THE UNIVERSITY OF ZAMBIA
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CERTIFIED MIDWIVES' EXPERIENCES ON MENTORSHIP AND SUPERVISION DURING INTERNSHIP AT UNIVERSITY TEACHING HOSPITAL, LUSAKA, ZAMBIA

By

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A dissertation submitted to the University of Zambia in partial fulfillment of the requirements of the degree of Master of Science in Nursing

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CERTIFICATE OF APPROVAL

The University of Zambia approves this dissertation on experiences of certified midwives on mentorship and supervision received during internship at the University Teaching Hospital in Lusaka District in partial fulfilment of the requirements for the award of degree of Master of Science in Nursing.

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ABSTRACT

Background: Mentorship is a program aimed at preparing midwives to concretize their knowledge and skills in order to provide quality services at all levels of health care delivery system. Understanding the experiences of those that undergo mentorship is important to improve the program.

Objective: The main objective of the study was to explore the experiences of certified midwives on mentorship and supervision received during internship at the University Teaching Hospital, Lusaka, Zambia.

Methods: A qualitative phenomenological study design was used to elicit the experiences of the certified midwives who had undergone internship during their training. Thirteen participants were purposively included in the study and In-depth interviews using unstructured interview schedule were conducted and recorded. Content analysis using Nvivo software version 10 was used to analyze data following transcription of the recorded interview.

Findings: Five major themes emerged from the interview data; clinical environment, the relationship that existed between mentors and mentees/ ward staff, availability of human and material resources, knowledge, attitude and skills of mentors on mentorship and supervision, and lessons learnt.

Conclusion: The results showed that certified midwives were not satisfied with the mentorship and supervision received during internship. Their experiences ranged from uncaring attitude from the qualified staff, inadequate equipment and staffing, inadequate clinical supervision, non-availability of mentors in the wards and labelling of certified midwives.It can therefore be concluded that there are still some gaps that need to be reviewed by the policy makers in order for the program to be beneficial.

Key words:*certified midwife, mentorship, supervision, internship, experiences.*

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LIST OF ACRONYMS

CMS……	Certified Midwives
DEM……	Direct-Entry Midwifery
DERM…….	Direct Entry Registered Midwifery
EMA……	Ethiopian Midwifery Association
GNC……	General Nursing Council
HSSP…….	Health Services and Systems Program
IOM…….	Institute of Medicine
IOM……..	Institute of Medicine
MCH……	Maternal and Child Health
MDGs……..	Millennium Development Goals
MOH……	Ministry of Health
NICU.....	Neonatal Intensive Care Unity
NMC…….	National Midwifery Council
PPH……..	Post-Partum Haemorrhage
SMS……..	Senior Medical Superintendent
UK……	United Kingdom
UNFPA……	United Nations Population Fund
UNZA……..	University of Zambia
UTH…….	University of Teaching Hospital
WHO……	World Health Organization
ZEM……..	Zambia Enrolled Midwifery
ZRM……...	Zambia Registered Midwifery

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CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND

Zambia has 2,783 midwives against an establishment of 6, 106 giving a deficit of 3, 323 midwives (54%) (MoH, 2013). In 2008, in response to the shortage of midwives, the Ministry of Health (MoH), the General Nursing Council of Zambia (GNC) and co-operating partners introduced the Direct Entry Midwifery (DEM) training program. A Direct-Entry Midwife is educated in the discipline of midwifery, a program or path that does not require any prior education or training as a nurse (GNC, 2010). A Certified Midwife (CM) or Direct Entry Midwife (DEM) is a candidate who has undergone six months of general nursing, one year of midwifery training and six months internship (MOH, 2013). The design of the curriculum comprises the first six months of general nursing where they learn general nursing that is aimed at giving the students basic knowledge in the following subjects: fundamentals of nursing; behavioral and social sciences and introduction to medical-surgical nursing. The twelve months of midwifery practice is based on the current one year Registered Midwifery curriculum (GNC, 2010). This course is aimed at equipping the Certified Midwives with knowledge in midwifery. The last six months is the internship program where the students are posted to accredited clinical sites where they are mentored and supervised by trained mentors. Internship constitute interdisciplinary learning that is 'truly integrated' into the community, and serve as a unique type of learning approach; a form of learner-centered education. The concept of an internship is to put learning into practice and to extend learning into applied experiences in which students actively participate (GNC, 2010). The areas for clinical experience are labour ward, postnatal, antenatal wards, maternal and child health and community midwifery as well as neonatal unit practice (MoH, 2007).

The study focuses on the experiences of Certified Midwives (CMs) on mentorship and supervision received during internship at University Teaching Hospital. One of the key mechanisms for facilitating learning for healthcare profession, such as students while on practice placements is mentoring (Gopee, 2011). This mechanism is well established and is an important component the of pre- registration education program.

Mentoring as a concept and practice that is related to facilitating professional learning in health care has evolved consistently since the 1970s and was formally implemented in pre-registration nursing and midwifery education in the 1980s (Gopee, 2011).

According to a report on mentoring by the Institute of Medicine (IOM) in 2010, mentoring is a good way to strengthen the nursing workforce and, in turn, improve the quality of care and patient outcomes.

Therefore, the mentorship program is an effort aimed at preparing certified midwives to gain competence in midwifery practice in order to provide quality services at all levels of health care delivery system in Zambia (GNC, 2010). It prepares the next generation of professionals and as such the mentors' role is key to the teaching, learning and assessment processes within the practical setting. A mentor should be a positive role model who is knowledgeable and skilled, helps students develop skills and confidence, promotes a professional relationship with students and provides the appropriate level of supervision (NMC, 2008). Supervision refers to a method of training and teaching in which experienced professionals provide guidance, opportunities for skill development, crucial feedback and general support in a field setting to graduate students who are enrolled in a professional preparation program(Hawkins and Shohet, 2006).

The inception of Direct Entry Midwifery (DEM) education program started in three schools of midwifery namely Nchanga, Roan antelope and Chipata schools of midwifery in 2008 was implemented in an effort to increase the number of midwives. This program was meant to accelerate the production of midwives so as to attain the Millennium Development Goals number 4 and 5 set by United Nations in the year 2000 to promote maternal and child survival (HSSP, 2006).A total number of 290 certified midwives have been trained so far from the three schools since 2008. In Zambia, certified midwives are sent for internship upon completion of training for six (6) months to health facilities that are accredited and meet the set criteria of50 deliveries per month, number of midwives which should be at least 3 registered midwives, availability of antenatal and postnatal wards and, access to rural outreach activities.

During the internship CMs are deployed to strengthen their core competences of midwifery before registration with General Nursing Council of Zambia. They are registered upon declaration of competencies by the mentors.

The midwives performing the role of the mentor receive continuing education in related aspects of midwifery including mentoring and supervision by the GNC. The current practice is that a mentor should; be a Registered Midwife who has responsibility of students, have two years of work experience as a midwife, have a good recommendation from immediate supervisor and willing to teach (GNC, 2010).

It is recommended that each practicum site should have at least two mentors against ten certified midwives and the competences recorded in log books by the mentor and then issued a certificate of completion at the end of each clinical experience (GNC, 2010).According to Hughes and Frazer (2011), mentors are used as role models by the students in both positive and negative ways.

According to a report by UNFPA, (2013), there is need to better organize the pool of senior midwives supporting students on site during internships and to further improve the interaction between the training schools and the midwives doing fieldwork at internship sites. In Ethiopia the mentorship strategy was implemented at health centers in six regions and required mentors to observe graduates, assess gaps in their skills, provide counseling, and monitor improvements. Mentoring took place over 15 days at each health center. The mentoring program resulted in significant improvements in accelerated midwife competency. In antenatal care provision, for example, only 25% of graduates were observed to have excellent skills at the initial observation but this increased to 86.3% following mentoring, while family planning competency increased from 30.4% to 76.4%. Excellence in labour and childbirth skills was initially observed at 10% but grew to 77% following the intervention. Postnatal care skills showed the greatest rate of improvement from 9% to 75%. The conclusion from this study is that mentorship is very important in delivering quality health services to client and gain competencies (EMA, 2013).

1.2 STATEMENT OF THE PROBLEM

The Government through the Ministry of Health has a vision of providing Zambians with equity of access to cost effective quality health by reducing the maternal and infant morbidity and mortality rates. Statistics show that there is a shortfall of 3,323 midwives (54%) (MoH, 2013). In order to achieve this vision, the government through the Direct-Entry midwifery program estimates to train more CMs to achieve this shortfall.

According to the Census of Population and Housing, (2010), the maternal mortality ratio for Zambia was 483 deaths per 100,000 live births while infant mortality rate was 76 deaths per 1,000 live births.

Midwifery care is critical in reducing maternal and neonatal mortality rates. The Ministry of Health in 2013, conducted an assessment of the Direct Entry Midwifery Program and results showed that there was a problem on mentorship and supervision. The results revealed that the certified midwives were supervised weekly to a quarterly basis which is contrary to the set standards of supervising by GNC guidelines of having a mentor on a daily basis (GNC, 2010). This may hinder Certified Midwives the ability to adequately develop competences and training on the job and may adversely affect service quality. If the mentorship program during internship is not followed according to GNC guidelines this can lead to production incompetent midwives.

1.3 JUSTIFICATION

The GNC has trained certified midwives who are irregularly supervised and mentored; this compromises competence building. It is against this background, that it becomes necessary to explore the experiences that certified midwives face during internship. The information obtained from this study will inform the GNC and MoH to help them review and strengthen the implementation of the guidelines on mentorship and improve the program.

1.4 RESEARCH QUESTION

What are the experiences of certified midwives on mentorship and supervision during internship?

1.5 MAIN OBJECTIVE

The main objective of the study was to explore the experiences of certified midwives on mentorship and supervision provided during internship.

1.6 SPECIFIC OBJECTIVES

The specific objectives of this study were to:

1. Describe the experiences of certified midwives on mentorship in relation to environment during internship.

2. Establish the relationship that exists between mentors and mentees during internship.
3. Investigate the availability of human and material resources during internship.
4. Explore certified midwives on the knowledge, attitude and skills of mentors on mentorship and supervision during internship.

1.7 CONCEPTUAL DEFINITIONS

Mentor

A mentor is a more experienced individual willing to share their knowledge with someone less experienced in a relationship of mutual trust. A mixture of parent and peer, the mentor's primary function is to be a transitional figure in an individual's development. Mentoring includes coaching, facilitating, counseling and networking (Brewerton, 2002).

Mentoring

Mentoring is 'off line help by one person to another in making significant transitions in knowledge, work or thinking' (Megginson and Clutterbuck, 1995).

Mentorship

Mentorship is a developmental process that occurs when a less experienced partner, referred to as a mentee and is guided by a more experienced person, who assists the mentee to gain insight into new situations or experiences, through the integration of prior learning (WHO, 2011).

Supervision

Barber and Norman (1987) define supervision as an interpersonal process in which the skilled practitioner or supervisor helps less skilled practitioners in relation to their professional growth.

1.8 OPERATIONAL DEFINITIONS

Mentor: Someone who guides, coaches, teaches or counsels learners.

Mentorship: Refers to the process of guiding, coaching and counseling learners.

Supervision: Overseeing the work performed by students in order to meet the expected objectives.

Internship: A program which a trained person undertakes upon completion of their training to strengthen their competencies before registration.

Experiences: Encounters of certified midwives during internship.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

Literature review is an organized written presentation of what has been published on a topic by scholars (Burns and Grove, 2005). The purpose of the review of the literature is to convey to the reader what is currently known regarding the topic of interest as well as presenting a strong knowledge base for the conduct of the research project (Lobiondo-Wood and Haber, 2005). This chapter discusses the literature available on the experiences of certified midwives on mentorship and supervision received during internship. Varied search engines were used to search for literature and these included; CINAHL, Pub Med, Google Scholar, Google books, Medline, online journals and others. No similar study that has been done in Zambia on the experiences of Certified Midwives on mentorship and supervision received during internship. This motivated the researcher of the need not only to conduct the current study but also to publish its findings in order to address this gap.

2.2 The experiences of certified midwives on mentorship and supervision during internship.

The literature is reviewed according to specific objectives; clinical learning environment, relationship that exist between mentors and mentees, availability of human and material resources and knowledge, attitude and skills of mentors during internship.

2.2.1 Clinical Learning environment for certified midwives

Clinical learning environment has been described as places where students synthesize the knowledge gained from the classroom and apply it to practical situations. In the United Kingdom, a study on the implementation and sustainability of nursing and midwifery standards for mentoring revealed that there is growing emphasis on the developing of sounder processes that nursing and midwifery students are appropriately supported and assessed in practice settings so that they are fit to practice at the point of registration(Andrews et al.,2009).

A conducive and supportive learning environment for certified midwives depends on the availability of placement support systems such as supervision, mentorship, preceptorship and relationships between the faculty and clinical staff. Spouse (2013) describes the learning environment as a place where there are policies and protocols and their effects on structures such as staffing levels and skill mix, number and range of visiting learners, delivery of care, reception and management of new comers, professional education, and interaction with health professionals. A clinical setting rich in learning experiences, but lacking a supportive environment, discourages learners to seek experience and results in loss of learning and growth opportunities. Foster et al. (2014), a study on nursing students' expectations and experiences of mentorship revealed that students' experiences were largely positive and that they valued the teaching, support and encouragement they received from mentors but there was need to address ways of strengthening the link lecturer involvement in mentorship which includes the imperative for the university to explore ways of better supporting mentors in their role. A study conducted on commencement of direct entry midwifery training revealed that there were some challenges in supervised clinical practice which was below recommended minimum of 50% of the program and the other biggest problem was with the mentors who had little time to attend to the mentee (Narchi et al., 2010; Bray and Nettle, 2007). A review of research of mentorship in nursing education by Ehrich et al. (2004) found similar results that a lack of time for mentoring was persistently raised by mentees.

Higgins and McCarthy (2005) explored mental health nursing students' experiences on a three year diploma programme in Ireland of having a preceptor (mentor) during their first placement experience. Results suggested that a mentor was important in contributing to their learning. The students also expressed that their initial encounter with patients was quite anxiety provoking due to the nature of the patients' illness. The students however valued having an identified member of staff who was there "just for them".

2.2.2 Relationship with mentor and mentee

Wilkes (2006) found that the mentorship relationship is complex and students wanted a mentor who was supportive and was caring for patients and students.

While in a phenomenological study which explored and described the lived experiences of general student nurses on their first clinical placement in an Irish school of nursing revealed that the presence of mutual respect and regard for others had a positive impact on the student's self-esteem (Chesser-Smith, 2005). Hughes and Frazer (2010) revealed that the relationship that students have with the mentor is fundamental to their confidence in practice, although there is an appreciation, sometimes there are problems of personality clashes. Altuntas (2011) in a study on mentorship among academician nurses in Turkey revealed that mentors and mentees consider the relationship between themselves as mostly a teacher-student relationship and some students experienced lack of interaction due to shortness of time. The other problem as indicated by Saarikoski et al. (2007) is the practical organization of mentorship such as not having named mentors, relationship between students and mentor, supervisor changing during the training and one mentor had several students to supervise. According to Webb and Shakespeare (2008), good mentoring depended on students building a relationship with their mentors and undertaking a great deal of emotional labour to convince mentors that they were good students in terms of attitude as well as clinical practice competence.

Sui and Sivan (2010), revealed that the main aspects involved in mentoring process are becoming acquaintances, developing bond, feeling of inclusiveness and obtaining affirmation as experienced by mentees and these are key to its success. The success of the student-mentor relationship was supported by a friendly, supportive professional relationship.

According to Winston and Creamer (2002), good supervision is based on a trusted and supportive relationship between supervisor and intern; an organizational structure that permits interns to observe widely and to assume some responsibility was associated with professionals on the site, theory-based practice, open communication and candor, mutual respect, practice that emphasizes observance of professional ethical standards and accountability. Therefore the quality of internship between mentor and mentee is the single most important factor in determining the ultimate success of the mentorship experience.

Mabuda(2006) writing from South Africa indicated that there are aspects which impact negatively on students' clinical learning experiences such as support, lack of opportunities for learning, poor theory-practice integration and poor interpersonal relationships between the students, college tutors and ward staff.

2.2.3 Availability of Human and Material Resources during Internship

Sibiya (2010), in a study on work integrated learning experiences of primary health care post basic nursing students in clinical settings in South Africa revealed that Work Integrated Learning is vital for the development of clinical skills amongst primary health care post basic nursing students.

However, shortage of staff, inadequate material/ non-human resources, lack of supervision in the clinical facilities, distant clinical facilities and insufficient practice in the clinical skills laboratory were identified as challenges that students experience during Work Integrated Learning placement.

In a study conducted by Magobe et al. (2010) revealed that there are challenges faced during clinical placement such as shortage of staff, students regarded as part of staff or workforce, lack of clinical equipment and other related resources. In addition Mabuda et al. (2008) indicated that there was no feedback given to student nurses and tutors never did follow-ups in real patient care settings. While on the other hand, ward sisters were reluctant to supervise student nurses. All participants stated that there were no clinical preceptors in the wards, and that, in their absence, teaching and learning in the wards became difficult or did not even exist, which negatively affects the clinical learning experiences of student nurses. Without any identified preceptors, student nurses had to rely on the ward sisters, who were also too busy to supervise and guide student nurses.

2.2.4 Attitude, skill and knowledge of mentors during internship

There is a growing emphasis on developing sounder processes that nursing and midwifery students are appropriately supported and assessed in practice settings so that they are fit to practice at the point of registration (Andrews et al., 2009).

The roles of a mentor are basically to encourage the students to learn from practice, to assist the students to acquire focused and specific clinical skills and to facilitate the professional socialization of student in clinical practice (Fulton et al., 2007).

As indicated by Durham et al. (2012), the Nursing and Midwifery Council (NMC) standards to support learning and assessment in practice were implemented aiming to ensure that all pre-registration nursing students are assessed by mentors in practice who are knowledgeable, up to date, and who can ensure that students are safe practitioners at the time of registration. Burns and Paterson (2005) and Khomeiranet al. (2006) reported that interactions between preceptors and students are important for student learning while expert clinical teaching is vital for the development of skills and knowledge for midwifery and nursing students.

The ability of the preceptor to teach effectively, applying good teaching methodologies, such as critical thinking methods for competency building, is crucial for the achievement of objectives. Myall et al. (2008) revealed that the importance of mentorship for pre-qualifying students and emphasizes that there is need to provide mentors with adequate preparation and support and also bridging the gap between practice and theory.

Finnerty et al. (2013) demonstrated that the pivotal role of mentors for scaffolding learning and also using fading techniques within a cognitive apprenticeship model where mentors need assistance to adapt their mentoring styles and to use a wide range of instruction strategies for student midwives. Licqurish (2008) revealed that, students identified midwife preceptors as helpful and unhelpful, and students indicated that they prefer to work with a caring midwife preceptor, who enjoys teaching, answers questions fairly and is philosophically similar. Students also felt that they benefited from opportunities for responsibility for care under supportive supervision, hands-on learning and debriefing. Midwife preceptors described as unhelpful were poor role models, did not allow the space for 'hands-on' practice or 'took over', were generally unsupportive and operated in a hierarchical system within the clinical agencies.

Sharif and Masouri (2005) showed that nursing students were not satisfied with the clinical component of their education. They experienced anxiety as a result of feeling incompetent and lack of professional nursing skills and knowledge to take care of various patients in the clinical setting.

Rhee and Wilson (2013) writing from Norway indicated that some students had experienced being met with an attitude characterized by surprise, unpreparedness or even negative reactions the first day in the ward. Some of the students raised a problem of being used as labour resource and at the same time being in a vulnerable position regarding sanctions if they complained or avoided to do what they were told. Another concern was prioritizing of time and facilities for student supervision and reflections. A study on current mentorship schemes revealed that time was an important factor which needed addressing, followed by increased awareness of students training and the need for mentors to choose their roles voluntarily as some mentees had an impression that some mentors are forced into mentoring (Nettle et al., 2008). Preceptorship for midwifery practice in African countries concluded that for most African countries to meet the MDGs, midwives cannot afford to exhibit professional excellence coupled with the right attitudes. Preceptorship facilitated by long-term mentoring and strong clinical supervision in regular practice is core to success (Dennis, 2011).

2.3 CONCLUSION

Literature shows that no studies that have been conducted on mentorship and supervision in clinical setting in nursing and midwifery in Zambia. More studies have been conducted on mentorship in the developed countries than developing countries. The study aimed at exploring the experiences of certified midwives on mentorship and supervision and has shown that there is inadequate mentorship and supervision in nursing and midwifery; hence the need to strengthen mentorship strategies so as to help improve nursing and midwifery competencies for pre-registered students in practical placements.

CHAPTER THREE

3.0 METHODOLOGY

3.1 INTRODUCTION

This chapter discusses the research methodology that includes the research design, research setting, population, sampling methods, sample size, inclusion and exclusion criteria, recruitment of participants, pilot study, data collection methods and analysis, ethical considerations and ends with limitations to the study (Burns and Grove, 2003). According to Polit and Hungler (2004), methodology refers to ways of obtaining, organizing and analyzing data. The main focus of this study was to explore the experiences of certified midwives on mentorship and supervision received during internship, therefore the research approach was qualitative. It is a systematic, subjective approach used to describe life experiences and give them meaning (Burns and Grove, 2003). Qualitative research is mostly associated with words, language and lived experiences rather than measurements, statistics and numerical figures.

3.2 Research design

A qualitative interpretive phenomenological method using Hermeneutics to explore the experiences of Certified Midwives on mentorship and supervision received during internship was used in this study. The phenomenological method is a process of learning and constructing the meaning of human experience through intensive dialogue with persons who are living the experience (Lobiondo-Wood and Haber, 2006). Hermeneutics proposes that there are no such things as measurable behaviors, stimuli and associated response. Instead, investigation is prompted through such things as encounters, life worlds and meaning (Holroyd, 2007).

3.3 Study Setting

The study focused on the experiences of mentorship and supervision by certified midwives working at the University Teaching Hospital (UTH) Lusaka, Zambia. The hospital has a bed capacity of 1800 of which 150 are for maternity wards.

The study was conducted in five (5) wards and the Neonatal Intensive Care Unit(NICU) including; antenatal and postnatal care wards (4), labour ward (1). The Neonatal Intensive Care unit had a cot bed capacity of 100.The unit admits neonates from labour ward and national referrals. It is a teaching hospital for various health related trainees from within and outside the country.

3.4 Study Population

The population for this study consisted of certified midwives who had completed internship and working at the University Teaching Hospital. Certified midwives who underwent mentorship and supervision were targeted for participation.

3.5 Sampling Method

A non-probability sampling was used in this study where participants were chosen by nonrandom methods. A purposive sampling method was used to select the participants. The participants were selected based on their knowledge of the phenomena, for the purpose of sharing their knowledge and experiences (Burns and Grove, 2005). The in-charge in each ward assisted in identifying the certified midwives before the interview and were informed about the study.

3.6 Sample size

Sample size was not predetermined since the study was qualitative. A total of thirteen (13) participants were interviewed and at that stage data saturation was reached by means of repeating themes. Data saturation in qualitative research is when data collection can cease, as no new information from participants is being brought out; data from subsequent participants becomes repetitive; inclusion of additional participants does not result into new ideas (Schneideret al., 2005).

3.7 The inclusion and exclusion criteria

3.7.1 The inclusion criteria

Inclusion criteria are sampling requirements identified by the researcher that must be present for participants to be included in the sample (Burns and Grove, 2005). The inclusion criteria were all certified midwives who had completed internship program from 2010- 2014; willingness to participate in the study and having been exposed to mentorship and supervision.

3.7.2 The exclusion criteria

Exclusion criteria refer to the characteristics that restrict the population to the homogenous group of participants (Lobiondo-Wood and Haber, 2006). The exclusion criteria was Certified Midwives; who were on leave during data collection, who did not consent to be involved in the study, who had not completed internship, who were on night duty and those admitted on sick register.

3.8 Data collection

Data collection is the precise, systematic gathering of information relevant to the research sub-problems, using methods such as interviews, participant observation, focus group discussion, narratives and case histories (Burns and Grove 2005). Data collection in this study was conducted using in- depth individual interviews. Interviews are structured or unstructured verbal communication between the researcher and participants during which information is obtained for a study (Burns and Grove 2005). The pilot study was conducted at Levy Mwanawasa General Hospital in Lusaka to test the practicability of data collection instruments and questions were modified accordingly.

3.8.1 Data collection tool

Unstructured interview schedule was used to collect data and included completion of demographic particulars followed by an interview. Each interview was conducted by the moderator (researcher). One tape recorder was used for each interview session which lasted between 20 to 45 minutes. Bracketing to enter into the interviews without any bias was used.

3.8.2 Data collection technique

The interviews were conducted in a noisy free and private environment. Permission from the participants was obtained prior to data collection. The purpose, nature, beliefs and risks of the study were explained to the participants including on how the findings were going to be utilized. Permission to use the tape recorder was sought from the participants. All participants were given information regarding direct and indirect benefits from the study. Participants were given time to go through the information sheet (appendix I) and thereafter signed the consent form. Assurances were given that all the information that was provided by the participants was treated with confidentiality. Participants were availed with the consent form (appendix II) on which they appended their signatures as endorsement to participate in the study.

Participants who wandered off the subject were guided by use of probing questions. During the interview, communication skills such as reflection, nodding, questioning, clarification and maintaining eye contact to facilitate and encourage participants to talk were used until there were no new issues emerging. The phones were switched off and the interviews were done in a quiet environment. Field notes were taken the interviews and follow-up interview was done with seven participants after first listening to the tapes. This was done to verify and allow the participants to expand and add descriptions to the phenomena (Burns and Groove, 2005).

3.9 Measures for trustworthiness

Assessing of trustworthiness was done according to Licoln and Guba (2000). All participants were taken through the same ground breaking question, debriefing with informants, and any additional information was taken into consideration during analysis. The participants were interviewed to the point at which there was data saturation (prolonged engagement) and the interviews were tape-recorded and transcriptions were made of each interview (referral adequacy). The researcher had prolonged time in the field to develop an in-depth understanding of the phenomenon under study and had more experience with the participants.

An independent coder was given the research objectives and some of the raw text from which the categories were developed to provide accuracy of findings. The independent coder was asked to create categories from the raw text.

A stakeholder check was also done to enhance the credibility of findings by allowing research participants to comment on or assess the research findings. The researcher checked all the transcripts to make sure that they did not contain obvious mistakes made during transcription. The researcher also made sure that there was no drift in the definition of codes, shift in the meaning of the codes during the process of coding. This was achieved through comparing data with the codes and by writing memos about the codes and their definitions. Member checking was done by taking the final report back to the participants so as to determine whether the findings are according to the information given during the interview. An external auditor was used to review the entire project to validate the findings. All interview materials, transcriptions, documents, findings, interpretations, and recommendations were kept, to be available and accessible to the supervisor and any other researcher, for the purpose of conducting an audit trail.

3.10 Ethical Considerations

Since the research involved human participants, strict ethical principles according to the Declaration of Helsinki (World Medical Association, 2008) were followed. Ethical clearance was sought from ERES, Ethics Committee, and from the Senior Medical Superintendent (SMS) of the University Teaching Hospital. The CMs were asked to give their consent and they were assured that participation or information provided was not going to be used against them. They were also assured of their right to confidentiality and anonymity. Confidentiality was ensured by guarding against unauthorized access to the data, the data was secured and erased from the tape after completion of the research. According to Lobiondo-Wood and Haber (2006), anonymity exists when the participants' identity cannot be linked to the information, even by the researcher, with his or her individual responses. Anonymity was maintained by numbering the participants and by destroying the names attached to the numbers after the research.

The principle of respect for persons was assured by providing the participants with information about the research, its purpose and the right to choose to participate or not participate in the study through the information sheet. The principle of justice requires that people should be treated fairly and should receive what they are due or owed (Lobiondo-Wood and Haber, 2006). Therefore, to ensure justice, participants were given equal opportunity to take part in the study.

CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.1 INTRODUCTION

This section describes data analysis characteristics of participants and the findings of the study which are discussed according to themes and subthemes, clinical learning environment for CMs, the relationship that exists between mentors and mentees during internship. The section further indicates availability of human and material resources during internship and knowledge, attitude and skills of mentors. The data is presented as excerpts from the participants.

4.2 Data analysis

In qualitative studies data collection and analysis sometimes occur simultaneously. Content analysis was used to analyze the data using Nvivo software version 10. Qualitative content analysis has been defined as a research method for the interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns, (Hsieh and Shannon, 2005). The analysis of the data started with transcribing, five themes and thirteen subthemes emerged. The researcher listened to and transcribed the audio tapes and read and re-read the verbatim transcripts to gain understanding of the interviews and to familiarize with the data.

Thereafter, the verbatim were imported into Nvivo software and analyzed them one by one. An independent coder who is familiar with Nvivo software assisted with the coding process of a few interviews and after a consensus discussion with the coder, the researcher continued with coding. From each transcription significant phrases or sentences that pertain directly to the lived experiences of certified midwives were identified through studying and reviewing the transcriptions (Hsieh and Shannon, 2005).The formulated meanings were clustered into themes or categories common to all the participants' transcripts to try and make sense of the information and pay attention to both manifest as well as latent content analysis in the text. Manifest content analysis involves looking at what the text says thus, dealing largely on giving descriptions of the visible and obvious components of the text.

In contrast latent content analysis requires the researcher to interpret the underlying means of the text (Elo and kyngas, 2008) looking at the social actor's expressions. Manifest content analysis was highlighted in this study by presenting reality in verbatim (quotations of parts of speech or the whole speech in italics). Latent content analysis was shown by the researcher's interpretation of the underlying meanings of the text by looking at the expressions, silence, size, laughter and posture of the participant. Then the results were integrated into in-depth, exhaustive description of the phenomenon. After open coding, similar codes were grouped in categories (Elos and Kyngas, 2008). The purpose of creating categories was to provide a means of describing the phenomenon, to increase understanding and to generate knowledge (Cavanaugh, 1997). The authentication of the analyzed data was done by going back to the seven participants.

4.3 Presentation of findings

4.3.1 Characteristics of participants

The findings indicated that 15% (n=2) of certified midwives were males and 85% (n=11) were females. Therefore, the majority of the CMs were females and this is attributed to the fact that the training is a more feminine profession. The findings also revealed that majority of students were between the ages of 22 and 40 years with the mean age of 28 years and mode was 22 years. The majority of CMs were below 30 years and age is one of the predictor of academic achievement. The age range is between adolescence and early adulthood which needs support from both the mentors and ward staff since they face a lot of challenges in adjustment.

Table 1: Summary of sample characteristics of the study population (n= 13).

RESPONDENTS			
		NUMBER	**PERCENTAGE**
TARGET GROUP			
Sex	Male Female	2 11	15 85
	Total	13	100
Age	20-25 26-30 31 and above	6 2 5	46 15 39
	Total	13	100
Marital Status	Not married Married	6 7	46 54
	Total	13	100
Qualification	Certified Midwives	13	100
	Total	13	100
Religion	Christianity	13	100
	Total	13	100
Number of children	None 1-2 Above 3	5 7 1	38 54 8
	Total	13	100

4.3.2 Findings

The findings are discussed according to the themes and their subthemes. Extracts from the participants' data are used to demonstrate how the themes emerged from the data. Below is a table showing the five themes and eleven subthemes that emerged from the specific objectives and interview data.

Table 2: Themes and Subthemes

THEMES	SUBTHEMES
1. Experiences on clinical learning environment during internship	a. Intimidation b. Support provided to the CMs
2. The relationship that exist between mentors/ ward staff and mentees during internship	a. Relationship with mentors b. Relationship with ward staff c. Attitude of qualified staff towards the CMs.
3. The Availability of Human and Material Resources During Internship	a. Availability of human resources b. End of allocation assessments c. Availability of material resources
4. Knowledge, Attitude and Skills of Mentors on Mentorship and Supervision During Internship	a. Inductions and orientations b. Role of mentors c. How mentorship was done
5. Lessons learnt during internship	

4.3.2.1 Experiences of certified midwives on mentorship and supervision in relation to clinical learning environment during internship

A conducive and supportive learning environment for CMs depends on the availability of placement support systems. Learning in clinical setting requires; a conducive environment providing an appropriate support from skilled and qualified educators. This is presented in two sub-themes; intimidation and support provided to the CMs.

4.3.2.1.1 Intimidation

Clinical learning environment is a learning environment where students are socialized into the profession. It is therefore, important that the clinical environment offer students opportunities for learning. The clinical environment was characterized by mockery from the qualified staff. This made the CMs feel intimidated and have anxiety and fear as they practiced. The CMs reported that there was intimidation from the senior midwives and they referred to them as "improved Traditional Birth Attendants" as exemplified by the following quotes;

> *Ok, the way they were behaving, their attitude towards us, there was poor working environment. It was full of intimidation if one makes a mistake instead of that person encouraging you or to show what you are supposed to do. They will start to tease you, this new program what….what…what. .. (Interview 07, 27 years)*

> *The negative effect was from qualified staff not certified midwives. They would complain about certified midwives. It was a feeling where you just have trained for one year six months and we have been trained for many years and you have the same uniform so these are negative remarks and people not being in terms due to unknown reasons (Interview 06, 22 years).*

> *They didn't accept the Salaries we were getting. They will be like how can you get the same salaries with registered midwives… No. we are not but we are on the same salary scale with registered nurses but them they will say we were getting the same with them (Interview 12, 24 years).*

> *Well, it wasn't really bad for me, yes, though we had some hiccups here and there but at least we managed because we knew why we were here.*

And we learnt a lot of things from different people like people from the ward and most of the times they are the ones who used to teach us. Our mentors never came (Interview 2, 22 years).

4.3.2.1.2 Support provided to the CMs

The certified midwives from the consecutive intakes reported that they were being supervised by the ward staff not trained in mentorships. They also reported that during the time when they had shortages of equipment the senior midwives were there to help them adapt to the situation. The mentors provided counseling and encouragement to the CMs from the first cohort before conducting the procedures and they supervised the CMs as explained by the following quotes;

In the allocation they could even ask the in charges to find out more on how we were working and if they see there is improvement, they would then take us to another ward for our allocation (Interview 03, 24 years).

Yes, she used to assist us a lot. She would come for us. Just like I said, the way we came we were overwhelmed and just used to assist us, she could counsel us and tell us to be calm not trying to do many things at a go….. yah, so she would talk to us just like that(Interview 04, 25 years).

Uhmm we were given the check lists. So when you do something, when you do a procedure those people you are working with, the qualified nurses they have to counter sign the check list which were taken to the mentors (Interview 07, 27 years).

We used to ask the nurses that were there and they'll show you what to use when you don't have the equipment (Interview 12, 24 years).

The support the CMs received was not according to the standards of mentorship where a mentor is expected to be on site on a daily basis as set by the NMC. The CMs were supported by senior midwives who have not undergone mentorship training and this compromised the quality of mentoring. A clinical setting rich in learning experiences but lacking in supportive environment discourages the learners in seeking help and results in the loss of learning and growth opportunities. Prior sensitization of ward staff about certified midwifery program and training of mentors should be a priority in order to have well mentored and competent CMs.

4.3.2.2 The relationship that exist between mentors/ ward staff and mentees during internship

Learning involves two parties; the mentor and the mentee. The relationship between the mentor and mentee plays an important role in promoting learning and meeting the objectives of the mentee. This theme is discussed in three subthemes; relationship with mentor, relationship with the ward staff and the attitude of the ward staff.

4.3.2.2.1 Relationship between mentees and mentors

The participants reported that there was a positive relationship between the mentors and the CMs as mentors corrected them during the practice. They were able to listen to them and guide the CMs on how to handle procedures in the ward. When it came to signing of log books some mentors were available to sign. Some also reported that the mentors were kind in helping the CMs when they made mistakes without shouting at them as indicated in the quotes below;

> *If you make a mistake, she'll correct you by showing you the right way* (*Interview 11, 34 years).*
>
> *She was very good and she was more like a mother she was good to us, at least whenever we went there with something or a complaint, she used to handle it like a mother. I remember there was one time I was in labour ward and the in charge there just one day she told me that I should stop going for lunch because there were a lot of deliveries and that she couldn't be doing them alone…..*(*Interview 04,25 years).*
>
> *It was good because the few times that we spoke to her she was good apart from that we never got to see her come and check on us. But each time we went to see her with a problem she would always give assistance* (*Interview 06, 22 years).*
>
> *The relationship with our mentor was ok though I cannot lie that she followed us even in the ward? No... She never followed, not until the time that you go and work in her ward* (*Interview 08, 28 years).*

In those few days in as much as we learnt in school but you go to a new place you have those fears but they helped me by telling me this is what you should be doing. In as much we had conducted 23 deliveries but it felt like first day in labour ward. They were calm and at the end of two weeks I was able to work (Interview 13, 22 years).

The In charges of the wards were described as good towards the midwives as they oriented and signed the log books for the CMs when they reported for work in the new wards and the CMs found this very helpful as explained in the quotes below;

Because, like for them to sign there was nothing like you just sign in your book and say I did this. They will ask you to do the actual procedure before signing. If it was not like that you have to be asked questions which you were going to give the answers before someone signs for you and they were strict on us. There was nothing like today you go for work; you don't go minus them questioning you. They would take us as part of the nurses group, so they will be following everything we were doing (Interview 06, 22 years).

4.3.2.2.2 The CMs' relationship with the ward staff

The CMs said that in some wards some qualified nurses were not ready to assist them, claiming that they were too busy. The CMs further reported that they were mocked over their qualification indicating that the training was not adequate as exemplified in the quotes;

Just the name CM, I don't know because they were like why did you choose to be a CM… what… what my answer was like it's not that I wanted to go for a CM, it circumstances. I applied everywhere but I wasn't picked where I was picked its being a CM of which I am not going to be a CM forever no. that's what I used to answer (Interview 10, 31years).

To some, the relationship was just okay but there are some to whom the relationship wasn't that okay… For example this nurse in neonatal ward, I wasn't good at annulations and she would come and help and even teach you how to do it. Even calculations on dosages for babies she would come and help. But for some they would just tell, "you didn't go to school for you to ask on calculations (Interview 01, 40 years).

Well, some it was good but some hmmm you just know how people are, some people are just like that.

Otherwise some you would go and ask and they would teach whilst others you go they will say no we are busy we don't have that time. So to some we did not learn anything but others were good and always willing to teach (Interview 02, 22 years).

Ok, work wise maybe I can say there was just too much intimidation. They were saying we didn't know how to work since we were just directly from school so how can we work and we were still young… yah. But they used to help even so and like I said if I have a question I could ask and they used to help. It's just on those areas and this conflict, I don't know if it is a conflict or what that how could we be getting the same salary as those direct from school(Interview 03,24 years).

The only difficult thing was that the qualified staff could not accept after they heard that the ministry had put us on the same salary for the EM, they didn't accept. They could say you just went to school for one year and you are getting that money and us who went to school and even did midwifery. It was really difficult (Interview 04, 25 years).

4.3.2.2.3 Attitude of qualified staff towards the CMs.

The CMs received a lot of intimidations and mockery about their qualification as senior nurses referred their qualification as that of a traditional birth attendants, because they were shouted at when they made mistakes in practice as exemplified by the quotes;

Like, most of the times we would want to learn something from them but they would say they are busy. And sometimes you would go at a time when you have even seen that they are not that busy they are just seated but they would tell you no, we are very busy, where is your mentor because she is the one who is supposed to do this and sometimes they would even pretend like they haven't even seen you because they don't want to be asked questions. But others were very good (Interview 02, 22 years).

Ok, the way they were behaving, their attitude towards us. For example when we make a mistake instead of that person encouraging you to show what you are supposed to do. They will start to tease you, this new program what….what…what. .. Ok, they referred us to be improved TBAs that we can't do anything minus doing general nursing, it's not possible (Interview 07, 27 years).

During my internship, the supervision was ok. To the in charges it was ok, but to other nurses like the registered midwives, there was much intimidation. They were saying that we were half baked; we were not fully baked so that was the problem we were facing. If you ask questions maybe you have severe pre-eclampsia patients, you ask a question how to give magnesium sulphate. They would say you are from school so you know everything just go and give (Interview 11, 34 years).

Ok sometimes it was challenging because it was depending on the way the staff is. In that some staff were very helpful while others were not. Others, when approached they'll be like you don't know these things, are you not from school, how come? Some will put you down but some, actually a lot of them were helpful (Interview 12, 24 years).

Mentor-mentee relationship is a tool of professional development of student nurses in Clinical Practice. However, problems of compatibility occurs between them and therefore, they both need to know their roles in order to ensure a good relationship. A negative attitude of nurses towards CMs in the clinical practice setting has the potential of obstructing learning and threatens student progression and retention within the program.

4.3.2.3 The Availability of Human and Material Resources During Internship

The shortage of human and material resources in the clinical area leads to non-orientation to proper procedures and work overload for students. The theme is discussed in three sub themes; availability of human resources, end of allocation assessment and availability of material resources

4.3.2.3.1 Availability of Human Resources

The CMs were made to work from 07:30 hours to 22:00hours (normal shift is from 07:30 to 13:00 hours) as reported below;

Yes…. sometimes madam we used to work….mmmm I would come in the morning in antenatal ward and knock off around 22 hours… Eeheeee, yes, because of the strike, there were no nurses, so I would work from…. That time we had the matron who retired, so she would just come, be it in Annex maybe you would be allocated in two rooms, so we were the ones who used to work, no nurses at all (Interview 01, 40 years).

Yes, and that was my first allocation for six weeks. I used to be alone in the ward. Sometimes the sister in charge would come and say ahh! You are alone, no ways you are not supposed to be alone and maybe she would tell someone in the annex to be helping you and such kind. So they could help us (Interview 01, 40 years).

The time that we came, we found there were about 4 midwives on duty per shift and sometimes maybe 3 and you would be the fourth one just like that. But this time I think there is a bit of improvement at least we can be 7 during the day or 8 and if we are many, we could even go up to 12. But that time during the night if you are well-staffed maybe you could be 5 or 6 during internship. So there was shortage (Interview 03, 24 years).

As I said earlier on, the staffing wasn't really good that's why we were even left alone even at night to do work. Because things we were told even at school they said you are going there as interns and you will be with someone to help you who is experienced. So that if anything happened that person would help out. But because the staffing was really good, we could be left out to do the things alone (Interview 04, 25 years).

During the period of staff shortages it was difficult to provide support to interns as they were left alone to work without a mentor as reported in the quote;

Hmm. It was done by some nurses and midwives. Sometimes they could come and ask us questions about a patient and things like that and we would explain everything that all. And where we were wrong they would correct us and teach us (Interview 02, 22 years).

Hmmm, ok, here for instance the mentor will be there especially during deliveries, she will show you how to suture and examining the baby. Also in clinics they will always be there. I remember there was a mentor who would always go with us to the children's clinic (*Interview 03, 24 years).*

It was done in wards and sometimes we used to go to the local clinics. They would give us a mentor to accompany us to go there. Even the in charges from the local clinics they were given authority, they were delegated to supervise us (Interview 07, 27 years).

Hmmm, mostly it was via the in charges because at the end of the allocations, the in charge should recommend to say that these they have done, they have worked as per expectation yes and the mentor will also get it from the in charge. Then if the in charge is not satisfied they will write a note. Like for me, there was one time when I got sick just for a day I was given two days sick offs then I exceeded one day. I wasn't recommended in D-block by sister in charge. She said I have to work for two days so that I can be a good nurse so that even if I qualify I wouldn't say no because I am sick and that note went to the mentor until I had to go back and finish that day to complete full allocation(Interview 08, 28 years).

Some CMs reported that they had support from trained qualified staff they worked with as explained in the quotes below;

There were some drugs that I had not used during the time that I was training like hydralazine in labour ward as I didn't know how to dilute it. So this sister who we were together on the table told me how to dilute and how to give so where I was not clear I will ask… On that one I can't complain much I was really helped most especially from my fellow certified midwives the ones I found in labour ward, I learnt a lot from them (Interview 05, 32 years).

Yes those things we did but not with the mentor, like I said we used to work like with the people we were working with were like our mentors. Like I will do something and after someone observe me then later on sign the log book (Interview 06, 22 years).

4.3.2.3.2 End of Allocation Assessment of the CMs

The CMs are supposed to be assessed by the mentors at the end of each allocation (6 weeks) then provided with certificate of competence. This activity was not done as indicated in the quotes;

Not really, only… I remember when I was in antenatal ward and gynecological ward that's where we were assessed. So assessment after the allocation no. unless just within the allocation (Interview 09, 33 years).

Maybe during a procedure because we used to ask and they would help us. But not like writing anywhere that you have been assessed.

It's just procedures, the sister will come and say oh you don't know this procedure and then she would walk you through and the things like that (Interview 09,33 years).

No, we never had any. We were only assessed by other staff and not them (Interview 02, 22 years).

There were books which we were given. If you want it to be marked if the mentors were not around we were using the in charges to monitor what we were doing. You just say I want you to mark, so the in charges were the ones who were doing the marking (Interview 11, 34 years).

4.3.2.3.3 Availability of Material Resources to use

The CM reported that sometimes they run short of some variable material resources such as delivery packs, cord clamps, catheters, and suctioning tubes where they had to improvise. In such situation where they did not have the right material to cut the cord they would use a lazar blade or a needle. Resources to use in labour were in short supply hence there was a lot of improvisation as explained in the quotes;

Yes, you will find that there are no blades but these blades have been there because even the disposable packs which we have they have blades in them but at that time when we came we 'll find that there was nothing so we will ask then what to use but now it's being said, you don't have to use a blade or a needle to cut a cord because if you hurt yourself, it's at your own risk, you need to use the cord scissors but they are usually not there(Interview 06, 22 years).

For instance, maybe we run out of delivery packs and the mother is there pushing you can't say no deliver after the packs are in. so we would improvise by using- maybe, we at times we could use two cord clamps and a needle to cut. And that's very risky but we would learn that because we had no option. Unless the mother has a blade then we could use it but if totally nothing we had no option but to learn that. Even this time sometimes we use cutting needles (Interview 03, 24 years).

For instance in labour ward, there were times when we could have a lot of deliveries and they could finish the delivery packs and we don't have any more left and babies are coming and you don't even have gloves. So we could just get 2 of them, you clamp the cord and sometimes you find even a razorblade you don't have at UTH, so we could use a needle sometimes just to cut the cord (Interview 04, 25 years).

For example the most places where we got to improvise a lot of things is labour ward because you would find that there are times when you don't have delivery packs, no cord scissors, there are no blades. So when we came we didn't know because where we are trained from you will find things are there because it's a small place. So now you have to ask what to do. You find that here you don't have those things. You only use the cord clumps and you cut a cord using a needle. Though it's kind of risk, the needle can prick you but those are things that are happening so we just learnt (Interview 06, 22 years).

However, some CMs who did internship in another facility outside Lusaka reported that they never had any shortages as exemplified in the quotes below;

Hmm, most of the times we would have the equipment available. Because even on weekends when the in charge is going she would leave the equipment that we needed to use so we would be on a ward to practice over the weekend (Interview 02, 22 years).

For equipment, it wasn't much of a problem. We had almost everything. I only remember that time whereby there is no power so delivery pack was not clear but we had equipment (Interview 13, 22 years).

Materials resources are valuable in the delivery of quality nursing care to patients. During delivery a midwife is expected to use sterile equipment to avoid infection. But this was not the case with the CMs despite their full knowledge of the risks attached to this method of cutting the code. This hindered on their practice and there is need to ensure that an inventory of material resources is done before posting the CMs for internship so that they practice using ideal equipment.

4.3.2.4 Knowledge, Attitude and Skills of Mentors on Mentorship and Supervision During Internship

The knowledge, attitude and skills were assessed using the three parameters; induction and orientation, the roles of the mentors and how mentorship was done during internship.

4.3.2.4.1 Induction and Orientations

Orientation is the core of effective and efficient working relationship. The first cohort who graduated in 2010 underwent induction prior internship placement for two weeks and the consecutive groups did not undergo induction as explained by the CMs below;

> *There was no induction. Yah… all I remember is an orientation here where we were taken through the various departments. There was no workshop of any kind. But it was just after internship when we had the orientation (Interview 01, 40 years).*

> *A lot of things like we shouldn't be intimidated when we go out there to practice, that they will always be there for us to help us as we practice (Interview 07, 27 years).*

However, for those who had the orientation described the process as per quotes below;

> *Yes, she came and introduced herself; she even gave us her phone number saying if anything please call me… yah… even the problem of accommodation, she was there for us. Yah… So she was nice, especially those who worked in her ward during internship she used to teach them (Interview 01, 40 years).*

> *We didn't have as our intake from Chipata, we were just taught by our tutor what we were going to do and that we were going to be there as qualified because we have already finished but the only thing we will not have is a license. We only had a temporal license, so we didn't have that (Interview 04, 25 years).*

> *No, when we came we only did the induction from here but that was after we had already started internship (Interview 06, 22 years).*

> *Hmmm, the induction that we attended was not really for certified midwives alone, it was for all new nurses because at the time when we reported, there were a lot of new nurses.*

So it was just being done on new nurses, RNs, certified midwives together they were just telling us about the dos and don'ts rules…. we were being told about the code of conduct, things like that. They also told us about the hierarchy at this hospital, such things I think that's what was discussed (Interview 01, 40 years).

4.3.2.4.2 The Roles of Mentors

According to the CMs they see the roles of the mentor as exemplified in the quotes;

The mentors should be following up at least 3-4 times in a week and when they go to an intern they have to observe an intern setting up a procedure in their presence (Interview 10, 31 years).

To monitor what we are doing and also demonstrate some procedures that we are not familiar with (Interview 11, 34 years).

They should follow us in our clinical areas and assess our work, where we are not good she would be there to teach us and see to it that at least you can now proceed. But when they are not there, maybe that we are being stuck and all. So they should be there for us. So even those books we are just writing on our own (Interview 01, 40 years).

Just as I have said, I think they should follow us up in the wards since we have got a lot of work. It is really hard where you are coming from school you come and learn midwifery just straight from school. So it takes time for us to adapt more to the environment so the mentor should follow us up a lot because even the general nursing we have is not that much (Interview 04, 25 years).

4.3.2.4.3 How mentorship was done

The CMs from the first cohort reported that the mentors were available when they were performing some procedures as reported in the quotes;

Actually I experienced a lot because certain things we were told that this is how you do it. This is how it's supposed to be done. From there I picked some things from there which I am able to do right now…

An example, like for instance, things like eclampsia we used to learn them just in the book but when I came here I was able to manage patients with eclampsia even now because that thing came from my mentors. They even told me that here at UTH things are done like this (Interview 10, 31 years).

I was conducting a delivery then she was there, I had a patient with PPH then I called for help and she came and fellow nurses came and she was observing me how I was managing the PPH that's how she said I should continue even when I have an emergency I should call for help so that we find in nursing we need to work hand in hand or in a team. In postnatal, we rush to call on doctors (Interview 11, 34 years).

It's good; I am able to do procedures alone. I am able to do everything from what they taught me. I can conduct deliveries alone, I can resuscitate a new born baby, I can cannulate, and I am able to manage shock, manage PPH because of what they taught us (Interview 12, 24 years).

However the consecutive CMs reported that they had inadequate mentorship and had this to say;

Yes madam, what can we do because it was only the nurses and the in charge but our mentor was nowhere to be seen. But she was a good lady maybe there was just something keeping her busy (Interview 01, 40 years).

She only came twice I think…Hmmm, probably I should say monthly. She took long, she just passed through and she didn't like even see what we were doing. And I think she just came to ask something else, something about books. We were just mentored twice (Interview 01, 40 years).

Usually per week maybe about twice per week something like that. Not like consistent. (Interview 09, 33 years)

Ok, the mentorship I received during internship was ok. Like when we were taken to labour ward the nurses that side are the ones who taught us things which were supposed to be done. They mentored us well, they taught us a lot of things like the other things we were learning from here we had not learnt from school. The nurses in labour ward were able to teach us. ..

They'll show you if you are not sure, they'll demonstrate what you are supposed to be doing and if they were busy they will tell you what to do (Interview 12, 24 years).

Over that they were just checking but the mentors when they follow, they will interview us and assess at least they will give you a procedure then they see the way you are going to perform and they get it from there. You will find that when you qualify some certain things you'll fail to perform them because you didn't do them nicely during internship (Interview 10, 31 years).

4.3.2.5 Lessons learned by CMs from mentorship

During internship the CMs are expected to gain knowledge and skills towards patient care before registration. Though it has been reported that the mentors were not there to teach, the ward staff were helping the CMs. The CMs reported that they learnt a lot of things from the staff who are not trained mentors during internship and reported that they are able to perform certain procedures as exemplified by the quotes below;

The good things I would say was, to be good to patients that is the first thing because when you are good to patients and humbleness because these people who come to us and at times a lot of people complain about our attitudes and behavior as nurses to patients. Therefore, listening to them is important as they are the people that are in pain. Therefore, humility is what I learnt as it helps to work well with patients (Interview 05, 32 years).

Ok, like coming to conditions at least I learnt how to deliver twins (multiple pregnancy) if it is multiple pregnancy and how to attend to a mother who is in shock and how to attend to a mother who is eclamptic ….. (Interview 03, 24 years).

There are a lot as I said earlier, I was trained in Chipata school of nursing we didn't have too much complications. Though we used to have but it was rare. So when we came here I found a lot of things, like how to manage PPH at least we have a lot of PPH so I have learnt how to manage it (Interview 04, 25 years).

The management of eclampsia; these people really taught us. They really helped us even management of other complicated issues or conditions (Interview 07, 27 years).

The most important though I can say everything was important. The first thing I can say they had a situation of magnesium sulphate from that time I was taught up to now it's still there in me and then also proper management of PPH I remember I was taught by a qualified nurse in labour ward. He told me to say if a woman starts bleeding make sure that you empty the bladder you do what and what. So PPH management, administration of Magnesium sulphate and suturing and when it comes to neonatology, I also learnt how to cannulate the neonates. To find the vein and also caring for pre-term babies, term babies and also observing the maternal wellbeing (Interview 07, 27 years).

The CMs learnt a lot of things during internship despite the challenges of not having mentors in the practical area. They appreciated everything experience encountered and able to work with minimal supervision. They learnt from the ward staff that are not trained in mentorship and probably missed out on the important issues which the trained mentors would have taught. This has posed a challenge on having incompetent midwives.

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS, IMPLICATIONS TO NURSING, RECOMMENDATIONS, DISSEMINATION OF FINDINGS AND LIMITATIONS OF THE STUDY

5.1 INTRODUCTION

This chapter discusses the findings of the study. The chapter further discusses results in light of previous literature. There were a lot of issues raised which were related to challenges with mentors, mentees and the environment in which they practiced.

5.2 DISCUSSION OF FINDINGS

Five main themes concerning the experiences of certified midwives on mentorship and supervision received during internship emerged from the interview data; clinical learning environment, relationships between mentors/ward staff and mentees, availability of human and material resources, knowledge, attitude and skills of mentors and lessons learned.

5.2.1 Clinical learning environment for CMs

The CMs reported that there was intimidation from senior midwives and they referred to them as "improved Traditional Birth Attendants and harassed them in most cases as well as blaming them if they made mistakes or mismanaged the patients. According to Dale et al. (2013), some of the informants had experienced being met with an attitude characterized by surprise, unpreparedness, or even negative reactions the first day in the ward. Mabuda et al. (2008) also supports the finding and found that students were labeled by the ward sisters as difficult and hazardous to patients, this compromised open and honest interaction between students and staff which impacted negatively on student learning. Bradbury et al. (2014) emphasizes that the feeling of being seen, heard and valued as individuals as well as students is described as an important pre-requisite for experiencing good learning situation.

The certified midwives from the consecutive intakes reported that they were being supervised by the ward staff and not mentors.

The mentors were not accompanying them during clinical practice. They also reported that during the time when they had shortages of equipment the senior midwives were there to help them adapt to the situation. This is supported by Pryce-Miller (2013) who said learning in clinical placement requires a conducive environment providing an appropriate support from skilled and qualified educators. Courtney-Prath et al. (2012) agrees with the findings and demonstrate that consistently high scoring of the clinical placement experienced by both undergraduates and registered nurses. There were high ratings of levels of support from clinical facilitators.

The CMs from the first cohort reported that mentors were helpful at the beginning of internship since the mentors welcomed them and helped with accommodation when they just reported. The mentors also provided counseling and encouragement before conducting the procedures and they supervised the CMs. This is supported by Dale et al. (2013) who found that feeling welcomed and wanted is very important as it shows having a positive start. This was also similar to the findings of Brynildsen et al. (2014)the results generally conveyed more positive than negative experiences. Students expressed most satisfaction with mentor support, the placement's contribution to awareness of future nursing role and described the learning arena as exciting and interesting. Licqurish and Seibod (2008) also supports the finding of this study who found that students identified midwife preceptors as helpful and they benefited from opportunities for responsibility for care under supportive supervision, hands-on-learning and debriefing. It is recommended that research is conducted on the perceptions of staff nurses on mentorship and supervision

5.2.2 The relationship that exists between mentors and mentees during internship.

The relationship with the qualified staff varied from different individuals. They said in some wards the treatment was good compared to others and some qualified nurses were not ready to assist them, claiming that they were too busy. The CMs further reported that they were mocked over their qualification indicating that the training was not adequate.

Lack of mutual respect between the supervisors and the certified midwives was also reported where the CMs were being shouted at when they make mistakes and this made them lack confidence. The findings are supported by Reuter et al. (2004) who found that student-staff relationships were bad, as student nurses perceived that some registered nurses did not value them or their nursing program. This is supported by Mabuda et al. (2008) who stated that interpersonal relationships were a problem. There were poor interpersonal relationships between the ward staff and the students. Students were called names, harassed and were in most instances used as escape goat for any wrong doings in the wards. Yang (2012) is consistent with the result that it was rare to see a ward nurse pleasantry greet students when they came into the ward. Most nurses appeared to be so focused on their work and almost ignored the students. Mongwe (2001) also agrees that inter-personal relationship between the registered nurses and student nurses in clinical area hampered the facilitation of learning of student nurses in the clinical area.

Pope et al. (2003) disagrees with the above findings, he revealed that the midwives were interested in the opportunity to discuss issues related to mentorship and made thoughtful contributions and they were aware of their role as a mentors and generally enjoyed the opportunity to support students.This difference can be attributed to the fact that mentors were supported and they must have been well prepared for the mentorship role.The current study is also contrary to Blaka. (2006) who found that it is crucial for the beginning practitioner to work alongside experienced staff where they are able to watch, listen, learn and practice in an effort to make the most of the learning opportunities available. He further stated that active participation must occur in a supportive atmosphere where the new midwife feels confident to take additional skills and responsibilities. The finding is in agreement with studies on student midwives experience of mentorship which found that the relationship that the student has with the mentor is fundamental to their confidence in practice, although there is an appreciation that sometimes there are problems with personality clashes (Wilkes, 2006; Hughes and Fraser, 2010; Attack et al., 2000). However, the student nurses had good interpersonal relationships with the in charges. This is supported by Tooskie et al. (1996) who found that about 95% of unit managers were giving student nurses the necessary support and had a positive attitude towards student nurses.

Ward in charges need to be sensitive to the study needs of student nurses and should be approachable, helpful, provide student nurse with necessary support and try to foster student nurses' self-esteem (Quinn, 2000).

Malmstrom et al. (2011) is also in agreement with the finding and found that ward managers play crucial roles in creating conducive learning environment for nursing students during their clinical practice. A study on midwives and mentors' perception of their roles in clinical teaching of student midwives is recommended.

5.2.3 The availability of human and material resources during internship.

There was a shortage of nursing staff in some of the wards where the CMs were allocated. This contributed to CMs working from 07:30 hours to 22:00hours (normal shift is from 07:30 to 13:00 hours) and this contributed negatively towards the CMs' learning. Some CMs reported that they would be left alone to work in the ward without a mentor. Moeti et al. (2004) supports the findings, who found that workloads and shortage of staff and equipment limits the opportunities for proper teaching and guiding student nurses allocated in clinical settings. This is similar to the findings of Dale et al. (2013) who indicated that some students raised the concern of being used as labour resource. When there is decreased numbers of staff nurses available to help, the learning experience for nursing student may suffer (Hathorn, 2006). On the contrary, Jones (2010) reported that students stated that they liked working longer shifts such as eight hours versus five hours because this gave them more time to practice their skills. The contradiction with the current study could be due to the support the students received from the staff and adequate staffing in the clinical area. The environment was conducive for practicing and mentors were readily available to guide the students.

The CMs were supposed to be assessed by the mentors and senior midwives and given feedback at the end of each allocation (6 weeks) then provided with certificate of competence. The end of allocation assessment was not done in some wards due to staff shortages. This is supported by Happell (2009) who found that students did not receive regular feedback regarding their performance. Similarly, Glover (2000) found that offering encouragement and support and quality feedback through ongoing assessment by the instructor has a positive effect on the nursing students.

Resources to use in labour were reported to be in short supply such as delivery packs, cord clamps, catheters, and suctioning tubes hence students were unable to practice according to set standards of clinical practice.

This is supported by Nabolsi et al. (2012) who found that students were unable to practice certain skills in various clinical setting due to either lack of material resources or policies of that setting. Lita et al. (2000) also agrees that shortage of equipment hinders the opportunities for properly teaching and guiding students in clinical settings.

5.2.4 Knowledge, Attitude and Skills of Mentors on Mentorship and Supervision during Internship.

The CMs from the first cohort reported that the mentors were knowledgeable as they were able to articulate issues pertaining to midwifery care. The attitude was described as good and caring since the CMs were assisted by the mentors.In support with the finding Jones (2010) asserts that students felt that a good mentor would possess the following qualities; professional, organised, caring, self-confident as well as enthusiastic, friendly, approachable, patient and understanding with a sense of humour. Matsumura et al (2004) also agrees with the finding and found that working with a staff nurse that is knowledgeable, friendly and willing to teach can help to decrease the level of stress which the nursing students experience in the clinical learning environment.The current study is supported by the (NMC, 2008), which states that a mentor is responsible and accountable for; Organising and co-ordinating student learning activities in practice; supervising students in learning situations and providing them with constructive feedback on their achievements; Setting and monitoring achievement of realistic learning objectives; assessing total performance including skills, attitudes and behaviours and Liaising with to provide feedback, identify any concerns about the student's performance and agree action as appropriate.

On commencement of the clinical attachments it is necessary to identify the CMs' learning need during induction process to discuss any concerns and anxieties that they may have. In this current study assessments and inductions were done in the first intake of CMs but in the consecutive cohorts no induction was done.

Hanna (2015) found that proper induction is essential to assist students with coping and starting to learn with less or without fear while being certain about expected outcomes. Orientation includes the integration of students into the practice system as well as health care team. This is supported by Pope et al. (2013) who revealed that students had received notification about their mentors, placement and the identity of their mentors prior to commencing the placement and their mentors also knew about them before they arrived. The assessment of their practice was more meaningful when there was continuity of relationship with a mentor and this meant that they did not have to repeatedly describe their level of skills to a new mentor every day.O'driscoll et al(2010) also agrees with the finding that it is necessary that an effort is made to enhance student learning and satisfaction in the clinical practice area and that students are trained to deliver high quality patient care, in order to meet these challenges, students need to perceive themselves as empowered and supported during internship. He further found that to provide effective student support, mentors must be positive role models, knowledgeable, and able to develop good working relationships. In agreement, Abiddin (2006) found that a mentor needs to poses certain qualities and skills that will help students meet the expectations of mentoring role such as intelligence and integrity, ability professional attitude, high personal standards, enthusiasm and willingness to share accumulated knowledge. Pope et al. (2013) also supports the current study and indicated that students felt mentors can be brilliant and that most mentors are careful about how they teach because they know that they are making competent midwives. Students identified a good mentor as someone who will sit down at the beginning and talk through the objectives.

The CMs from the consecutive intakes reported that their mentors were introduced when they had already started internship a month later and some never saw their mentors until the last week of internship when they were coming to sign the log books. No induction and orientation that was done. A review of research of mentorship in education by Ehrich et al. (2004) found similar results in that lack of time for mentoring was persistently reported by the mentees. This is supported by Nabolsi et al.(2012) who found that due to lack of orientation during clinical placements, students experienced periodic feelings of despair, frustration, anxiety, uncertainty and lack of motivation. The development of a positive working relationship, effective communication and mutual respect between mentor and student enhance quality of learning (Saarikoski, 2002).

Field (2004) also agrees with the finding and found that the students' experience in their first hospital placement was described as having no clarity and understanding regarding their role and expectations as students and that of the preceptors in achieving learning objectives. A study on the roles and perceptions of mentors on mentorship and supervision should be conducted in order to gain more understanding on the challenges they encounter during internship.

5.2.5 Lessons learned during internship

The CMs learnt a lot of things during internship and expressed confidence in their ability to handle certain procedures on the wards after undergoing mentorship. The finding is supported by West et al. (2011) who found that students after undergoing mentorship their grades improved compared to the previous years, they were able to apply technical knowledge to a practical application and initiated development of critical thinking and all essential elements to being a good nurse. On contrary, Benner et al. (2009) revealed that the majority of the students had not experienced good clinical environment which limited their ability to draw on prior knowledge.

The difference in findings with current study could be poor integration of theory to practice by the CMs as well as poor mentoring strategies. Research should be conducted on student and faculty role expectations.

5.3 IMPLICATIONS TO NURSING

5.3.1 Nursing Practice

Mentorship plays a vital role in shaping future nursing professionals and the future of certified midwives. To ensure that certified midwives receive high-quality mentorship, mentors must be given support at the point of care delivery. Staff nurses need to know how important they are as role models for future midwives and the student's professional socialization. Nurses and midwives need to be informed on how their professional socialization affects certified midwives and must take an active role in changing situations that create negative attitudes.

5.3.2 Nursing Administration

All Registered Midwives, regardless of their position are leaders and should have the ability to teach and guide students in clinical setting.

Management should also ensure that training of mentors should be reinforced. Management should look at issues of giving some incentives to enhance their morale in teaching and encouraging the feeling of professional worth. Staff nurses should be allowed to voice out concerns and participate in problem-solving activities that are identified when working with certified midwives. The job description and roles should be clearly written and responsibility for working with certified midwives included.

5.3.3 Nursing Education

The main interest of nursing education is to produce a competent and independent caring midwife who is capable of providing quality care based on the needs of the patient, family and community. The findings show that there is a gap in the mentoring of CMs; mentors are not available to teach the CMs which compromise the quality of midwifery clinical teaching. It is therefore, important for nursing education to improve mentorship by introducing the clinical education mentorship team which is made up of nurses and midwives with a passion for improving standards of care. Nursing education can assist in the provision of continuing education programs for midwives that focus on topics such as how to work best with certified midwives and faculty in clinical setting as well as training of mentors. The nurse education department should inform the staff nurses that they are responsible for delegation and supervision of certified midwives.

5.3.4 Nursing Research

Literature show that little has been done on mentorship and supervision in nursing and midwifery in Africa and nationally. It is recommended that more studies should be undertaken on mentorship and supervision of student nurses in Zambia. Studies on the role of mentors, experiences of mentors on mentorship and supervision as well as staff nurses' perceptions of mentoring in clinical areas should be conducted.

5.3.5 Contribution to the body of knowledge

The findings from the study provide new insights into the complexity of mentorship in nursing and midwifery. The role of the mentor needs more clarification and possible training to be undertaken.

The findings will help the GNC, MoH and other stakeholders in implementing mentorship in nursing and midwifery. The CMs also perceived that they needed more direct mentorship in the clinical practice. The study has also provided new insight on inter-relationships that exist between mentors and mentees which needs improvements.

5.4 CONCLUSION

The findings of this study and literature support the need to revisit mentorship and supervision programs in nursing education. It is evident from the themes that emerged that they play a major role in student learning and nursing education. There were some similarities between the findings of this study with other studies and confirm that some of the problems are universal in nursing and midwifery education. The certified midwives expressed that they were not satisfied with mentorship and supervision during internship and mentioned that the working environment was poor due to intimidation from the qualified staff, inadequate clinical supervision by some midwives, shortage of human and material resources which compromised their learning opportunities, poor relationship with ward staff, name calling, poor staff attitude and non-availability of mentors in the clinical area. Accompanying and teaching CMs by the mentors during internship is very important in midwifery so as to produce midwives who are competent and confident to provide midwifery care independently. The results of this study will help the mentors, nurse educators, General Nursing Council of Zambia and the Ministry of Health to design strategies for more effective mentorship and supervision during clinical placement.

5.5 RECOMMENDATIONS

5.5.1 Recommendations to mentors

- Mentors should design a program for accompanying and avail themselves in clinical practice during internship on a daily basis to guide the certified midwives.
- They should also regularly update their knowledge and skills on latest trends in clinical practice to enable them to teach procedures which are relevant to the current practices and new technology.
- Mentors should act as positive role models to the interns.

5.5.2 Recommendations to the University Teaching Hospital

- The Registered midwives must be encouraged to view clinical teaching and supervision of certified midwives during internship as part of their teaching function and quality improvement strategy in the wards.
- Mentors should be chosen among the registered midwives working in the clinical area other than picking nurse tutors who are not always in the clinical area and busy with their teaching. This will help in having mentors in wards all the time because that is where they operate from.
- The ward staff should promote a positive psychological learning environment and offer a supportive environment as well as viewing CMs as part of the nursing team.
- Qualified midwives and certified midwives should show interest in each other.
- Management should ensure that certified midwives are allocated to a mentor and supervised by senior midwives in the ward.
- Accommodation should be provided for interns.

5.5.3 Recommendations to General Nursing Council

- The sister in- charges should assist the General Nursing Council to identify registered midwives who are interested in clinical teaching and allocating them as mentors to facilitate clinical teaching and learning.
- There should be adequate preparation for the role of the mentor and training in the area of clinical practice during internship so as to provide adequate support to the certified midwives.
- Induction for certified midwives should be done prior to posting for them internship
- Mentors and senior midwives should be encouraged by awarding incentives to guide, support and mentor students during their placements, as this will enhance teamwork and motivation levels.
- The GNC should increase the number of mentors and reduce the ratio from 1:10 to 1:5.
- Career progression for certified midwives should be well stipulated and the provision of study leave from the institutions they are working from.

- Considerations should be made to find a specific uniform for certified midwives to avoid confusion in the wards.

5.5.4 Recommendations to the Ministry of Health

- The Ministry should consider revising the salary scale for certified midwives since their program is different from the usual midwifery program to avoid frustrations in work places.
- The conditions of service regarding career progression should be well stipulated and issues of study leave for the certified midwives.
- The Ministry should consider increasing the number of years for training of CMs, taking into consideration the general nursing part since it is vital in nursing. Instead of having six months of general nursing it should be one year.
- The Ministry should train mentors and not just relying on ward staff to mentor the CMs.

5.5.5 Recommendations for further research.

- The study was conducted in one hospital, it may be important in future to conduct another study which will focus on the certified midwives from all the hospitals where they are posted for internship.
- A study on experiences of mentors on mentorship and supervision during internship.
- A study on midwives and mentors' perception of their roles in clinical teaching of student midwives is recommended (what are the perceptions of senior midwives and mentors of their roles in clinical teaching of student midwives).
- An evaluation of the Direct-Entry Midwifery program should be done so as to work on the gaps identified in this study.

5.6 LIMITATIONS OF THE STUDY

Qualitative studies do not generalize findings therefore, the findings are not going to be generalized (Lobiondo-Wood and Haber, 2006). The study sample was limited and focused only on Certified Midwives who were posted at the University Teaching Hospital and also looked at only the CMs who had completed internship. During data collection in the labour ward the office

that was used for interviews had acoustics and the researcher had to change the room for the interview and moved to D- block office.

5.7 DISSEMINATION AND UTILIZATION OF FINDINGS

The findings of the study were presented at the postgraduate seminar week. The results will also be presented to the University Teaching Hospital, the General Nursing Council of Zambia and the Ministry of Health for implementation of the gaps identified in the study. The findings will also be published in a midwifery journal and the medical journal of Zambia.

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APPENDIX I

INFORMATION SHEET

EXPERIENCES OF CERTIFIED MIDWIVES ON MENTROSHIP AND SUPERVISION RECEIVED DURING INTERSHIP AT THE UNIVERSITY TEACHING HOSPITAL.

INTRODUCTION

I, Miyanda Mwiinga Betty, a student in the Masters of Nursing Sciences degree program at the University of Zambia is kindly requesting for your participation in the research study mentioned above, because it is important to explore the experiences of certified midwives on mentorship and supervision received during internship. Before you decide whether or not to participate in this study, I would like to explain to you the purpose of the study, any risks or benefits and what is expected of you. Your participation in this study is entirely voluntary. You are under no obligation to participate; you may choose to participate or not to participate. If you decline to participate, no privileges will be taken away from you. If we get to a question that you are not comfortable or willing to answer, you can tell me so that we proceed to the next question. If you agree to participate, you will be asked to sign the consent form in front of someone. Agreement to participate will not result in any immediate benefits.

PURPOSE OF THE STUDY

The study will obtain information on the experiences of certified midwives on mentorship and supervision received during internship in Zambia. This is important as the data obtained from this study will help the nursing council in implementing training of mentors in practical setting and also assist policy makers and stakeholders to improve on the gaps that will be identified. The findings will also inform curriculum development education and clinical area support.

PROCEDURE

After you have signed the consent form, and have had a chance to ask questions, you will be asked questions concerning the experiences of certified midwives on mentorship and supervision received during internship. You will also be given a chance to make suggestions on what you think would assist on the mentorship and supervision received during internship.

RISK AND DISCOMFORTS

Risks and discomforts are involved since you will have to spend time in answering questions which is stressful and the presence of the research assistants will cause some discomfort. Answering questions will take approximately 90 minutes and this will be tape recorded for easy capturing of data.

BENEFITS

By taking part in this study, you will be able to provide us with information that will help the GNC, hospitals, Ministry of Health and MAZ relevant authorities and policy makers to come up with effective strategies and policies to promote mentorship and supervision during internship. There will be no money provided in exchange for information obtained.

CONFIDENTIALITY

Information obtained from this research will be locked or a password confidential to the extent permitted by law. You will be identified by a number, and personal information will not be released to other persons. The Ministry of Health, General Nursing Council of Zambia and University of Zambia as well as Research Ethics committee may review your records again this will be done in confidence.

APPENDIX 11

INFORMED CONSENT FORM

The purpose of this study has been explained to me and I understand the purpose, the benefits, risks and discomforts and confidentiality of the study. I further understand that:

If I agree to take part in this study, I can withdraw at any time without having to give an explanation and that taking part in this study is purely voluntary. I am also free not to answer questions that I may feel to be too personal.

I…….. (Names)

Agree to take part in the interview schedule

Signed/ thumb:…….. **Date:……**

Signed/thumb:…….. **Date:……**

PERSON TO CONTACT FOR PROBLEMS OR QUESTIONS

Miyanda Mwiinga Betty. University of Zambia, School of Medicine, Department of Nursing Sciences, P.O. Box 50110, Lusaka, Zambia. Mobile Phone: +26**0977760707/0955760707.Email address:** bmwinga07@yahoo.ca

The Chairperson, ERES Converge, 33 Joseph Mwilwa Road, Rhodes Park, Lusaka, Tel: +260 955 155 633, +260 955 155 634, +260 966 765 503, Email: eresconverge@yahoo.com.

APPENDIX III

INTERVIEW SCHEDULE

TITLE: **Experiences of certified midwives on mentorship and supervision received during internship in Zambia.**

Place of interview…….

Date of interview……..

Time started…….

Time ended……

Name of interviewer…….

Identity of interviewee…….

Hospital……

Ward…….

Index number……

Instructions

1. Introduce self to interviewee
2. Remind interviewee that the interview will be tape-recorded
3. Reassure confidentiality
4. Obtain consent

Demographic data

How old were you on your last birthday? .....

What is your marital status? .....

What is your religion? .....

How many children do you have? .....

What is your highest level of education? .....

Opening question

Describe your experiences on mentorship and supervision received during internship.

Probing questions

1. How was the induction done during this placement?
2. How did you know your mentor?
3. What was the staffing in the wards you were allocated?
4. How were the supervision and mentorship done?
5. How were you managing the situation where you had no equipment to use?
6. How did the mentor assist in your placement?
7. How was the relationship with your mentor?
8. What were the most important lessons learned from the experiences?
9. What was the negative experience that you had during internship?
10. What is your experience with the mentorship you have received?
11. In your own opinion what role should the mentor play when mentoring
12. How do you think mentorship and supervision can be improved during internship?

APPENDIX IV

TIME SCHEDULE- JANUARY, 2014-AUGUST, 2015

ACTIVITY	**J**	**F**	M	A	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**
	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8
Identify topic																				
Writing background and objectives																				
Literature review																				
Ethical clearance																				
Pilot interview																				
Data collection																				
Transcript data																				
Data analysis																				
Report writing																				
Submission of report																				
Presentation																				

APPENDIX V

BUDGET

Category	**Quantity**	**Unit cost (ZMW)**	**Total cost (ZMW)**
Stationary			
Reams of paper	5	35	175
Tape Recorder	1	1000	1000
Rubbers	4	5	20
Scientific Calculator	3	95	285
Spirals	4	20	80
Transparent paper/ Manila paper	2	5	10
Binding research report	4	200	800
		Subtotal	**2,370**
Personnel			
Transport and lunch for literature review	1	100 x 20 days	2,000
Training of Research assistants /pretest	3	300 x 2days	1800
Transport/ Lunch allowance for researcher/assistants	3	70 x 30 days	6300
Statistician	1	2000	2000
Research Ethics Fees	1		1000
Refreshments during interview			1000
		Sub total	**14, 100**
		Total	**16, 470**
		Contingency10%	**1, 647**
Grand total:			**K 18, 117**

Budget justification

1. **Stationary / Binding**

   The researcher required a total of **2,370** for stationary and binding of the report.

2. **Personnel**

   The researcher required**K2, 000** for transport during literature review. The two research assistants were trained for a day at a cost of **K300**. A pre-test was conducted for a day at a cost of **K300**. The researcher required **K300** for 2 days as allowances during training and pre-test. The researcher and the two assistants who required transport and lunch allowance during the period of collecting data which amounted to **K6, 300.** A statistician was consulted for use of Nvivo software and data analysis, at a cost of **K2, 000** giving a total of **K16, 470.**

3. **Contingency**

   10% of the total budget (**K1, 647**) was set aside as contingency to cover up for any unforeseen expenses.

4. **Total budget**

   The total budget for the study was **K 18, 117.**

APPENDIX VI

APPLICATION LETTER FOR AUTHORITY

The University of Zambia
School of medicine
Department of nursing Sciences

P.O Box 50110
Telegrams: UNZA, Lusaka
Telephone: 2526412
Fax: +260 257706

The Senior Medical Superintendent
University Teaching Hospital,
RW
Lusaka.
UFS. The Head of Department
Department of Nursing Sciences
University of Zambia
School of Medicine
P.O. Box 50110
Lusaka

Dear Sir/Madam

Ref: Permission to conduct a study on experiences of certified midwives on mentorship and supervision received during internship at University Teaching Hospital.

With regards to the reference above, I am here by requesting for permission to undertake a study at the University Teaching Hospital. I am a student pursuing a Master of Science in Nursing, majoring in Maternal and Child Health (MCH) at the University of Zambia.

The purpose of the study is to explore the experiences of certified midwives on mentorship and supervision received during internship. The information to be generated from the study will form a basis of conducting large scale studies, influence GNC on improving mentorship and supervision in schools of nursing.

Prior to the main study, I would like to conduct a pilot study at the University Teaching Hospital in order to test the trustworthiness of my data collection tools and make necessary adjustments.

Thank you for your support.
Yours Faithfully,

Betty Miyanda Mwiinga
Master of Science in Nursing Student

Appendix VII

APPLICATION LETTER FOR AUTHORITY

The University of Zambia
School of medicine
Department of nursing Sciences

P.O Box 50110
Telegrams: UNZA, Lusaka
Telephone: 2526412
Fax: +260 257706

The Medical Superintendent
Levy Mwanawasa General Hospital,
P.O Box
Lusaka

UFS. The Head of Department
Department of Nursing Sciences
University of Zambia
School of Medicine
P.O. Box 50110
Lusaka

Dear Sir/Madam

Ref: Permission to conduct a pilot study on experiences of certified midwives on mentorship and supervision received during internship at Levy Mwanawasa General Hospital.

With regards to the reference above, I am here by requesting for permission to conduct a pilot study at Levy Mwanawasa General Hospital. I am a student pursuing a Master of Science in Nursing, majoring in Maternal and Child Health (MCH) at the University of Zambia.

The purpose of the study is to explore the experiences of certified midwives on mentorship and supervision received during internship. The information to be generated from the study will form a basis of conducting large scale studies, influence GNC on improving mentorship and supervision in schools of nursing.

Prior to the main study, I would like to conduct a pilot study at Levy Mwanawasa General Hospital in order to test the trustworthiness of my data collection tools and make necessary adjustments.

Thank you for your support.

Yours Faithfully,

Betty Miyanda Mwiinga

Master of Science in Nursing Student