonging to them. The colleges then become responsible of teaching and accompanying the students."

Lecturer #4 said: *"No we use to have preceptors, they are no longer there, by the time we were having the preceptors, students used to perform better because they have full-time person responsible for them working with them when they are allocated to maternity sections. She is with them demonstrating procedures, reinforcing, assessing and help them in smaller groups and they get more chance to practice. So the doing away with preceptors was the disadvantage as far as learning in the clinical area is concerned. The problem arise when the management or political change came in, it was said that every tutor can teach in class and go for accompaniment, so there is no need for the full-time preceptor, every lecturer can go with her students to clinical areas, but you will bear with me we cannot be with them every day even if we go is for a short period."*

In support of the respondents' views, the role of a lecturer in the clinical placement was shown to be of particular importance in a study done on caring as a core concept in midwifery learners (Chokwe & Wright, 2012:1). This qualitative study indicated that midwifery educators needed to be role models and competent practitioners who could apply the model of caring to those they teach. Furthermore, the study stated that midwifery educators were guardians of safe, competent and respectful midwifery care and should create conducive environments for learning in clinical practice. Lekhuleni,

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van der Walt and Ehlers (2004:15), further indicated that both the student nurse and unit managers expected nurse educators (lecturers) to accompany students, i.e., to assist student nurses to merge theory with practice in the clinical areas. By contrast, nurse educators did not perceive clinical accompaniment to be one of their tasks.

Moleki and Mogotlane (2011:81) indicated that there was a detachment between students and lecturers. The non-visibility of the lecturer was interpreted as a lack of support and guidance. Students in the clinical settings experienced a lack of recognition as intensive care student nurses compared to the support given to their counterparts doing the same course at residential institutions. As a result, the students' relationships with their preceptors amounted to requesting favours and exercising diplomacy in order to get assistance and guidance in the clinical situation, which was not supposed to be in so far as it was the responsibility of the lecturers to avail themselves of the clinical practice to support students. Clinical accompaniment in the education and training of nurses is an essential and interrelated function that ensures the integration of theory and practice, the integrity of clinical services provided to the clients and the development of student nurses' competencies.

4.3.2 Theme 2: Factors Related to Learning by Students

Table 4.4 summarizes theme 2: factors related to learning by students and its sub-themes. The respondents indicated that students' lack of interest towards midwifery practice and absenteeism by students affected the students' ability to merge theory with clinical practice. Some students just came to nursing because there were few opportunities for employment in other fields compared to the nursing profession, and some male students had a challenge to fidget with female genitals as this was not

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socially acceptable in most black communities.

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Midwife #2 said: *"It seems as if these students (vho tou da nga) had come because outside there, there is nothing, and this nursing (yashu heyi) they get stipend, they concetrate on their phones."*

Lecturer #4 said: *"Another thing is being the attitude for midwifery practice, especially for our male students, you will find that mostly they will hide behind others for anything that is related to midwifery practice."*

Pilkenton and Schom (2008; 29) indicated that there is still less interest amongst male nurses to choose midwifery as a carrier path due to social stereotypes and gender problems. There is 0, 6% of male midwives applying for midwifery training, this is due to few male midwives who can act as mentors to the male midwives. The poor interests to midwifery also impact their interest towards learning and practicing midwifery skills.

4.3.2.1 Sub-Theme 2.1: Lack of Interest Towards Learning and/or Midwifery

Lecturers and midwives indicated that the students showed lack of interest towards learning and/or midwifery practice, by not carrying their notebooks along to record important educational conditions, procedures or information. Some of the students were not aware of the objectives to be covered when allocated the specific unit. Some students did not bother to ask professional midwives if they met an interesting case that they were taught in the classroom so that they got opportunity to relate theory with practice.

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Lecturer #2 said: *"Ooh, the other things concerning students, as far as students are concerned, we've got students who are not committed to their learning (with a frowning, angry face), because now if you go for accompaniment you will find that if in the nursery there is a child under phototherapy they can't even ask from the sisters there what are the normal bilirubin levels, why are they covering the eyes, why is this baby under phototherapy, and so on. These students seem as if they are not motivated to learn. I don't know but they are just reluctant themselves. Again, also when they are in the clinical areas they've got this thing of that they put in their ears, earphones connected to the cell phones, so how can a person learn at the same time listening to music and attend to the patient. They don't care about the management. If the students have zeal to learn you will see that when she reaches the clinical area and will try to know or get information from the seniors or ask questions. If you go for accompaniment you will find them seated and when you ask them about the cases that are available and that they have learned about them in the class, when you ask of the things appearing of the patient, they don't know, meaning that they are not committed to learn."*

Midwife #2 said: *"Hey, someone must have that passion within tyhemselves (ya u ita mushumo) to do the work, it seems as if this students (vho tou da nga) had come because outside there,there is nothing, and this nursing (yashu heyi) they get stipend, they concetrate on their phones, and the other thing is this that they want to work together as a group/mob, he or she cannot do a procedure alone,this makes them not to learn because the one who is hands-on will benefit and the follower will not learn.".*

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Some students allocated in maternity units only work to meet their requirements because they just needed a certificate, after that they became relaxed, and not keen to practice. Moreover, college students tend to look down upon the practising midwives and do not follow their instructions, they only cooperate in the presence of their lecturers from the college. Some did not fill in their maternity case register in time; they waited until it was their final year and thought that they could fill the book in one day and forgot that the case register also assists them to integrate theory with practice and acquire skills.

> **Lecturer #4 said:** *"And you find that mostly the students they just want to fill the requirements, they want to complete the requirements instead of learning and as a result once the students finish the requirements they are no more keen to practice, they are no more keen to clinical exposure. They rather give themselves time off or they sit and do nothing at all."*

In support of the respondents view, Nordkvist, Pyykkö, Klingfberg-Allvin and Vu Tam (2010:21) indicated that becuase of the attitude that young people in Vietnam had towards HIV-infected pregnant women it affected them as student midwives. Their negative attitude towards HIV-infected women made them to lose interest towards midwifery practice; some were blaming the women that they were unfaithfull in their marriages becauseit was believed so in their culture.

Loss of interest affected their ability to learn midwifery and to implement the theory they had learn in the classrom in the practical placement. Poor implematation of theory with practice made them to fail to intergrate theory with practice properly, and this retarded their competency in midwifery skills. Furthermore, in support of what

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respondents said, Dr Mothiba from the University of Limpopo Turfloop Campus during practical moderation at Thohoyandou Campus commented about lack of commitment to learning (Practical exam held on 10/10/2013).

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4.3.2.2 Sub-Theme 2.2: Student Absenteeism

The lecturers indicated the factor of absenteeism, students usually absent themselves from work without valid reason. This factor made them to lose clinical hours and missed golden opportunities to acquire clinical skills.

> **Lecturer #4 said:** *"They rather give themselves time off or they sit and do nothing at all, they absent themselves from duty."*

Midwives indicated that students tended to dodge if there was no one directly supporting them during the clinical allocation, that is, when there were no lecturers accompanying students in the units.

> **Midwife #1 said:** *"Mmm, you will find that they are here at the hospital for the whole week and there is nobody comes for follow-up it makes them to dodge and just move around not concetrate on their learning."*

According to the literature consulted, there was increased rate of absenteesm since the studentnurse status changed from being part of workforce (apprenticeship) to being supernumerary or not forming part of the workforce(Timmins & Kaliszer, 2002:251).

The students of today have more freedom than those before them. This made students to absent themselves from classes or clinical areas. The absenteeism impacted

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negatively their training and perfomance in examinations as they lost valuable hours and precious time to learn nursing fundamentals and to practice nursing skills. This led to studnts being incompetent and lacking clinical skills proficiency. The most cited factors that led to absenteeism were personal reasons,poor suport, relations in the units and stress (Timmins & Kaliszer, 2002:262) .

Absenteeism is a problem all over the world and a solution cannot be easily found. This is also a challenge faced by employers in South Africa. Absenteeism exacerbates the difficulty of health service delivery in many countries and affects training if the person absent is a student. In this regard, South Africa is no exception. Increased rates of absenteeism were common amongst nurses who took themselves as less important than those with post-basic specialties (Singh, van der Colff & Stellenberg, 2012: IV). In this study, student would be most vulnerable to the absenteeism as they would see themselves as less important causing them to lose golden opportunities to learn midwifery fundamental theory and link theory with practice. The literature supports the view that persons who are not well-supported or who had problems with asupervisor tended to absent themselves from work and absenteeism retards prorgress of nursing care delivery as well as training. If studentsare absent they will miss valuable opportunities to learn and put theory into practice (Meyer et al., 2009:245).

4.3.2.3 Sub-Theme 2.3: Ability to Understand the Theory as Taught in Class

Lecturers and students indicated that students had difficulties to understand the theory in class. Students indicated that there were many factors that affected their listening in class, for example, room temperature, social stressors and other factors or problems. Lecturers cited factors like high ratio of students to lecturer and the intelligent quotient

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(IQ) of students. The teaching strategies employed in class and practice influenced the attention and retention of theory. The number of students in class affected the facilitation by the lectures, if students were more than the desirable lecturer: student ratio, they did not receive the attention they needed, leading to poor retention of theory taught in class.

> **Lecturer #3 said:** *"The numbers of students that we placed though I'm not exactly sure as to how many students are placed in maternity wards at a time, but that can have an influence because you may find that they don't get direct supervision because of the high number compared to those who are supervising them. Another thing you know "uri" when students are many and they might not be controlled."*

In support of what respondents said, Sarbornie (2010:2) indicated that poor space organization or overcrowding in the classroom may pose a threat to students' achievement and can influence students' behaviour, especially unwanted effects that may have a negative impact on the process of learning, poor spacing is also associated with students dissatisfaction, increased aggressiveness and off-task behaviours. Such environments render students ability to understand theory in class very difficult thus affecting their ability to implement theory into practice.

> **Lecturer #3 continued:** *"Mmm, what can be the other one? The other factor, even from the side of student is that did the student understand the theory in the first place, because I've got to go to the ward as a student and I didn't understand the theory when I was taught in class, what theory am I going to integrate, so students also have got a role to play of ensuring that they do have*

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the theory that they are going to practice or correlate it to practice. Is fine the college is doing well when assessing understanding of the theory in the form of tests, but again the truth is some of students would have failed the test to show that I don't have the theory."

Student #1, Focus Group 1 added: *"I think is when I've got some problems at home and may be around here."*

Davis (2004:1) corroborated that stress can impair concentration and affect sleep patterns, this can modify a nursing student's performance and cause him/her to get lower grades. The academic impact which could be poor progress might compound the anxiety. Davis warned that nursing programmes have one of the highest dropout rates because of burnout. Students who cannot handle the stress often become exhausted and experienced problem in class and in clinical placement where they would fail to implement what they had been taught, and because they did not understand the content some ended up quitting due to poor stress management skills.

4.3.2.4 Sub-Theme 2.4: Attitude of Students Towards Midwifery Practice

Lecturers and midwives indicated that students had a negative attitude towards midwifery practice and the midwife practitioners. This attitude stemmed from reports they received from others outside the work environment which made them to come to the units with misconceptions on midwifery practice and midwife practitioners.

Lecturer #4 said: *"Another thing is being the attitude for midwifery practice, especially for our male students, you will find that mostly they will hide behind others for anything that is related to midwifery practice."*

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Midwife #1 said: *"And mmm (shelaughs), "na"and attitude "ya" of student towards midwives, because when they are out of their learning situation they use to tell one another I mean "na havha vhanwe vha saathu daho uri eeh" those who are still to come that so and so is rude towards students which means eeh, when students come they will be very negative.That one we have a bit/little problem,because most of them they use to dodge, may be is affecting them because when you try to interview them they tell you ha, no this thing will make us not to marry when we just see this ladies delivering,because some students use to fall/fainting the process of delivering. Even during Caesarean birth, you find uri there was a boy who want to go to theatre, but was always fainting there,because he use to concetrate much on the knife that is cutiing the uterus. One day I went with him and made him to concetrate onthe preparation of the neonatal tray to receive the newborn, the only time I allowed him to turn it was when the baby was out, that day he did not faint,so there are very few guys who likes midwifery, but most of them no."*

In suport of these findings, Klingfberg-Allvin,Vu Tam, Nga, Ransjo-Arvidson and Johansson (2005:39) indicated that because of cultural beliefs in Vietnam it is a taboo for teenagers of age 10-18 years to engage in sexual activities, students were having negative attitude towards teenagers who were pregnant coming to gynaecological section seeking assistance to abort their pregnacies. Because of this attitude, student midwives found it dificult to assisst those teenagers coming for such services. This attitude made the students to lose interest towards midwifery training, thus affecting their ability to learn and implement midwifery procedures.

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Attitude can influence the progress in all areas of life; one academician once said *"Attitude is like a flat tire, you cannot go anywhere if you do not change it. Attitude is a foundation of daily life, so for one to achieve you need to have a positive attitude towards life"* (Nne na vhone (Me &You) Phalphala FM, 23/08/2013 at 11h00).

Social learning theory, in support of what the respondents said, accentuates the importance of cultural and emotional stability; and further indicates that an environment that accommodates cultural diversity reduces stress and promotes learning. Students' negative attitudes can be changed to positive if the issue of culture and emotional stability is addressed well. Then a positive learning environment will motivate students to execute/put in practice what had been taught which would assist them to integrate theory with clinical practice (Quinn, 2007:100).

4.3.3 Theme 3: Factors Related to Midwives in the Clinical Areas

Table 4.4 represent Theme 3: factors related to midwives in the clinical areas and its sub-themes. The respondents indicated that shortage of midwives in the clinical areas led to fewer numbers of mentors whom the students could observe and imitate to acquire clinical skills. Some of the midwives were reluctant to teach students and others midwives had negative attitude towards college students because they got stipends to support their training. The other factor indicated was the issue of declining midwifery practice standards wherein some midwives no longer set trolleys for procedures and some did not observe basic principles of performing procedures, for example, just opening the glove and performed vaginal examination without washing hands.

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Midwife #2 said: *"Ok, shortage of staff, we have got few midwives who need to attend to students as well as patients. Lack of accompaniment, sometimes you find that students need to be taught certain procedures and due to this shortage of staff we do not manage to teach them,we will just do a summary."*

In suport of what respondents said, Nash, Sacre, Calleja and Lock (2010:667) indicated that clinical placement is a core to undergraduates nurses and plays a significant part in their decision to pursue a career in nursing beyond graduation. Besides, this does not translate to a positive learning experience to develop as nurse neophyte, this is because there are less than the required number of mentors (midwives) to provide suporting learning environment, in addition to their already busy work schedule.

4.3.3.1 Sub-Theme 3.1: Shortage of Midwives

The respondents' lecturers and midwives indicated shortage of midwives in the unit as a factor that interrupted the proper integration of midwifery nursing science theory into clinical practice. The units needed to have sufficient numbers of midwives to cover for the needs of patients and those of the students. Midwives indicated that evenif 3 midwives were on duty with 12 students, the latter would be outnumbering the midwives on duty for that day. The same midwives were expected to provide care to pregnant and postnatal women and their newborn babies. This made it difficult for the midwives to execute their teaching role; they ended up helping the mothers to avoid loss of life.

According to the social learning behaviour theory used in this study, midwives are the role models. Competent, expert midwives motivated the students to perform skills

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diligently with confidence. The shortage of midwives in the unit interrupted the role modelling function of the midwives, thus interrupting the process of assisting student to put theory to practice (Quinn, 2007:100).

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Lecturer #3 said: *"I think there are many factors involved, the numbers of students that we placed, though I'm not exactly sure as to how many students are placed in maternity wards at a time, but that can have an influence because you may find that they don't get direct supervision because of the high number compared to those who are supervising them."*

Midwife #2 said: *"Ok, shortage of staff, we have got few midwives who need to attend to students as well as patients. Lack of accompaniment, sometimes you find that students need to be taught certain procedures and due to this shortage of staff we do not manage to teach them,we will just do a summary."*

In support of the respondents' views, the WHO (2006:19) indicated that there is shortage of skilled midwives worldwide. In this 21st century, women cannot dissociate birth from death and midwives were faced with a challenge to play their part in making childbirth safer. MDGs 4 and 5 included efforts to reduce child mortality and improve maternal health (Macdonald & Magill-Cerden, 2010:3). To meet the MDGs, many countries needed a skilled workforce and it is now widely accepted that the dire shortage of health workers in many places is among the most significant constraints to achieve the MDGs. Skilled attendance refers exclusively to people with midwifery skills who have been trained proficiently in the necessary skills to manage, diagnose and refer complications. To produce these skills, attendances need proper integration of midwifery nursing science theory with practice (Macdonald & Magill-Cherden, 2010:9).

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A study done in Malawi by Ngalande (2009:1) indicated that there were few registered nurses as well as midwives in clinical areas that pose a major challenge for students to acquire basic competencies during training. The shortage was evidenced by Malawi having a nurse midwife dense capacity of 0.59 per 1000 people compared to the recommended dense capacity of 25 per 1000 people. In South Africa, the National Perinatal Morbidity and Mortality Committee Report 2008-2010 indicated that the Eastern Cape had vacant post for nurses of 66.4% (DoH, 2008-2010:114), Mpumalanga 67.4% (DoH, 2008-2010:15) while the North West shortage was critical in all level of health care providers (DoH, 2008-2010:163). Shortage of staff disturbed the facilitation of training as there were too few midwives to assist students to apply theory and acquire the required proficiency of midwifery skills.

4.3.3.2 Sub-Theme 3.2: Attitude Towards Student Midwives

The lecturers, midwives and students indicated the factor of attitude of qualified midwives toward students. Some midwives had a negative attitude towards teaching students. Some midwives developed the negative attitude due to the problems they encountered with previous groups of students. Some midwives labelled the comprehensive (R.425) four year program students as lazy and irresponsible.

> **Lecturer #4 said:** *"Is not that much good, sometimes because of the attitude of the ward sisters, they think that this integrated students are for tutors and they don't teach them. They concentrate on their routine instead of teaching them. If they involve and supervise the students it can help students to integrate theory with practice because they are in the unit 24 hours and some of the*

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procedures they are conversant with them more than the lecturers, because that's where they should get a cream of information."

Student #4, Focus Group 2, said: *"At large I can say that the attitude of midwives towards students is also negative and also makes us to be negative towards midwifery.*

Student #2, Focus Group 2, said: *"Sisters must not take us all the same, labelling us by the mistakes of all R.425 students, and sisters should appear appreciable to us and not scary. What affects our motivation is this that we have been labelled there at the hospitals especially us R.425 integrated course as lazy, dodgy, that things somewhere it grows in a person you may find that I may say because they know I am lazy I may just go and just sit down and not work, moreover I am not taught, supervised so I just stand up when I want."*

Midwife #1 said: *"Mmm, the first one I think is the attidude of the midwives towards students; others are being negative about teaching students. Yaa, some of the students are meeting those problems of being generelized by one student's mistakes,although it will depend on the team that had worked with that particular student, becuase in other teams you will find that if one student made a mistake s/he will be corrected and not generalize,and when maybe that student comes to your side you will find that they are not willing to assisst them because of what was said about them. That is why i have agreed that some of them are called names, they are told they are lazy, whereas you will be suprised when you work with that same person, that person will just be working very hard."*

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Midwife #2 said: *"Another thing is the attitude of the midwives towards students and visa versa. Therefore, if I have identified that student so and so is a dodger I will have a negative attitude to her and this jeopadizes her learning, the other thing is that some procedures will be done when she is absent and she will never know because(o vha a siho) she was not there."*

One midwife indicated that some midwives had an attitude towards the comprehensive (R.425) students because they would be more qualified at the end while they themselves were doubly qualified.

Midwife #3 said: *"Some like us bar one becomes jealous because these students will come out with three bars."*

The midwives were also alleged to have called college students names, for example stipend because they received financial assistance during training, they tend to treat those from other institutions well because they did not receive stipend. Because of the stipend they also took them as workforce and not consider them as students who needed their assistance to acquire midwifery skills.

Student #4, Focus Group 2, said: *"The other thing is that we are getting a stipend when we get there our names are stipend; those who are not getting stipend are treated well. The way they treat us that side is very bad; mind you I am also a human being I have emotions."*

Midwife #1 said: *"Yeah, I think this will come back to the attitude, some students will be called by their hairstyles, the way they dress, yeah, not all midwives do so but others do or can call them names."*

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Students also complained about the treatment they received if they made mistakes, they would be harassed in front of patients, and they would be mocked and told that we did not expect such silly mistakes from a finalist (level 4) student.

> **Student #3, Focus Group 2, said:** *"Another one I think professional nurses should have a good working relationship with students because I am a student and learning even if I have done a mistake to the pregnant woman they should not tell me in front of that patient because the patient will lose trust in me, tell me separately because it demotivates me to work."*

> **Student#2 continued:** *"To me is criticism, sometimes you did mistakes you will be told what you have been learning at college, like it was said, and we are not the same you may find that you have been taught, but I am not yet there. You will find "uri" they will say that you are not willing to learn how come you don't know as you have been taught so many times I become discouraged."*

Hunter (2005:260) indicated that in Wales, students experienced problems with the senior midwives; they were expected to comply with wrong things in fear of being labelled and treated badly. Most of the midwives would not act as role models, but rather treated students in a manner that they should feel inferior or useless. This negative attitude towards students created an environment that made the student felt inferior and cannot say anything contrary to that of the professional midwives, even if they saw that what the midwives were doing was not procedural. This situation paralyzed the relationship between midwives and students. The students were emotionally traumatized and were unable to implement the theory to practice as their

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mentors were not assisting them and they were not allowed to be actively involved in the unit's activities.

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4.3.3.3 Sub-Theme 3.3: Reluctance of Midwives to Perform Teaching Function

The lecturers, midwives and students indicated that midwives were not keen to teach, some say they were not lecturers while others lacked the skills to teach. Some midwives would go to the extent of telling students that "I am not a lecturer, wait for your lecturers to come they should teach you."Some midwives chased away the students when they were dealing with emergencies like pre-eclampsia, they told students that this was above your scope it needed a midwife who were experienced. Some midwives refused to answer questions asked by students; they referred them to their books or their lecturers.

> **Lecturer #1 said:** *"Poor supervision in the sense that as a lecturer it is not always the case that you will be there with the students every day, and the days when you are not there you will find that registered midwives do not take over the function to teach and to supervise the students and then on how to do the procedures or daily routine because they feel it is not their responsibility."*

> **Lecturer #3 said:** *"Another factor could be that people who are supervising them, because not all people are interested in teaching the students. If a person is there and not very keen to teach the students, who might see students as a burden to them and they will expect students come knowing what they are there for, forgetting that "uri" they still need guidance, but still need someone to help them to put this theory into practice, or who will show them this you've*

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done in class. You know" uri" to some students is difficult to understand there and there. I don't want to call it attitude; it's like the preparedness of the supervisors to teach, because in most cases we take it for granted that if you are a professional nurse one of your functions is to teach, but that not necessarily mean people are keen to teach, they might want to work peacefully, not to teach, when they got to teach to them is double. So that can also be a problem to some."

Student #3,Focus Group 1, said: *"And also you should remind those sisters in the ward that teaching us is not a favour is something they have to do because they keep on telling us "uri yena ha bereki ke mastudents"(I am not an educator). I think this is more important because some tell us is not their scope to teach students."*

Midwife #1 said: *"Eish, there are some midwives who totaly do not want a student (also make the hand emphasis and shakes her head) to come into the wards, they say they do not see their help whereas they forget that they were once being a student in the previous years. Then you will find that when a student tries to ask they are scolded,told other wordsand then they did make them to fear some of the midwives,but is not all of them, there are those who are willing to help the students."*

Midwife #2 said: *"Some of the professional nurses are bossy and they don't want to teach the students. Lets say at that time there is a teachable moment and the student asked a question, they will sometimes say were you not taught*

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at the college, me I am not a tutor whereas teaching is one of the functions of a professional nurse, not so?"

Midwife #3 said: *"Comming to us profesional nurses, some of us do not tolerate student nurses, some become discouraged and do not like to teach the learners; they say they make them to delay routines. Some they are not able to teach by nature, some like us bar one becomes jealous because this students will come out with three bars."*

According to Meyer et al. (2009:101), professional nurses need to allow students to participate actively and enhance professional socialization, and delegate the students with some responsibilities under supervision and not see all students as irresponsible. Delegating students' responsibilities allowed students to get more chances to practice and achieve the required competency. Students also indicated that midwives shifted responsibility, if one midwife was working with students attending a case and a problem arose that midwife would vanish and leave students alone without supervision. They did not want to be accountable for the mistakes made by students under their supervision, making them to avoid working with students and resulting in students being deprived of opportunities to practice what they were taught, thus leading to poor integration of theory with practice.

Student #6, Focus Group 2, said: *"When we do mistakes they run away they do not want to be responsible. They were supposed to supervise us to prevent that mistake to occur."*

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Student #2,Focus Group3, said: *"Professional nurses shift responsibilities if maybe I am working with a professional nurse and the problem arise they hide; if you call them they will say go and tell who or who they don't want to be involved anymore."*

Some students said that when they were in level 4, midwives did not supervise them, they left everything upon them, and the midwives said that as they were in level 4, they were now colleagues and students could do things on their own. This was not appropriate because students needed their support until they become qualified; even after qualifying they would still need support from the experienced midwives.

Student #5, Focus Group 2, said: *"Sometimes when you are in 4th level and ask them a question they will say no now you are in 4th level we are colleagues do it yourself so in that situation what are supposed to do, even if I am a professional nurse if I don't know a thing I have to ask the response must not be negative, we might be colleagues but you may be having more knowledge than that I have."*

Student #6 continued: *"Another thing is that when we arrived there is like we are replacing them they just leave everything to us and the work becomes too much and we get exhausted."*

Student #2, Focus Group 3, said: *"Professional nurses sometimes leave us alone to monitor patients, even if we are level 4, we need mentoring."*

According to the literature, midwives need to act as a resource for students,i.e., provide them with answers to what they do not understand. Midwives need to make

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sure that students receive maximum benefit from their allocation to the units while caring for the mother and her newborn baby during midwifery training. For students to get maximum midwifery exposure to perform procedures skilfully, midwives need to follow correct principles to assist students to learn through observation (Quinn, 2007:377).

Moreover, professional nurses need to be available and guide or support students in clinical practice. They also need to assist students to move from the state of not knowing to knowing, this will assist students to gain confidence as they become more knowledgeable and independent (Meyer et al., 2009:106). In line with the findings of this study, Singingtree (2006:1) indicated that being a good midwife does not necessarily make a good teacher, but knowledge of basic educational principles will help a midwife to be a more effective teacher. During the clinical placement, a midwife could take advantage of clear written objectives, skill check-off sheets and other written guidelines to assist students to learn and implement midwifery procedures.

4.3.3.4 Sub-Theme 3.4: Language Barrier

Students and midwives indicated that qualified midwives were using their own language during report giving; this made them not to learn as they were all not Venda's or Pedi's. Midwife #2 supported the issue of language problems in a training hospital; midwives were using their native language when they are executing duties in the units. The respondents further emphasized that it was a must to use English, more especially in training hospitals because English was their medium of instruction during training.

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Student #4, Focus Group 2, said: *"Some other problem is language you will find "uri" we learn in class in English, I know in RSA is democracy, but when I get to the hospital I have to grab complicated words in Venda words, so that thing discourages me to learn, some of the words you can't hear properly as you are not Venda speaking. I am not a Venda or English, the two languages make things complicated. At the hospital I am going to perform a procedure with a Venda person it is difficult to correlate theory with practice."*

Midwife #2 said: *"Yes is true, I am from advanced midwifery training at Polokwane Hospital, there they will be using Sepedi in everything,we from Venda we don't learn, except in the class for theory. Yeah, they are right there for patients also who is a Pedi and me who is a Venda it was not easy to communicate,well and this demotivated us to learn; besides because they were using Sepedi in everything we were even afraid to ask certain things because they will be amazed and say where do you come from or they will stress(mo rena re bapedi) here we are pedis and in a teaching institution this is not allowed."*

In line with the findings, Fransen,Wildschut, Mackenbach,Steegers and Essink-Bot (2012:7) indicated that language barierswere the main dificulty in providing cultural competence care in diverse pregnant women who were to be counselled for Down's syndrome care and were not proficient in English. Some midwives used translated materials, others needed an interpeter and ended up using family friends who were not trained interpreters. This led to huge backlogs as women could not become conversant of what was expected of them due to language problems. The same would apply to

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training students who are not proficient with the language used by the midwives inthe training hospitals of the Vhembe district. The students missed important information and the opportunity to apply theory to practice during report times as midwives were using their own native languages.

In support of what respondents said, Au, Taylor and Gold (2009:1) indicated that more than 23 million Americans had limited English proficiency which had complicated their ability to obtain quality health care. Language barriers in the healht care sectors led to delayed or denied service,issues with medication, management and underutilization of preventive services. Likewise, the outcomes of the language problem would as well affect the training of midwives in the Vhembe district. The students placed in the hospital where midwives are using their own native language will be delayed to get the opportunity to practice the skills as demonstrated to them in order to attain proficiency. Because some patients were Venda speaking and students were Pedi speaking it also presented them with problems to perfom procedures on such patients due to language barrier. Furthermore, students can be delayed to implent what they were taught and to merge theory with practice.

In suport of the findings of this study, Perkins (1999:38) indicated that a language problem existed in North Carolina most citizen had limited English proficiency. The citizens that came to seek medical treatment, received delayed and inapropriate care due to the language barrier. Health care providers were English speaking. The same applies to people from the Central American countries like Mexico and Vietnam who experienced dificulties withmedical health care providers. The same problem would occur if the midwives in the units use their own language, students would be delayed

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to learn skills as they need to learn the language first, then try to impement what has been taught to clinical practice.

4.3.3.5 Sub-Theme 3.5: Declining Midwifery Practice Standards

The lecturers, students and midwives indicated that midwife practitioners were no longer committed to their practice; they usually overlooked issues of maintaining sterility during internal examinations and other procedures that needed sterility. They no longer set trolleys for procedures, and did not follow some steps in their daily routine care, for example, washing of hands in between patients. They also no longer took their responsibility to supervise students in the clinical settings. According to social learning theory, learning occurs through observation students learn by observing practitioners who are experts in the field of midwifery. If the standards were declining, proficiency by the midwife would be minimal, interrupting the vicarious reinforcement that learning happens by imitating others (Quinn, 2007:100).

> **Lecturer #3 said:** *"The issue I forgot about supervision is delegation, if the students are not delegated it becomes very much difficult to control them and to check whether students have done anything, but if students were delegated, the supervisor will check what the student has achieved, learned or challenges and, or because delegation goes on with supervision you will be able to pick up what students know and help you to follow-up students and give students time to give feedback, if it is lacking, tomorrow you delegate student to the same situation to ensure competency."*

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Student #6, Focus Group 1, said: *"Shortcuts, at the hospitals; they don't know or do the way things should be done so those things also affect us."*

Student #5, Focus Group 2, said: *"When we are supposed to correlate theory with practice you may find that the procedure that we have learned in class is not the same with the one in practical. Maybe PV exam the way you teach us here is not the way they are doing it at the practice, if you want to do the procedure the way you have been taught, they will tell you the patients are so many so we can't do this thing procedurally as they taught you in class, and so you find that you don't get the time to practice what you were taught."*

Student #4, Focus Group 2, said: *"Nurses to try by all means in our presence, to do things procedurally, because we are still learning. Stop to do things haphazardly since time management is important to them."*

Student #2, Focus Group 3, said: *"Practice what they preach, if they expect us to be experts even they need to be experts. "Mam" because they want us to do things perfectly, "yena" at the same time is failing to do a procedure properly, they must follow the right procedure, they have to be punctual in time, sometimes they sit in tea rooms for 2 hours when you go for tea 1 hour they say tea is only 15 minutes you have to come back but they are in tea room."*

In support of the respondents' views, the NMC set standards and expected each nurse and midwife in the UK to adhere to them. The standards included delegating students according to their level of competence and supervise or support them. The midwives

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were expected to provide a high standard of practice and care at all times, to keep their skills and knowledge up-to-date, not to be partial, uphold the reputation of their profession and act with integrity. All these standards were meant to facilitate excellent patient care and thus assisted the students in the placement to learn by imitating and observation (NMC, 2008:5). Declining midwifery standards meant that the explained standards were low, distorting the image of midwifery practice and thus made students to observe and learn poor midwifery care.

According to the social learning theory employed in this study, the professional midwives acted as the role models. The midwife practitioners needed to adhere to midwifery care standards to provide competent, proficient midwifery care. The students were motivated to learn when they saw a professional who were skilled and competent enough to provide excellent and accurate care (Quinn, 2007:100). Failure to adhere to midwifery standards deprive students of the opportunity to learn by observation and imitating the midwives.

The literature supports the notion that a professional nurse or midwife should help a student to make things happen and to diagnose, plan, implement and evaluate systematically. The professional nurse or midwife smoothens problems encountered by calling upon experience, contacts and extra resources. She sets standards and criteria that are to be maintained to help students to focus within each topic or subject in order to merge theory with practice. She sets outcomes that are measurable, and assessment tools, which will help students to meet their training needs (Neary, 2000:31).

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4.3.4 Theme 4: Factors Related to Systems in the Organization

Table 4.4 summarizes theme 4: factors related to systems in the organization and its sub-themes. The respondents indicated that shortage of material and medical supplies in the training hospitals affected the training of students. They further explained that there were no gloves which were essentials in the maternity section and which made it difficult for students to perform procedures as they were demonstrated to them in class. When they arrive in clinical areas they become spectators instead of being active learners due to lack of equipment. The other factor indicated was shortage of accommodation inside the clinical areas which led to travelling by students from the college to hospitals resulting in them losing critical hours to be spent in the unit trying to merge theory with practice.

> **Student #3, Focus Group 1, said:** *"There is shortage of gloves and they did not allow students to do procedures because they will waste gloves; also delivery packs and suturing materials."*

> **Student #6, Focus Group 1, added:** "*There was another time were they will not allow us to do PV, we just go there for vital signs only."*

According to social learning theory, organizational policies, mission, vision and standards would serve as basis of a well-established culture. A well-established organization has less emotional instability or stress, and this environment is conducive to learning. This environment was favourable as far as social learning theory was concerned, learning through observation would take place with ease (Quinn, 2007:101).

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4.3.4.1 Sub-Theme 4.1: Shortage of Student Accommodation Next to Clinical Placements

Lecturers mentioned the factor of lack of accommodation inside the hospital or inside the nursing campus. They further argued that it was ideal for student to be next the clinical placement as this would give them more time to practice, if they stayed inside campus or the clinical area, they could also use their spare time to go to the units and rehearse or practice the skills they were not yet competent in. This factor, according to them, contributed to late coming and early departure leading to students having less time of exposure to clinical placement and thus poor integration of theory with practice. The students also mentioned this factor caused students to stay away from the clinical placement and, as such, they were transported daily to their clinical placements. Daily travelling exhausted them and contributed to late arrival at work and early departure; they also arrived late at their residential areas and failed to read or rehearse what they have learned due to exhaustion. This problem made them to lose hours and fail to meet clinical requirements.

> **Student #1, Focus Group1, said:** *"The issue of travelling is a problem, we become tired before we arrive to work, even the knock-out time, suppose you have the patient to monitor, then the bus comes, you had to leave the patient and go."*

Clare, Edwards, Brown and White (2003:10) indicated that due to the increased number of health care students there were shortages of accommodation in the clinical areas, but accommodating students in their clinical placement had an influence on student training. Staying inside the clinical premises during clinical placement gave students more opportunity to be next to the patient and allowed them to execute their

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health care with fewer problems. The g[illegible]t tried to resolve the problem by advocating for accreditation of more clinical areas that would accommodate students during clinical placements.In the then Venda Nursing College senate meeting held in 1986, it was agreed that nursing students were supposed to stay inside the hostels of hospitals or nursing college, unless exemption had been granted by the college principal. Staying close to the hospital or college helped the student to be next to the patient and afforded them with more time to apply their theory to practice (Venda Nursing College Senate Meeting, 1986:2).

4.3.4.2 Sub-Theme 4.2: Shortage of Material Resources and Physical Structures

Lectures and midwives complained of the shortage of medical equipment and supplies as another factor that put the training of midwives at risk. There is shortage of gloves, per vaginal (PV) examination packs and other medical supplies. Lack of gloves does not allow midwives to teach procedures like PV examination, suturing of episiotomy and many others; in fact in maternity sections, gloves are a priority because health care providers are dealing with human blood and other body fluids that are potentially infectious. Thus, the absence of packs makes it difficult to demonstrate sterile and other surgical clean procedures. All this jeopardize training of students.

> **Lecturer #1said:** *"You may find that maybe you want to show the students how to do per vaginal examination, you'll find that there is no complete pack where you find that you will have to improvise and learners usually grab things that they see in the first day . This also makes you do the wrong things or not able to show students the correct way of doing things."*

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Lecturer #2 stated: *"The other thing is shortage of equipment, of which that this one is very much serious, that is why nowadays we are producing the midwives who are not skilled. We are running short of gloves, you can imagine if we do not have gloves how are we going to teach per vaginal examination, etc. It is also difficult to control infections because we do not have gloves; other things are soaps, eye ointment, suturing material, to name just a few. The instruments we are talking about are found in the hospitals. In the hospitals there is no water to wash hands, one of the MDGs is to prevent infection and control it, how are we going to control it without water, soaps and gloves? There is no suturing material, cord clamps, not one at all; all 3 hospitals where we allocate our students have some stage of shortage of equipment. Linen we don't even talk about it, is not there at all, no sterilized packs autoclaving machines are out of order. This makes it difficult to produce skilled, competent midwives."*

Midwife #1 said: *"As far as equipment are concerned we are having a problem,we donot have enough equipment,more especialywhen we come to suturing or stitch packs,you will find that in this situation now we are not having stitch packs. Sometimes you may find that inside the delivery packs there is no needle holder,when you teach the student you will find that there is an artery forceps, it will need somebody who is experienced to suture. You may find that there is no delivery pack you will need to use a PV pack to deliver patients. PV packs do not have all equipment for delivery. Yes just like some months back we were not having the cord clamps,and you find "uri" that we are using tags or ligatures to tie the newborns cords and is very dificult to*

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teach sudents because we ourselves are not used to this tags, so when it comes to students it becomes very tough."

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In support of what the respondents said, the National Perinatal Morbidity and Mortality Committee Report 2008-2010 outlined the survey of equipment, which was done by Nkwanyama and Velaphi in neonatal units of South Africa. The report showed that 64 district hospitals accounting for 68% of total hospitals lacked radiant warmers, 63 lacked resuscitation equipment and 19 had no suction machines, while 82 lacked equipment to monitor vital signs. The shortage of equipment affected training negatively as students would not get the opportunity to observe essential procedures as there was no equipment to perform such procedures. Midwives did not execute their duties procedurally where there were no gloves and this interfered with their functions as role models and mentors to student midwives (DoH, 2008-2010:88).

From the focus groups interviews, students also mentioned the above factors, to them were problems because they were denied the opportunity to practice as they would waste material and contributed to more shortages. In some instances, they went to the clinical placement only to take vital signs so that they would not waste gloves and other materials. Shortage of equipment deprived them of the opportunity to do skills repeatedly so that they would become competent.

Student #3, Focus Group1, said: *"There is shortage of gloves and they did not allow students to do procedures because they will waste gloves."*

Student #6 said: *"There was another time when they will not allow us to do per vaginal examination (PV), we just go there for vital signs only."*

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Student #2,Focus Group 2, said: *packs, they will tell you that eh they are limited numbers of PV packs and it is a waste to always open a new pack for one patient, they will tell you are wasting resources by using so many PV packs in one patient and patients are many. Even gloves are short; they will tell you to use one glove for one patient ant the other one glove for one hand the second glove for the second patient."*

Student #1 added: *"I just want to add on that, when doing PV you are supposed to use sterile gloves, so at the hospitals we are not allowed to use sterile gloves; they will tell you it is a waste even if you use them "mam" you use one glove from the pack and the other one is for the next patient."*

A study done in Pakistan indicated that government hospitals lacked resources as well as the required number of doctors. Hospitals where doctors were present were helpless due to the absence of proper resources to treat their patients. Those who can't afford private doctors waited for death to ease their suffering. Most of the health care facilities in such areas were provided by non-government-run hospitals and clinics due to the lack of resources. Lack of materials also affected training of health workers as there would be no equipment to show student practitioners correct procedures. Students ended witnessing wrongly performed procedures, thus affecting their chance to put theory into practice (Khan, 2012).

Students also complained of shortage of study material in the library. There were a limited number of recommended books in the library and those that were there were old, most especially research books. Midwifery was using about 3 prescribed books

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which made it difficult to buy all of them, some were borrowed from the library, but copies were limited.

> **Student #4,Focus Group 2, said:** *"To add on that the other problem is the reference where we get the information we know "uri" we are having so many books in terms of midwifery, are they are 4 or 3,"hoo" they are 3. You may find that if maybe you are reading LGA you may find that in Myles you get certain portion, e.g. Causes for complications and others you need to go and refer in the other books and mind you the time is going and then each information you have to go slowly reading to understand. The other thing when you go to the library you find "Uri" there are no books they are limited. In the issue of books at library the recommended books are limited you cannot get them , when you go up and down looking for information you get tired before you start to study."*

In support of what the student respondents said, the nursing education in the EMRO has a standard which ensures that all training institutions had a well-equipped library, laboratories and media resources. The equipped libraries assisted students to have more references on the theoretical parts searching for the fundamentals or basic information necessary to apply theory to practice. Laboratories assisted students to simulate procedures before they perform them in a real life situation, whilst media resources assisted them to view some procedures and rehearse some steps they had forgotten, after rehearsing they went to real life and perform the procedures with confidence, thus practising procedures to produce expected competencies (EMRO, 1998:20).

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Midwife #2 complained of medical equipment like a foetal cadiotocograph (CTG) machine, blood pressure monitoring machines and many others. Besides the limited number of some equipment there was no or less maintenance, therefore the equipment was overused and became damaged before their actual lifespan.

> **Midwife #2 said:** *"We don't have, we don't have. For example, we have a blood pressure machine for the whole of maternity section starting here in labour ward to postnatal ward. Cadiotocograph (CTG) machine at least each unit need to have one, but we are having one CTG machine for the whole maternity section; moving the machine from one cubicle to the other can make it fall and break (ra dovha ra vha na problem) and then we will have a problem. Resuscitation unit is also only one, to mention just a few."*

In support of what the midwife respondents said, EMRO recommended that all training institutions staff must include trained technicians to handle maintenances, to maintain optimal functioning of all educational equipment. Well-maintained equipment has a longer lifespan and could be available for use by everyone and produce reliable outcomes that would assist students to practice and learn correct procedures (EMRO, 1998:20).

Some of the lecturers also raised the issue of the environment; they further explained that the college has classrooms that could carry a maximum of 30 learners. Currently, because of political influence, the intake was between 50 or more students. The number was large compared to available classrooms and this led to overcrowding. The other factor was that the classrooms also lacked heating and cooling systems. The

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lighting and ventilation was also affected. The other issue was that the classrooms were dirty and not well kept.

> **Lecturer #2 said:** "*Okay, sorry can I add something; I've missed the issue of environment; we've shortage of rooms as our college is old, the class rooms are also small and not well ventilated and we have large groups, there are no fans or air cons and is very hot here. The classes are packed as they were meant to accommodate students and now we are taking 50 and above. The environment is not conducive for learning. There is also shortage of cleaners; the environment is so dirty, cleaned once a weak is not right, this is also contributing to students not learning properly.*"

Some also mentioned the problem of the number of hospital/clinical placements, the number of hospitals had not increase and the college was taking in more students. Some hospitals were too old and dilapidated. The units to allocate students were small to accommodate all training students from different training institutions.

> **Lecturer #4 said:** "*Also the number of clinical areas is not increased and we are taking large groups that cannot be accommodated at the hospitals. The hospitals also catering for other training institutions and I cannot mention their names. Taking 10 students at the same time in a unit is very difficult; this then now will affect issue of commitment, only committed students will learn, the rest will come back to class without learning. Environment also contributes to poor participation by the students in the clinical learning.*"

In support of what the respondents had said EMRO standards stressed the need for

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sufficient numbers of classrooms, which appropriate in size, have equipment to support learning and teaching, e.g., group lectures, conveniently located offices for teaching staff, administrators and support staff. Learning laboratories are well-equipped and large enough to meet students' needs without crowding and run by qualified staff. Facilities for clinical training include hospitals, clinics and other agencies, industries and home (EMRO, 1998:20). Quinn (2007:203) affirmed that a well-organized environment, arranged before, can facilitate learning, the classroom setting should be well-ventilated and have good lighting, and not overcrowded. An overcrowded classroom would interfere with students' ability to learn and retain theory taught in class, thus resulting in the students' inability to execute theory in the clinical practice.

4.3.4.3 Sub-Theme 4.3: Short Periods of Learning and Clinical Exposure

The lecturers, students and the midwives mentioned this factor, the students said this repeatedly in almost all their focus group sessions. The lecturers explained that the students were expected to cover objectives for 4 major subjects in 4 years, which is sometimes not possible. Students tended to gain more theory than practice because of time. They further said that theory was easy to cram and recite, but practice needs prolonged exposure to clinical placement.

> **Lecturer #4 said:** *"Time allocated for the programme is limited; the students are taught at the same time they are being evaluated, at the same time they need to practice and you find that mostly the students they just want to fill the requirements, they want to complete the requirements instead of learning and as a result once the students finish the requirements they are no more keen to*

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practice, they are no more keen clinical exposure. They rather give themselves time off or they sit and do nothing at all."

Student #1, Focus Group 3, said: *"I think it is the integration of the course in general, is it not that we do MID, PNS and GNS at the same time, this contributes to us not correlating theory with practice and the time is limited."*

Student #6 said: "*Eeh our allocation at the clinical, you will find that you are allocated at the PNS ward 2 weeks, MID 2 weeks, we find that the time is short in one unit in one month we do two different things that's why we cannot correlate theory with practice."*

Midwife #2 said: *"I think the time is short, is it not that you allocate them 2 weeks,2weeks in a unit , this is not enough for learning. If you allocate them 1 month in a unit, is just that the schedule is too short because they must be in labour,nursery and postnatal,no is too much in short space of time."*

In suport of what the respondents said, the NMC in the UK stated that the length of training was no less than 3 year's equivalent to 156 weeks fulltime, full-time not more than 5 years and part-time not more than 7 years; where a student was already registered with NMC as a nurse, the length was 18 months. By this period the council believed that student would have had adequate time to apply theory of nursing to clinical practice and produce the competencies required to become a professional nurse or midwife (NMC, 2009:17).

Student in their focus gruops indicated the issue of long teaching periods. They complained that they attend classes like secondary school students and were not given

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opportunity to do self-study like university students. They viewed self-study as more effective than the lecture method where they listened to one voice for a long time.

Student #3,Focus Group 1, said: *"Attending for a lot of periods, let's say for the first 3 hours you were attending something, the next four hours something it makes you tired."*

Student #5,Focus Group 2, said: *"I think the thing that umm...that stop or affect us to retain the theory that have been taught is that time is limited; you may find that the tutor teaches so many topics at the same time,"ke uri" the tutor teaches so many study units at the same time, obviously you may not manage to cram all the study units."*

Student #4 from the same group said: *"To add on what has been said, at times you may find "uri" the learning hours are too long, and imagine getting to class at about seven in the morning, to knock off at 16h00, so you find "uri" at times you have to be seated for a long time, from 7-10 is better, but from 10-13h00 that period is too long to such an extent that concentration you had in the morning is no longer there, so that thing affects us also."*

Student #6 from the same group said: *"Do the schedule that will give us more time for self-study like in the universities setting where people go to class maybe for an hour and the rest is for them to read and learn, with us we attend the whole day 7-16 hours."*

In support of the respondents' views, Rumpus (2009:2) indicated that long lectures overload students with information and did not ensure that students had learned.

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Students usually lose concentration within 20 minutes and if a lecturer continued they would not learn from such presentation. If a lecturer took long some students lose track and resort to their cell phones and other things. This affects students' ability to retain the theory and apply it in practice.

Contrary to what the respondents said, Ryan, Delaney and Harmon (2010:15), indicated that the factor that encouraged students to learn were neither the economic status of the parents nor that of the country, neither the number of hours taken to attend a lecture or time spent in the studies. The factor of student cognitive ability/Intelligent Quotient (IQ), age and year or level at which the student were strong determinants of student progress at the tertiary schools. According to social learning theory, the students with good IQ could manage to pay attention to theory lectured, retained the theory learned, rehearse the theory while they were observing the midwives in maternity units and applied the theory (developed psychomotor behaviour) in the clinical placements.

4.3.4.4 Sub-Theme 4.4: Student Selection Criteria

The lecturers and midwives complained about the student nurses' selection criteria. They stated that due to political changes students were just selected without considering the matric scores and subjects. Previously, for a student to qualify for selection s/he was supposed to have science subjects and English as an additional language. The subjects were no longer considered; every student who had passed grade 12 with bachelor's certificate was selected for training. This factor affected the training as other students who were selected without the basics of science subjects were not coping with the training.

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Lecturer #4 said: *"As far as student selection is concerned, I'm concerned about the subjects; nowadays they take all the subjects even accounting and economics, previously they used to consider biology which has something to do with nursing, you are to consider English and you find that at some stage students are not able to express themselves, in writing you will find that in the midst of the script she uses her own language to express herself, that is another problem. Another thing is the M-score is it not that the M–score has been reduced. Previously the score used was 30 M-score. The failure rate we see today was not there during that time, when they really take students that had passed well."*

Midwife #3 said: *"Selection criteria, nowawdays all students are just taken wthout considering their subjects. Atleast a student for nursing need to have biology,like in engeneering you cannot do it without science and mathematics. For the students to start something new makes them to be behind and not perform."*

The Durban University of Technology (DUT) Handbook (2013:7) indicated that for a student to be admitted for a nursing degree s/he must have a national senior certificate with endorsement or a matric certificate with exemption. The compulsory subjects were English with E higher grade (HG), life sciences or biology with D (HG) and physical science or math literacy/mathematics with D (HG). The criterion was meant to select students who would be able to cope with training and pursue the degree until fourth level and register with the SANC as a nurse or a midwife. The student would have ability to learn in class and implement the theory learned into clinical practice.

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In support of what the respondents said, Kathmandu University Medical College (KMC) indicated that students selected for training should be capable and would manage to complete training without difficulties. All applicants at KMC were required to have A or B scores in their secondary examinations, the C score were only called if there were enough space and A or B score was not enough. All applicants were to be interviewed to identify those who would be able to deal compassionately and effectively with patients, and try to elicit the motivation to seek medical profession. The candidate needed to score not less than 28 points to qualify for selection. This process is believed to select the candidate who would progress well in their training without difficulties. Students learn theory in class and manage to apply it when they are expected to deal with patients in the clinical placements (Maharjan & Dixit, 2003:254).

In support of what the respondents said, EMRO entrance requirements to nursing was that candidates needed to have 12 years of general school and preferably in the science stream, and passed the national secondary school examination with a minimum of 65% or its equivalent. Candidates would be required to attend a personal interview, and admission requirements include proficiency in the language of instruction. This made it easy for students to understood and passed theory in class and they also managed to put what had been taught into practice (EMRO, 1998:21).

4.4. Summary

This chapter focused on the analysis and discussion of the data in the context of the literature control. The findings were discussed and grouped according to the identified relationships. The grouped information was categorized and contextualized against the background of the literature and social/observational learning theory. The next

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chapter deals with the recommendations, conclusions and limitations of the study.

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RECOMMENDATIONS, CONCLUSIONS AND LIMITATIONS OF THE STUDY

5.1 Introduction

The previous chapter encapsulated the responses of lecturers, students and midwives with regard to factors that were affecting the integration of midwifery nursing science theory with clinical practice. These responses were analyzed and discussed in the context of relevant literature on the topic. This chapter provides an overview, recommendations, conclusion, and limitations of the study.

5.2 Overview of the Study

The study sought to identify the factors that affected integration of Midwifery Nursing Science theory with clinical practice in selected training hospitals of Vhembe District, Limpopo Province.

The objectives of the study were to:

- Explore the factors that affected the integration of midwifery nursing science theory with clinical practice.
- Describe the factors that were affecting the integration of midwifery nursing science theory with clinical practice.

To achieve the above objectives, the researcher did the following:

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The researcher explored the factors referred to above through in-depth one-to-one interviews with the lecturers and midwives selected from training hospitals of Vhembe District, Limpopo Province. Four lecturers and 3 midwives participated in the study. Interviews were recorded with the consent from the respondents. The researcher also took field notes of non-verbal responses to help the researcher to retrieve and explore the processes of the interview and to minimize loss of data. The raw data were then transcribed verbatim as explained in Chapter 3 of this study.

The data from the students was explored using focus group interviews which were also recorded and transcribed verbatim. The researcher used the principles of social learning and behavioural theory to develop the focus group interview guide which comprised of 5 questions (Annexure 3B).Three focus groups were composed of 6 students each. Focus Group 1 was from Donald Fraser Hospital, Focus Group 2 from Tshilidzini Hospital and Focus Group 3 from Siloam Hospital. The researcher had one session of between 30 and 90 minutes duration—data saturation was reached within each session. Below follows as evaluation if the objectives of this study were met:

5.2.1 Objective 1

Explore factors that affected the integration of midwifery nursing science theory with clinical practice.

The major theme was poor integration of midwifery nursing science theory with clinical practice. Four themes emerged and under each theme different factors that affected the integration of theory with practice were revealed. Theme 1, which is factors related to teaching and facilitation by lecturers, yielded sub-themes,viz.,

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shortage of lecturers, systems of teaching and lack of student accompaniment in the clinical areas. Theme 2, i.e., factors related to learning by students engendered the sub-themes, viz., lack of interest towards learning and or midwifery, student absenteeism, ability to understand the theory as taught in class and attitude of students towards midwifery as well as midwives. Theme 3, which is factors related to midwives in the clinical area, was borne out by several sub-themes, which includeded; shortage of midwives, attitudes towards student midwives, reluctance to take their teaching function, language barrier and declining midwifery practice standards. Theme 4, which is factors related to systems in the organization, produced the sub-themes shortage of students, accommodation next to their clinical placements, shortage of material resources, short periods of learning and clinical exposure and student selection criteria.

5.2.2 Objective 2

Describe factors that affected the integration of midwifery nursing science theory with clinical practice.

5.2.2.1 Theme 1: Factors Related to Teaching and Facilitation by Lecturers

Shortage of lecturers at the Limpopo College of Nursing was identified by the respondents as a factor that impacted negatively on the integration of midwifery nursing science theory with clinical practice. The large student to lecturer ratio resulted in fewer than the requisite number lecturers being available for clinical accompaniment to guide students to correlate midwifery nursing theory with practice. In addition, respondents felt that the systems of teaching, in particular the traditional lecture method of transferring information to students, were outdated. Relating to the

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social learning theory, this shortage of lecturers adversely affected the capacity of the lecturers to teach students the fundamental theories of nursing or midwifery basics before their placement in clinical practice, and hence lecturers could not accompany students to clinical areas to act as role models that would assist students to merge theory with clinical practice.

5.2.2.2 Theme 2: Factors Related to Learning by Students

Lack of interest and commitment by students towards learning and/or midwifery were described by midwives as a major obstacle for integrating theory with clinical exposure. Moreover, midwives regarded absenteeism without valid reasons and dodging behaviours by students as evasive manoeuvres to hide their failure to understand and inability retain theory as taught in class. The negative attitude of students towards midwifery as well as midwives also created a discouraging perception towards the discipline and midwife practitioners. In terms of social learning theory, lack of commitment affects students' attention span while absenteeism threatens their opportunity to learn through observation which would enable them to retain theory taught, develop psychomotor skills to perform procedures proficiently and become competent in their ability to integrate theory with clinical practice. Lack of competency will affect students as they will fail skills assessment which, in turn will prevent them to progress to the next level of study. Progressing to the next level of study is a reward that should motivate students to carry on with the skilful work and providing quality health care services.

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5.2.2.3 Theme 3: Factors Related to Midwives in the Clinical Area

Shortage of midwives was described as less than the ideal number of midwife practitioners relative to the number of students in a teaching hospital unit. In this study, it was revealed that midwives also had a negative perception of and attitude towards students. The reluctance and unwillingness of midwives to perform their teaching functions, for example, to mentor or demonstrate procedures to students have become major stumbling blocks in the provision of efficient nursing and midwifery training. This, coupled with the language barriers imposed by midwives when they communicate to students in the vernacular instead of the English (academic) language, as well as non-adherence to midwifery practice standards and norms, continue to compromise nursing and midwifery education and practice.

According to the social learning theory, practising midwives are considered as role models who are knowledgeable, should lead by example and be open to all sorts of questions and have the aptitude to engage students in all spheres of the profession. Midwives should be mentors who are willing to perform procedures step-by-step, giving students' the opportunity to practice what they had been taught and assist them when they get confused. Midwives with negative attitudes toward students and who are not willing to teach students deprived them of the opportunity to learn through observing and rehearsing in order to develop critical competencies. Likewise, midwives who unwaveringly use their own vernacular language deny students of their legitimate expectations to ask questions to become conversant with midwifery procedures and patient care.

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5.2.2.4 Theme 4: Factors Related to Systems in the Organization

Shortage of student accommodation next to clinical placements in the training hospitals, scarcity of material resources, unavailability of library books and teaching aids, as well as lack of medical supplies and equipment, short periods of learning and clinical exposure and student selection criteria were described as significant impediments to effective integration of midwifery nursing science theory with clinical practice. According to social learning theory, shortage of accommodation will deprive students of longer periods of exposure to clinical areas affecting the time spent for observing of their role models. Shortage of library books affects students' access to theoretical basics for midwifery practice. Lack of materials in the hospitals leads to shortcuts being taken by midwife role models which then expose students to observe incorrectly performed procedures, thus affecting their learning through imitation and imagination, and their ability to integrate theory with practice. Less than adequate time spent in clinical areas reduces their chances for rehearsing procedures to develop their psychomotor skills and hone acquired competencies.

5.3 Recommendations

The following recommendations emanated from an analysis of the findings:

5.3.1 Lecturers

Thohoyandou Nursing Campus needs to fill all the vacant post for lecturer to reduce staff shortages. The campus needs to appoint preceptors who can be stationed at the training hospitals and who will assist and guide students at least 5 days a week to strengthen student accompaniment. Full-time clinical lecturers could also help in the

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monitoring of students' movement in the unit and reduce absenteeism. The college should consider implementing a rural allowance and other incentives for lecturers as a recruiting and retaining strategy. The lecturers need to update themselves with the current teaching strategies that are student-centred and promote students' active participation, for example, group case discussions.

The lecturers need to have a programme that allows them clinical placement for updating themselves with current protocols and procedures in the maternity section and to remain competent in midwifery practice. The campus needs to acquire adequate and up-to-date library resources to facilitate proper midwifery training and achieve its ideal for establishing a centre of excellence in nurse training. The campus needs to make budgetary provisions to subsidize lecturers with cars that will assist them to reach clinical placements in time and make sure that students are accompanied. Students need accommodation within the training hospitals to eliminate long travelling times that cause them to miss crucial hours required in the clinical areas. The college should include schedules for clinical meetings in its strategic planning to maintain good professional relationships between clinical staff and students.

5.3.2 Students

During the orientation period students need to be motivated to become actively involved in their learning to instil the interest towards midwifery. Students are supposed to carry along their clinical objectives relevant to the level of study to enable them to learn and correlate theory with practice. There is a need to introduce a strict measure to control students' movement within the units to reduce absenteeism. It has

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become essential to draw up a remedial programme that will assist slow learning students to catch up with the content to address the failure rate. Students may be given a module for each clinical placement from which they can compile a portfolio of evidence of what they did during that particular placement. The students need to hand in their workbooks and maternity case registers every quarter to the lecturer for checking and control and a certain percentage of workbook mark should contribute to their year mark. They need to have access to a number of midwives per each clinical placement to assist them.

5.3.3 Midwives

Training hospitals should employ more staff to cater for the needs of both patients and students. The training hospitals need to include the role of teaching and modelling in the orientation programme for all newly employed midwives and conduct regular in-service training on their roles as teachers and models towards midwifery students. Unit managers need to devise teaching programmes in consultation with midwives and students and make sure these are implemented. The unit manager and the college management need to develop guidelines that would allow midwives to discipline students who misbehave in the clinical placement, for example not to sign for procedures that the student did not perform or take the student time off if need be. Midwives need the support of supervisors and courses on stress management techniques to reduce stress and promote a good working environment conducive for learning. Midwives in the units need to treat students as unique and not generalize or judge all students on the basis of a mistake of one student. Midwives need to use the academic medium of instruction, which is English, to facilitate learning during report giving. Midwives need to involve themselves in personal development and growth to

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become familiar with contemporary issues in midwifery to boost their self-esteem and ability to assist students with confidence.

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5.3.4 Systems in the Organization

The system policies and procedures need to be mechanisms that promote nurse education and training. The system needs to budget for equipment and supplies to minimize the identified shortages as this interferes with midwifery training. They need to provide students with suitable accommodation within the college and next to clinical areas to accommodate students during their training. They need to budget and put in place back up electricity systems in case of power failures on campus.

They need to improve in their selection criteria, at least considering English and a science subject for prospective students. The college's physical infrastructure needs to be upgraded to be habitable and to add more classes that will accommodate more than 50 students. The management need to advocate for accreditation of more hospitals to accommodate increases in the clinical placement loads and avoid students overcrowding during clinical placement. The curriculum needs to provide uninterrupted clinical placement, i.e., allocate students to clinical 6 months in succession to allow enough clinical exposure and promote students clinical competency. The system needs to liaise with universities that share the clinical areas to reduce overcrowding.

5.3.5 Recommendations to Policy Makers

Policy guidelines should be developed to assist in the development of a curriculum that will enable students to integrate theory with practice. There is a need to develop

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guidelines that will train clinical mentors or link midwives to role models in the clinical placement settings to enable students to learn through observation. Policy guidelines are needed to establish proper communication channels between institutions of learning and training hospitals to enable smooth placement of students in clinical facilities.

5.3.6 Recommendations for Further Research

The same research topic can be repeated on a wider scale in the province to develop a model for student accompaniment in clinical practice that will bridge the gaps that exist between theory and practice integration.

5.4 Conclusions

The results of the study revealed various factors affecting integration of Midwifery Nursing Science theory with clinical practice in selected training hospitals of Vhembe District, Limpopo Province. The results also indicated that there was poor integration of midwifery nursing science theory with clinical practice in the Vhembe District.

5.4.1 Factors Related to Teaching and Facilitation by Lecturers

The study implied that the high rate of vacant posts at Thohoyandou Campus was the underlying cause for the unfavourable student to lecturer ration. The shortage of lecturers impinged on the facilitation of learning in the classroom and in clinical practice. Students who did not grasp the meaning of midwifery theory were not able to apply theory to practice. The staff shortages also affected student accompaniment as students stayed in the clinical areas without support by the lecturers, hence hampering vicarious reinforcement or learning by imitation. Lack of accompaniment

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deprived students of chances to practice procedures repeatedly before they did actual assessment, and therefore compromised student's competency.

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5.4.2 Factors Related to Learning by Students

There was lack of commitment by students towards learning. The study findings indicated that students were less interested in midwifery due to the fact that midwifery is associated with complex terminologies. The other factor that made students to lose interest was that midwifery is an inclusive package to their course and, some of them did not choose midwifery as a field of expertise therefore they were subjected to learn midwifery to complete the course. Some lost interest because they were males, and culturally as a male you are not supposed to see the genitalia of somebody's wife, besides either male or female they were still young and to them it was a taboo to fidget with the female private parts. Some of them were unable to grasp theory in class due to poor learning (cognitive) abilities, social problems and systems of teaching strategies used by the lecturers.

5.4.3 Factors Related to Midwives in the Clinical Areas

There was shortage of midwives in all three training hospitals which made it difficult for midwives to perform their dual roles of patient care and that of teaching the students. Shortage of midwives led them to take shortcuts in most of the procedures. Such practices can defame their role-modelling image, and cause students to learn wrong principles and methods of procedures, hence interfering with successful integration of theory with practice. Midwives also had negative attitudes towards the comprehensive 4 years course (R.425) students because they received stipends and wanted them to become part of the workforce and not learners who needed their

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assistance. Midwives in the units also communicated in their own languages when reporting and so another learning opportunity was wasted because some students came from different regions of the Limpopo Province and were not acquainted with the Venda language commonly spoken in Vhembe district. Some midwives were reluctant to teaching students and some were intimidating students.

5.4.4 Factors Related to Systems in the Organization

The study findings indicated that there was shortage of resources, human, material and physical structures. The shortages in human resources affected facilitation of learning in the classroom and mentoring in the clinical facilities. Material resources like gloves, procedure packs, and suturing items contributed to the shortcuts in patient care as depicted by midwife practitioners exposing students to learn the incorrect procedures. Physical structures included dilapidated small classrooms, few accommodation rooms and limited clinical facilities. Small rooms did not accommodate the large groups well, leading to overcrowding. Some rooms were old and there was no proper heating or cooling systems to regulate extreme temperatures this affected learning negatively. The limited number of clinical facilities led to overcrowding in the clinical areas, therefore learning was affected as only committed students had learned. The time allocated for midwifery practice was too short, for example, two weeks in a unit the short periods deprived the students from adequate clinical exposure time and hence resulted in poor integration of theory with practice.

5.5 Limitations of the Study

The study was limited to Thohoyandou nursing campus and only 3 training hospitals of Vhembe district and out of 5. The sample size was also limited to lecturers at

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Thohoyandou Campus, midwives from the three training hospitals and the R425 students, and the one-year R.254 programme students were excluded which made transferability of the findings difficult.

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ANNEXURE1A

Request to Limpopo Province Department of Health to Conduct the Study

P.O. Box3179
Sibasa
0970

The Head of Department (HOD)
Department of Health
Limpopo Province

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am a Master's degree student at the University of Venda in the School of Health Sciences. The topic of research is "**Factors Affecting Integration of Midwifery Science Theory with Clinical Practice in Selected Training Hospitals in Vhembe District of Limpopo Province.**"

I hereby request permission to conduct a study in your department. The study will be conducted among professional nurses/nursing students /lecturers. The purpose of the study is to identify and describe factors affecting integration of midwifery science theory with clinical practice in training hospitals in Vhembe district of Limpopo Province.

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I am hoping that the results of the study will assist in integrating theory with practice, and help in the reduction of maternal and perinatal mortality in Limpopo Province.

Thank you

Mrs T. Malwela

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ANNEXURE 1B

Request to Vhembe District Office to Conduct the Study

P.O. Box3179
Sibasa
0970

The District Senior Manager

Vhembe District

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am a Master's degree student at the University of Venda in the School of Health Sciences. The topic of research is "**Factors Affecting Integration of Midwifery Science Theory with Clinical Practice in Selected Training Hospitals in Vhembe District of Limpopo Province.**"

I hereby request permission to conduct a study in your district. The study will be conducted among professional nurses/nursing students /lecturers. The purpose of the study is to identify and describe factors affecting integration of midwifery science theory with clinical practice in training hospitals in Vhembe district of Limpopo Province.

I am hoping that the results of the study will assist in integrating theory with practice, and help in the reduction of maternal and perinatal mortality in Vhembe district.

Thank you

Mrs T. Malwela

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ANNEXURE 1C

Request to and Permission from the University of Venda to Conduct the Study

P.O. Box3179
Sibasa
0970

The CEO/Principal
University of Venda

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am a Master's degree student at the University of Venda in the School of Health Sciences. The topic of research is "**Factors Affecting Integration of Midwifery Science Theory with Clinical Practice in Selected Training Hospitals in Vhembe District of Limpopo Province**."

I hereby request permission to conduct a study in your Hospital/ training institution. The study will be conducted among professional nurses/nursing students /lecturers. The purpose of the study is to identify and describe factors affecting integration of midwifery science theory with clinical practice in training hospitals in Vhembe district of Limpopo Province.

I am hoping that the results of the study will assist in integrating theory with practice, and help in the reduction of maternal and perinatal mortality.

Thank you

Mrs T. Malwela

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OFFICE OF THE DEPUTY VICE-CHANCELLOR: ACADEMIC

TO : MR/MS T MALWELA
SCHOOL OF HEALTH SCIENCES

FROM : PROF J.E CRAFFORD
ACTING DEPUTY VICE-CHANCELLOR: ACADEMIC

DATE : 11 October 2013

DECISIONS TAKEN BY UHDC OF 20 AUGUST

Application of Master's research proposal in Health Sciences: **T. Malwela: 11626137**

Topic: *"Integration of Midwifery Nursing Science Theory with Clinical Practice in Selected Training Hospitals of Vhembe District, Limpopo Province"*

Supervisor: Prof. M.S Maputle
Co-Supervisor: Dr. P.R Risenga

UHDC approved Master's proposal

Prof J.E Crafford
Acting Deputy Vice-Chancellor: Academic

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ANNEXURE 2A

Informed Consent Letter

P.O. Box3179
Sibasa
0970

Dear Respondent

I am a Master's degree student at the University of Venda in the School of Nursing Sciences who is conducting a research. The topic of my research is "**Factors Affecting Integration of Midwifery Science Theory with Clinical Practice in Selected Training Hospitals in Vhembe District of Limpopo Province**."

You are requested to participate in the study. You are not forced to take part in this study; you have the choice to agree or refuse to take part. There will be no financial reward or any form of reward for participating in the study. However, I would appreciate it if you agree to share your thoughts with me. There will be no adverse effect even if you refuse to take part in the study. If you agree to take part in the study and change your mind in the middle of the interview, you will be allowed to withdraw without any penalties. The interview will be recorded and the answers you provide will not be traced to you. The information will be confidential, only the supervisors will have access. The tapes used for recording will be destroyed after the data analysis.

Your cooperation will be highly appreciated

Thank you

Mrs T. Malwela

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ANNEXURE 2B

Informed Consent

I _____ hereby consent to participate in the study entitled "**Factors Affecting Integration of Midwifery Science Theory with Clinical Practice in Selected Training Hospitals in Vhembe District of Limpopo Province.**"

I understand that I can stop this interview at any time should I want to discontinue. My anonymity is granted by the researcher and data will under no circumstances be reported in such a way that they would reveal my identity. The condition of the study has been fully explained to me and I fully understand the circumstances of my participation.

Participant's Signature: ..... Date: .....

Researcher's Signature: .....Date: .....

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ANNEXURE 2C

Consent Form for Voice Recording

I (respondent) ---------- hereby consent to be tape-recorded during interviews in a research study entitled "**Factors Affecting Integration of Midwifery Science Theory with Clinical Practice in Selected Training Hospitals in Vhembe District of Limpopo Province**." It was explained to me that the interview will be recorded and that the answers that I will provide will not be linked with my name or used against me and that the information provided by me will remain confidential; only supervisors of this researh will have access to the information. Once the information has been analyzed it will be destroyed. The conditions of the study have been fully explained to me and I fully understand the circumstances of my participation.

Participant's Signature: .....Date: .....

Researcher's Signature: .....Date: .....

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Interview Guide for Lecturers and Midwives

- What do you think could be the factors affecting integration of midwifery science theory with clinical practice?

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ANNEXURE 3B

Interview Guide for Focus Groups

- What do you think can be the factors that affect your attention in the unit as you are observing the midwives?
- What do you think can be the factors that affect your retention of observed midwifery- nursing science skills?
- What do you think can be the factors that affect your ability to perform the observed midwifery- nursing science skills?
- What do you think can be the factors affecting your motivation to imitate the observed midwifery -nursing science skills?
- Can you explain any other factors that may affect your ability to integrates midwifery- nursing science theory with practice

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ANNEXURE 4A

Lecturers' Interview Transcript

Key: R: stands for the researcher and P: for the participant

R: Explain in your own words what could be the factors that affect integration of midwifery nursing science theory with clinical practice in training hospitals in Vhembe district?

P: Mmm, I think that they are some few problems that we can highlight for example, for example we've got shortage of staff namely, lecturers that can be able to teach the learners at the theoretical areas and that are supposed to teach them in the clinical areas. You will find that it will be very much difficult to integrate the information that they have learned in class because you may find that the lecturer who is supposed to help them is still attending other things here at the school but in reality she was supposed to be accompanying them.

The other problem apart from shortage of transport, we've got shortage of transport, at some stage you may find that you are available and free, you want to go to accompany the students so that you reinforce the theoretical aspects taught in class in the clinical areas, but unfortunately you find that there is no transport to can take you to the clinical area.

The other thing is shortage of equipments, of which that this one is very much serious, that is why nowadays we are producing the midwives who are not skilled. We are running short of gloves, you can imagine if we do not have gloves how are we going to teach per vaginal examination etc. It is also difficult to control infections because we do not have gloves; other things are soaps, eye ointment, suturing material to name just a few.

Mmm, I think those are the most important things that are making it difficult to can be able to correlate theory with practice

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Ooh, the other things concerning students, as far as students are concerned we've got students who are not committed to their learning (with a frowning, angry face), because now if you go for accompaniment you will find that if in the nursery there is a child under phototherapy they can't even ask from the sisters there what are the normal bilirubin levels, why are they covering the eyes, why is this baby under phototherapy and so on. The students seem as if they are not motivated to learn. I don't know but they are just reluctant themselves. Again also when they are in the clinical areas they've got this thing of that they put in their ears, earphones connected to the cell phones, so how can a person learn at the same time listening to music and attend to the patient. They don't care about the management. Absenteeism as well is a problem

R: Concerning shortage of staff, what type of staff, do you know what is contributing to the shortage?

P: We've got a lot of vacant post here at the college may be because there is no rural allowance for lecturers. Whenever people think of coming this side and lose their rural allowance they feel is better to stay at the hospital rather than joining the lecturers. May be the other thing that can relieve is to appoint clinical lecturers who are full time with the students, it can assist students as far as imparting knowledge is concerned, because lecturers from the college are short, we go may be once a week to hospitals rotating from one hospital to another .the accompaniment the we give to students is not enough, is not adequate.

R: Is rural allowance an incentive or salary?

P: Jaa, is an incentive because this rural allowance is supposes to maintain the staff so that at least they try to keep the staff and not run away from the college.

R: Any other incentives

P: None

R: Can you explain more on shortage of transport

P: We are using fleet cars, the cars that are available, as I'm talking you may find that one car has gone for service ,may be other staff members are trans ported to other meetings as such we become short of the car to go for accompaniment.

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R: Is there any provision to use your own car for accompaniment

P: Not to my knowledge, but if a discipline can be given the car or one vehicle especially for that discipline e.g. midwifery, or if we got subsidy cars to help to move around to do accompaniment .If each discipline have own car it will be helpful.

R: Can you explain more on shortage of equipments

P: The instruments we are talking about are found in the hospitals. In the hospitals there is no water to wash hands, one of the MDG's is to prevent infection and control it, how are we going to control it without water soaps and gloves? There is no suturing material, cord clamps, not one at all; all 3 hospitals where we allocate our students have some stage of shortage of equipments. Linen we don't even talk about it, is not there at all, no sterilized packs autoclaving machines are out of order. This makes it difficult to produce skilled competent midwifes

R: Do you have any knowledge on what is leading to these shortages?

P: I don't know, they told us they do order but not issued, the answer is that out of stock, machines not repaired.

R: Students commitment can you explain a bit more

P: If the students have zeal to learn you will see that when she reaches the clinical area will try to know or get information from the seniors or ask questions. If you go for accompaniment you will find them sited and when you ask them about the cases that are available and that they have learned about them in the class, when you ask of the things appearing of the patient, they don't know, meaning that they are not committed to learn

R: How will you describe a committed student?

P: I may say that is a student who when is in the ward she would ask, because if you don't ask, people think that you know, but if she asked about the abdomen she has examined e.g. The abdomen which is not round, she will ask and want to know shape anomalies. A round broad abdomen may be indicating transverse, oblique or any abnormal lie. She can't just ignore the abnormal shapes.

R: Lack of motivation what do you mean by this?

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P: Mmm, I don't know exactly but nowadays no interviews, students just apply and just selected. There is also a lot of unemployment so probably they are here for work and nothing else. They don't take nursing at heart or committed to it. They take it as work.

R: What do you mean by clinical instructors?

P: They can be mentors, but I want to further explain that it can be any person who will be with the students most part of the day .If this person is at the clinical area, students will report on duty to her and she will monitor their absence. It will be much better they will not wait for someone who is stacked by transport

R: Where there preceptors before

P: Yes

R: What happen to them?

P: It just stopped, the nursing colleges become independent, and the hospitals withdraw their nurses who were preceptors as they were belonging to them. The colleges then become responsible of teaching and accompanying the students.

R: Midwives are with students daily in clinical areas are they not teaching them

P: They do very little because they also have their own work. They just teach on sport and only if the students have asked questions. I think they are also short staffed and are overworked.

R: Do you have anything to add

P: If ever this study can assist in improving teaching or integrating the theory with practice, that will be better currently teaching theory and integration with practice is not adequate.

R: Than you

P: Okay, sorry can I add something; I've missed the issue of environment we've shortage of rooms as our college is old, the class rooms are also small and not well ventilated and we have large groups, there are no fans or air cons and is very hot here. The classes are packed as they were meant to accommodate students and now we are taking 50 and above. The environment is not conducive for learning. There is also

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shortage of cleaners; the environment is so dirty, cleaned once a weak is not right, this is also contributing to students not learning properly .Also the number of clinical areas is not increase and we are taking large groups that cannot be accommodated at the hospitals. The hospitals also catering for other training institution and I cannot mention their names. Taking 10 students at the same time in a unit is very difficult; this then now will affect issue of commitment only committed students will learn, the rest will come back to class without learning. Environment also contributes to poor participation by the students in the clinical learning

The other thing is large groups causing overcrowding, more especially in the neonatal Units, they do not want too many to avoid infection.

R: When did this problem starts?

P: It started with the political changes; politicians just propose to train more nurses and promise to increase the infrastructures, but till today there are no changes. This led to taking of many students leading to poor quality of learning. The numbers of clinical areas are still the same and only one college.

R: You are still allowed to add more if possible

P: Let me add something under accommodation , some students are staying away from the college and are transported from that areas to clinical or to class ,they arrive late and knock early depriving them enough time to learn. You know is difficult to report at work early and they are knocking off early because the drivers also supposed to go home. This affect numbers of hours to be covered.



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ANNEXURE 4B

Focus Group's Interview Transcript

Key: S = Student R = Researcher

R= what do you think can be the factors that affect your attention in class and in the unit as you are observing the midwives?

S1=what I think that is affecting us is that you are not doing midwifery only there are other subjects to consider ,may be eeh MID theory is being taught I may be thinking of the PNS test to come on Friday that affect mu attention some how

S3= I also want to add on the point mentioned; the experience expected from me may not tally with the given time as you are expected to learn and within a short space of time.

S2= The other thing is that we are being taught a module this block of the things you are going to write test on in the next block, when you come to block you start by the things which are not in the coming test, then we tend to concentrate on the module for the test and not concentrate on the module being taught at that time.

R=what do you think can be the factors that affect your retention theory and observed midwifery nursing-science skills?

S5=I think the thing that emm..,that stop or affect us to retain the theory that have been taught is that that time is limited , you may find that the tutor teaches so many topics at the same time ,*"ke uri"* the tutor teaches so many study unit at the same time., obviously you may not manage to cram all the study units.

S1= the other thing is that Mam , our attending also affects us , because you may find that MID is coming after lunch when we are fatigued and then you may find "*uri*" you are not really concentrating you just came only to pass time and after the class you will

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be busy with another matter from another subject and not concentrate on what was being taught earlier on.

S4= to add on what has been said, at times you may find "*uri*" the learning hours are too long, and imagine getting to class at about seven (7) in the morning ,to knock off at 16h00 , so you find "*uri*" at times you have to be sited for a long time , from 7-10 is better ,but from 10- 13hours that period is too long to such an extent that concentration you had in the morning is no longer there , so that thing affect us also. We are faced with a huge work to cover for example today we have to cover this certain amount of work, then the teacher also will have to make sure that she covers this much scope, for myself as a student have a little time to cover that work . It can be better if I am allowed to attend little time and be given the other work to study on my own, mind you we have the other work to do not MID only, and this work is much to cover.

S1= the tutor will like to cover the work let's say today is Monday the teacher will push to finish the work because the test is coming on Friday. Without assessing whether the students have understand the content , you will find that the teacher will ask to say did you understand , we will say yes to satisfy her, but in reality not understanding ,so you need to assess before you push all the study units

S4=to add on that the other problem is the reference where we get the information we know *"uri"* we are having so many books in terms of midwifery ,are the 4 0r 3 ,3or4 *"hoo"* they are 3. You may find that if may be you are reading LGA you may find that in Myles you get certain portion e.g. causes for complications and other you need to go and refer in the other books and mind you the time is going and then each information you have to go slowly reading to understand. The other thing when you go to the library you find "Uri" there are no books they are limited. Another factor is the way we learn sometimes our learning depend on how practical is the topic, when we go to the practical we become more knowledgeable. if my practical is not productive it means I may not have more knowledge., for example if I am learning about pre-eclampsia , if I met this woman impractical and get someone there teaching me again I may retain the information for good.

S= My problem is on the audiovisual material where students manage to view/ read while you are teaching I think it will be better if we are seeing something when you are teaching.

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S=I forgot to mention on the issue of bo[illegible] topic is not found in one book a tutor she can maybe supply us with handouts because going from this book to that book always consume our time for reading. If you supply us with handouts it will be simpler to grab

S = May be when our teacher doing evaluation when she say did you understand and maybe we say yes just to push time knowing that 805 is to be done by us and the work is huge

S=The time from 16h30 we need to cook there is no electricity we need to wait for 1 ½ hours to cook, the period we are waiting for cooking the eagerness to read diminishes.

S =In the issue of books at library the recommended books are limited you cannot get them , when you go up and down looking for information you get tired before you start to study

R=How best can the tutors cover the prescribed scope and improve retention

S= obviously the scope should be limited in such a way that a person can grab the information so as to can use. As a tutor you can check if the students are tired, you can give then a break. If the tutor can just do the facilitation work and give us more time to study. We spent a lot of time in class without doing things for ourselves like may be in group work is batter and the tutor just come and check "*uri*" where do we stuck, that is better because listening to the person talking is tiresome. The tutor need to leave us and do things on ourselves and the tutor come just to evaluate if we have understood and correct us where we are going wrong, I think that can be good. Do the schedule that will give us more time for self-study like in the universities setting where people go to class may be for an hour and the rest is for them to read and learn, with us we attend the whole day 7- 16 hours. The time to read is at night when there is no tutor if you stuck nowhere to go, to add on that it must not be the matter of finishing the that 4 hours period in that 4 periods the tutor can use 1 hour and the rest leave to read give us handouts if you are using information from Myles, olds' or Harrison.

S =some of the conditions that we are learning now they are no longer there, you find "*uri*" you are teaching us a condition which was there long ago, why are you still doing them may be they should review them because such things they make the

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content to be more. You may find those conditions are not there in practice then why do them reduce them.

S =I don't know if is possible to restructure the practical time like at least in level 4 we are having 3 subjects let's say first block MID then practical MID , 2nd block GNS then practical GNS and 3rd block PNS then practical PNS this will encourage retention. Also reduce rare conditions in all subjects

R=Can you explain any other factors that may affect your ability to integrates midwifery nursing -science theory with practice

S = When we are supposed to correlate theory with practice you may find that the procedure that we have learned in class is not the same with the one in practical. May be PV exam the way you teach us here is not the way they are doing it at the practice, if you want to do the procedure the way you have been taught they will tell you the patients are so many so we can't do this thing procedurally as they taught you in class, and so you find that you don't get the time to practice what you were taught. The other thing is the resources whenever you want to do the thing procedurally you will find "uri" there are no resources let's say you want to do PV they say you have to save the pads,gloves so many times you spare for emergencies this affect us to correlate theory with practice

R= Can you explain more on resources?

S=PV packs , they will tell you that eh they are limited numbers of PV packs and is a waste to always open a new pack for one patient , they will tell you are wasting resources by using so many PV packs in one patient and patients are many. Even gloves are short; they will tell you to use one glove for one patient ant the other one glove for one handthe second glove for the second patient. I just want to add on that, when doing PV you are supposed to use sterile gloves , so at the hospitals we are not allowed to use sterile gloves they will tell you is a waste even if you use them "mam" you use one glove from the pack and the other one is for the next patient .

S=some of us get threatened by the staff there in the ward, they will be this thin ooh are you doing this procedurally ooh well, shouting at you then you are forced to do things wrongly. The other thing is that they will be saying ooh if students are here we are going to run out of stock ooh we will have more work we won't finish, so to avoid

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such things we try to go with their pace th[illegible]get that we are there to learn and to integrate theory with practice

S=Another thing is this that if there is an emergency, may be a woman with pre-eclamsia, you may find that the midwives are the ones who attend to the patient even if you can go as a student to assist they won't even look at you even if you ask questions to help they will say this is for us students are not allowed, so how are we going to correlate theory with practice when they do not engage us students. You may find *"uri"* at the classI have learned that I must do steps for a woman with pre-eclampsia the sister will come and say no you are not supposed to do this thing.

S4= at large I can say that the attitude of midwives towards students is also negative and also makes us to be negative towards MID. The other thing is that we are getting a stipend when we get there our names are stipend those who are not getting stipend are treated well. The way they treat us that side is very bad mind you I am also a human being I have emotions. I wake up in the morning to go to work being happy, but the attitude I get that side is making me even to forget the theory that I have learned in class and loose ability to work and learn .one other thing is that a student is a student, if I did a mistake may be the sisters need to attend to me well.

S5= the other thing is that sisters give us different ideas, some will tell you to flush the drip which is not running some will tell you know you will kill the patient because flushing may cause the emboli to dislodge in the heart. Sometimes when you are in 4th level and ask them a question they will say no now you are in fourth level we are colleagues do it yourself so in that situation what are supposed to do, even if I am a professional nurse if I don't know a thing I have to ask the respond must not be negative, we might be colleagues but you may be having more knowledge than that I have

S3= another one I think professional nurses should have a good working relationship with students because I am a student and learning even if I have done a mistake to the pregnant woman they should not tell me in front of that patient because the patient will lose trust on me . Tell me separately because it de-motivates me to work. There are some sisters who are reluctant to teach students but in the earlier years first level they use to call us *"Mutshudeni"* (students) but now that we are in level 4 we still need their supervision but you will find that they tell you to do things on your own

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S5 =another thing is that when we are rive[illegible] like we are replacing them they just leave everything to us and the work becomes too much and we get exhausted; when we do mistakes they run away they do not want to be responsible. They were supposed to supervise us to prevent that mistake to occur.

S4=I don't know if it is allowed our tutors need to accompany us every day. We were taught pelvic assessment 3 month ago, the overload that we were doing there makes us not to practice that. If "Mam" is there every day that thing will be better.

S3=Let me get in there, even if is not every time, but most of the time because if our tutors are there the sisters assist us and see to it that everything is done properly. Mind you our learning capacity or IQ are different, our tutors taught us procedures 2 month ago so *"nna"* I cannot grab that there and there. I need more time to understand , moreover we don't get enough time at the practice to do things procedurally , it is difficult to grab even the time to record what have learned is not there.

R=What do you think can be the factors affecting your motivation to imitate the observed midwifery -nursing science skills?

S1=What affects our motivation is this that we have been labelled there at the hospitals especially us R425 integrated course as lazy, dodgy, that things somewhere it grows in a person you may find that I may say because they know I am lazy I may just go the and just sit down and not work, moreover I am not taught, supervised so I just stand up when I want.

S2= to me is criticism, sometimes you did mistakes you will be told what you have been learning at college, like it was said, and we are not the same you may find that you have been taught, but I am not yet there. You will find "uri" they will say that you are not willing to learn how come you don't know as you have been taught so many times I become discouraged

S =Some other problem is language you will find "uri" we learn in class in English, I know in RSA is democracy, but when I get to the hospital I have to grab complicated words in Venda words , so that thing discourages me to learn ,some of the words you can't here properly as you are not a Venda speaking. I am not nor Venda nor English, the two languages make things complicated. At the hospital I am going to perform a procedure with a Venda person it is difficult to correlate theory with practice.

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S6= to add on that language barrier in the you will find *"uri"* professional nurses giving report in Venda about all the patient. This makes us not to go to the ward in the morning because you won't even learn. We are not saying they must use English every time but when giving report use English for us to understand.

R=what can be done to motivates you

S =Sisters need to respond to your questions even if you don't know talk to me well, don't tell me to go and consult or better refer to another sister. The litigations in midwifery de-motivate us sometimes we just become scared to touch the patients because of the litigations. Lack of resources and super this also de-motivates us. Time allocated in practical is short, 2 weeks is not enough to learn, it can be better if long like university students they go there for three month. Appreciate us in whatever we do well. The attitude should be positive, attitude de-motivates. Stop calling us grown up or colleagues. Nurses to try by all means in our presence, to do things procedurally, because we are still learning. Stop to do things haphazardly since time management is important to them. The tutors in class try to instil that confidence to the learners so that when they will be able to apply what taught in class .instil it to an extent that we can stand up against sisters who call us names. The clinical people need to submit truth full reports about us for you to do follow up. You need to have meeting with the clinical staff to improve. Sisters must not take us all the same, labelling us by the mistakes of all R425 students. Sisters should appear appreciable to us and not scary. Our tutors need to demonstrate the procedure to us not by the students, that is tutor A need to demonstrate the procedure A to all of us. Accompaniment can help, this also gives us time to discuss our challenges and you act as consultants.

R=Can you explain any other factors that may affect your ability to integrates midwifery nursing -science theory with practice

S= Nothing more

R =Thank you

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ANNEXURE 4C

Midwives' Interview Transcript

Key: R: stands for the researcher and M1: for the participant

R: Explain in your own words what could be the factors that affect integration of midwifery nursing science theory with clinical practice in training hospitals in Vhembe district?

M1: Mmm, the first one I think is the attitude of towards students , others are being negative about teaching students. And mm;(shelaughs), *"na"*and attitude *" ya" of studente* towards midwives ,because when they are out of their learning situation they use to tell one another I mean "*na havha vhanwe vha saathu daho uri eeh"* those who are still to come that so and so is rude towards students which means eeh, when students come they will be very negative.

R: Can you expand more on the issue of attitude?

M1 : *eish*, there are some midwives who totally do not want a student (also make the hand emphasis and shakes her head) to come into the wards, they say they does not see their help whereas they forget that they were once being a student in the previous years. Then you will find that when a student tries to ask they are scolded, told other words and then they did make them to fear some of the midwives, but is not all of them, there are those who are willing to help the students.

R: can you tell me something concerning number of staff /midwives in the unit

M1: according to me the number of staff is adequate; I don't think it can affect anything, if midwives are willing to teach the students, because according to me the staff is adequate.

R: Which means according to you midwives students ratio is not a problem?

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M1: yes, it means that if the midwives are willing to teach " *hudo bvelela zwene* you will find that "*uri*" if one midwife is willing to assist the students , the students will stick to one midwife who is assisting them whereas other they are six those will say no we don't want to help you. There is no shortage of midwives, it is only that the midwives do not want to help the students even if they did not do anything wrong to them.

R: can you explain how accommodation can affect students training

M1:*Ee*, yes we just heard them complaining that where they are staying the accommodation is too small and they are many and may be if they are staying inside the hospital it will be better for them to , now that they are staying outside is a problem. Staying outside makes them to arrive late at work and leave early and this interrupt their learning.

R: What can you tell me regarding equipments and training?

M1: As far as equipments are concerned we are having a problem, we do not have enough equipments, more especial when we come to suturing or stitch packs, you will find that in this situation now we are not having stich packs. Sometimes you may find that inside the delivery packs there is no needle holder, when you teach the student you will find that there is an artery forceps, it will need somebody who is experienced to suture. You may find that there is no delivery pack you will need to use a PV pack to deliver patients. PV packs does not have all equipment for delivery.

R: except the packs can you explain any other shortages

M1:Yes just like some month back we were not having the cord clamps, and you find "*uri*" that we are using tags or ligatures to tie the newborns cords and is very difficult to teach students because we ourselves are not used to this tags , so when it comes to students it becomes very tough.

R: What do you think can be done to improve supply of equipments?

M1: May be the government can provide some funds/money because when you tell the hospital management they will tell you there is no money to buy the equipments.

R: Some students complains that they are being called names can you explain this issue

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M1: Yaa,I think this will come back to the attitude, some students will be called by their hairstyles, the way they dress, ya , not all midwives do so but other do/can call them names

R: Can you explain, is it true that sometimes students are treated badly due to mistake done by one student

M1: *Yaa* , some of the students are meeting those problems of being generalised by one student mistakes, although it will depend on the team that had worked with that particular student, because in other teams you will find that if one student made a mistake she/he will be corrected and not generalizes ,and when may be that student comes to your side you will find that they are not willing to assist them because of what was said about them. That is why i have agreed that some of them are called names, they ate told they ae lazy, whereas you will be surprised when you work with that same person, that person will just be working very hard.

R: Some students had complained that midwives are using their language (Tshivenda) to give report, can you explain this

M1: *Hai*, no, that one, because normally when we give report we give them chance to read the report so that they got acquitted. May be the first year who do not understand midwifery terms, but fourth years they understand midwifery language, the finalist they do not have problem they give reports.

R: Can you explain the attitude of male students towards midwifery

M1: That one we have a bit/little problem, because most of them the use to dodge, may be is affecting them because when you try to interview them they tell you ha, no this thing will make us not to marry when we just see this ladies delivering, because some students use to fall/fainting the process of delivering. Even during caesarean birth, you find uri there was a boy who want to go to theatre but was always fainting there, because he use to concentrate much on the knife that is cutting the uterus. One day I went with him and made him to concentrate on the preparation of the neonatal tray to receive the newborn, the only time I allowed him to turn it was when the baby was out , that day he did not faint, so there are very few guys who likes midwifery, but most of them no.

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R: Do you think culture is also contributing to male students' attitude?

M1:*Hai* ,no, even some of us, midwives attitude towards students, what they tell them contributed also. Yes may be culture can affect, but if one explains midwifery to them nicely they later become interested because if you do teach them how to suture and you do it nicely they do it perfectly even more than females.

R: Can you explain something concerning preceptors and training?

M1: Ooh, *"hoo"* ok, I think if there are preceptors it can help because if there are preceptors they will do follow ups, they will give them time may be at 11hoo or 14hoo for procedures. It will also help them in the issue of dodging because they know that at 11 or 14hoo there is a procedure to attend

R: explain accompaniment

M1: Mm, you will find that they are her at the hospital for the whole week and there is nobody comes for follow-up it makes them to dodge and just move around not concentrate on their learning. And the other issue is that you will find that students in certain procedures complaining that what we were taught by our lecturer is different from the ones we are seeing here in the ward.

R: different in which way?

M1: May be if i can give an example "*eeh*", like when they are suturing you find *uri"* in the ward we are using the old style of tying 2-2-1,they come and say at the college we were taught 3-2-1. So they will tell you is different from the one we were taught.

R: Except suturing what about those other procedures?

M1: *"Aah"* , there are no any other differences

R: Are you midwives acting as role models as far as procedures are concern?

M1: "*Hai*", no procedurally we can't say we are doing procedures accodingly, because you just find that for example may be you want to do the PV they just put on gloves without a trolley no pack and not maintain sterility, but we use to tell them that you must do the correct things, but later when they are to do the PV they do the same as we are doing.

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ANNEXURE 5

Letter from the Language Editor

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To Whom it May Concern

This serves to confirm that I have edited the language, spelling, grammar and style of the MCur thesis by **Malwela Thivhulawi**: "**INTEGRATION OF MIDWIFERY NURSING SCIENCE THEORY WITH CLINICAL PRACTICE IN SELECTED TRAINING HOSPITALS OF VHEMBE DISTRICT, LIMPOPO PROVINCE**"

Sincerely Yours

Donavon C. Hiss
Dip. Freelance Journalism, Dip. Creative Writing, MSc (Medicine), PhD

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