UNVERSITY OF CAPE COAST

PERCEPTION OF CLIENTS AND PRIVATE MIDWIVES ON STUDENT MIDWIVES DURING CLINICAL SESSIONS IN BEREKUM DISTRICT BRONG AHAFO REGION,GHANA

BY

HALIMA OPOKU AHMED

Dissertation submitted to the Institute for Educational Planning and Administration of the Faculty of Education, University of Cape Coast, in partial fulfilment of the requirements for award of Master of Education Degree in Educational Administration

OCTOBER 2011

DECLARATION

Candidate's Declaration

I hereby declare that this dissertation is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature…….. Date……

Name: Halima Opoku Ahmed

Supervisor's Declaration

I hereby declare that the preparation and presentation of the dissertation were supervised in accordance with the guidelines on supervision of dissertation laid down by the University of Cape Coast.

Supervisor's Signature…….. Date……

Name: Dr. A. L. Dare

ABSTRACT

The purpose of the study was to identity the challenges in deliveries and family planning services in the Berekum District. The study sought to investigate the extent to which clients and private midwives have interest with the students mid wives and the relationship of the students to their clients.

The descriptive survey design was used for the study. A total of 80 respondents were used for the study comprising 60 randomly sampled clients, 5 professional midwife and 15 ward assistants. Questionnaires were used for the study. The Questionnaires were rated on a five point likert scale while frequencies and percentages were used for the analysis.

The result of the study revealed that: Clients dislike the performance of students during delivery; Clients do not want to discuss family planning issues with respondents.

Based on the results of the study, it can be concluded that student midwives were incompetent therefore it is recommended that student midwife must have mastery of the practical areas in the demonstration room before going out in the community to practice.

ACKNOWLEDGEMENTS

I wish to express my sincere gratitude to my supervisor, Dr. A.L. Dare for all the time he spent reading through my script and also for the necessary comments and suggestions that he offered me. I also thank the Director of Institute for Educational Planning and Administration, Prof. George K.T. Oduro, for his encouragement, I say thank you.

Other Lecturers and individuals who have been specifically very helpful to me are not left out. They showed special interest in my research and thereby gave me the necessary information and help I needed from their outfit.

I also register my sincere thanks to family planning services in the Berekum District and staff of Midwifery Training School, Goaso for their unflinching support.

Lastly, to the staff of Institute for Educational Planning and Administration. I say thanks so much for your support.

DEDICATION

To My Family

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER ONE

INTRODUCTION

Background to the Study

According to Myles (1996), a midwife is a person who has been regularly admitted to a midwifery educational programme duly recognized in the community in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualification to be registered and legally licensed to practise midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period, to conduct deliveries on her own, to care for the newborn and infant and provide family planning services. She has an important task in health counselling and education not only for patients but also within the family and the community. Midwifery is a very important professional vocation. A competent midwife renders useful services to her clients and the community in which she lives.

Quality community experience is fundamental for the consolidation of knowledge and the development of a professional identity in domiciliary midwifery in the training of midwives. To improve domiciliary midwifery practice in the curriculum, information from the communities is very important. The main objective of midwifery training schools is to educate students, and

increase the quality of experiences that students need in the community (Norton, 1994).

To ensure a holistic training of students, opportunity is provided for each student in the course of her training to understudy a professional midwife based in the community. She experiences day-to-day interaction with community members. The aim of the district practice is to develop students' level of competence beyond the traditional education and provide opportunities for students to resolve inaccuracies in midwifery role concepts to integrate selected aspect of midwifery education and practice in the actual community setting. The experiences are designed to enhance both academic and organizational role and socialization for the students through additional learning (Chickerelle, 1981). During the district experience, the student is exposed to the community. Initially the student and the midwife work closely together. Emphasis in the beginning is to orient the student to develop greater confidence and competences in order to be more independent.

Pierce (1998) acknowledges that district experience prepares students towards future roles as midwives by providing feedback to the students regarding clients care, organizational skills, psychomotor skills and problem solving. The student midwife does eight weeks attachment of domiciliary midwifery under the supervision of a registered midwife. This gives her the opportunity to gain experience outside the hospital setting. During this period, the student midwife learns to understand the values and beliefs of the community regarding childbirth. She also learns to use certain languages that are accepted by the community.

Some community members in Berekum believe that, the more children one has, the more important one is recognized in that community. The woman who delivers 10 children gives a sheep to her husband as a symbol of her appreciation for giving her the children. The Berekum community is made up of a mixture or religious groups such as Christians, Muslims and followers of traditional religion.

The student midwife needs to employ a range of psychological approaches in her interactions with the education of the clients. Because of the competencies student midwives gain, some clients appear to prefer their services. They like the student midwives and have confidence in them. On the other hand, some of the clients regard the student midwives as strangers and feel reluctant to share their reproductive health problems with the midwives in the presence of the students. Others consider the students too young and tend to be embarrassed to receive family planning services especially when the students have to insert intrauterine contraceptive devices into the birth canals of more elderly women and when such women have to purchase contraceptive pills and condoms from them. These clients want to remain anonymous in receiving such services and consider the students as a threat to their dignity in the community.

In the mid-1920s midwifery in Ghana was the function of private medical practitioners and private birth attendance and doctors, like Tettey, Mensah Annan and Van Piercy, who treated pregnant women and delivered them in their own homes. They did what is known as Domiciliary Midwifery. These doctors were later joined in the domiciliary practice by nurses, such as Cole Benjamin and John Williams, who were trained in the United Kingdom as midwives and mainly

worked at Christiansburg (Osu), in Accra. Sometime later, the early midwifery practitioners were joined by F.V. Nanka Bruce. Nanka was a member of the Legislative Council by then. He thought it necessary to have a separate hospital to cater for pregnant women, labouring women and their babies. Through his influence the old maternity block of Korle-Bu (maternity), was started and completed in early 1928.

Grace Summerhayes, an obstetrician gynaecologist was the first doctor to be appointed to take charge of the maternity hospital in the country. She started her work in May 1928 with nursing sister Paur and five other nurses. In addition to the nurses she had three health visitors. Summerhayes gave midwifery lectures to the five nurses and three health visitors. As the work progressed an antenatal clinic which the state had built, and a few of the patients turned up at the antenatal clinic with conditions like anaemia and oedema of hand and face. During the course of the work Summerhayes and her nurses and few voluntary workers such as Mrs. Wikie, the wife of a Presbyterian Minister and Miss Magdelene Wulff, contributed a lot to help pregnant women in Christiansburg area to patronize the antenatal clinic. The first in-patients to be admitted were all from Christiansburg. These patients were kept in the hospital for weeks and they were under treatment for such cases as anaemia before delivery. These patients were given everything free of charge, including treatment.

During the early days, Selwyn Clerke invited the traditional birth attendants and taught them how to keep the umbilical cord clean. He also gave them cord dressings free of charge. As the work progressed, sister Paur at the

maternity hospital left for home on marital ground and her place was taken over by Sister Victor. Anytime Summerhayes went on leave, Sister Victor was released by other doctors to manage the maternity hospital. In 1982, a new maternity hospital in Accra was built for pupil midwives Sister Victor Selwyn Clerke who led the pupils to analyze things in the laboratory. They also led the pupil to study complicated things in the ward and at the clinic. The midwives who passed through the training school had certificates issued out in 1932. The Midwives Board Ordinance (The Midwives Act), was established in 1931 and the Midwives Board was formed to administer the provisions of the ordinance which sought to legalize the training, examination, registration and practice of Midwifery in the Gold Coast (Abado,1971). Through the effort of the various regions, scientific midwifery practice is now all over the country. There are now schools of Midwifery in Accra, Kumasi, Offinso, Koforidua, Berekum, Hohoe, Bolgatanga, Jirapa, Mampong and Atibie.

Statement of the Problem

For some years now, it has been observed that in the Berekum District, the number of delivery cases and family planning attendance get reduced around the period that the students are having their district practical**.** During the period, private midwives whose maternity homes are used for district practical record fewer cases of deliveries and family planning attendance.

Preliminary investigations have shown 20 deliveries and only five family planning service reciepients in almost all the maternity homes. Other indications have also portrayed high patronage of antenatal and postnatal services. When

students are on the district practice, the pregnant women monitored by these midwives deliver at the traditional birth attendants' centre or at the district hospital, irrespective of the travelling distance. The midwives only get to know that the clients have delivered when they visit the clients in their homes. Their regular family planning clients now receive services from the district family planning centre.

It is therefore important to find out the reason why clients' attendance tends to reduce whenever the student midwives are on district practice leading to a total reduction of attendants in the maternity homes. One cannot tell whether the clients have a peculiar problem with the students. Or could it be that, the students are too young or unapproachable to the clients or do they feel shy in the presence of the students? Could it also be that the clients are familiar with the students or are related to the students? These questions constitute a gap that needs to be filled and the present study was designed to fill in that gap.

Purpose of the Study

The purpose of the study was to identity the challenges faced by private midwives in deliveries and family planning services in the Berekum District. The study sought to investigate the extent to which clients and private midwives have interest in the students and assess the relationship between students and their clients.

The study also tried to find out from the private midwives the attitudes of students towards their clients. Moreover, there was the need to find out the competence level of the students in the practice of domiciliary midwifery from the

clients and why the number of deliveries and family planning attendants reduced when students were on district practice.

Research Questions

The following research questions were formulated to guide the study:

1. How do the clients and the midwifery supervisors perceive the student midwives' performance in the community?
2. What are the reasons for the periodic reduction in service delivery at the maternity homes?
3. How do the clients and supervisors perceive their relationship with the student midwives?
4. To what extent do the communities and the clients benefit from the students' district practical sessions

Significance of the Study

The outcome of this study is expected to help midwives in the light of our changing society. Midwives will appreciate the need to open up and allow the student midwives to use their facilities during their practical activities in their maternity homes. In addition, the findings of the study will form a database for further study on domiciliary midwifery.

Delimitations of the Study

The study was delimited to the five maternity homes in Berekum district. They are the clinics where students go for their district practice. These homes were selected because they assist Berekum midwifery Training School in training midwives by admitting the Midwifery students to undertake practical activities.

The study also focused on domiciliary midwifery and these maternity homes are situated in typical communities where students can gain rich experience.

Limitations of the Study

In spite of reassuring clients of their confidentiality, some clients felt that divulging true information may tarnish the image of the maternity homes, which might make midwifery training colleges discontinue sending students to the clinics for practice. In addition, most of the clients could not read therefore, the questionnaire was read to them in the form of an interview. It was also realized that clients were shy given out information. These midwives exhibited some doubts about giving the researcher the information required. It is therefore possible that some information that might have enriched the study was withheld. Furthermore, findings may only be applicable to the homes studied.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

The purpose of the study was to identify the challenges in deliveries and family planning services in the Berekum District. The study investigated the extent to which clients and private midwives had interest in the midwifery students and assessed the relationship of students with clients. This chapter presents the review of related literature. Various books have been written on domiciliary midwifery and different authors have contributed their quota in diverse ways to the improvement of domiciliary midwifery. Therefore, there is the need to review literature on this concept to reflect how domiciliary midwifery has been evolving over the years. The review is organised under the following headings:

1. The role of the midwife
2. skilled attendants
3. District midwifery
4. The nurse-midwife's preparation for the birth
5. The women's/couples preparation for the birth
6. Developing a partnership
7. Delivery/home births
8. Home health care

9. Family planning
10. Counselling services in family planning
11. Reduction of risk through birth prevention
12. Trends in contraceptives usage
13. Benefits of contraceptives
14. Effectiveness of family planning programmes

The Role of the Midwife

According to Chickerell (1981), a midwife's role involves relating to people who are usually healthy and who are facing a natural, exciting change in their lives. Yet for some, childbirth can be less exciting due to anxiety, depression or fear. How a couple feel when their baby is about to be born, means that they are facing a change of life which is inevitable no matter what circumstances surround the event.

As a result of the change in a couple's lives, Ovellet (1998) stressed that the role of the midwife is to be alert and sensitive to the consequences of such change and be ready to offer the most appropriate helping skills out of the range of skills available as she seeks to support the woman and her partner through childbirth and parenting.

Hopson (1978) described a number of roles played by people in caring professions. These are teaching, advising, guiding, taking direct action, managing and counselling.

Rogers and Myrick (1998) summarized the role of a midwife as empathetic. As such, the midwife needs to be able to put aside her own thoughts,

feelings and experiences and "be with' someone in their experiences. Being empathetic also implies that the midwife responds to a new mother and father from where they are in their difficulty or distress rather than from the place where the midwife thinks they ought to be. It is not about hiding behind the professional role but rather about being spontaneous in defense and thoughtful midwives are partners in the care of the mothers and fathers. Stevenson went on further to say that it is helpful if the midwife is seen by the parents and other relatives as trustworthy, dependable, thoughtful, warm and caring if they are to be enabled to become the parent they want to be.

Norton (1994) stated that integral to the role of community midwife is health education and preparation for birth and parenthood, both on a one-to-one basis and with groups as well as in the home and at clinics. Possible settings include antenatal and postnatal classes. He went to say that, the midwife is involved in the training of student midwives.

A Skilled Attendant

A skilled attendant refers exclusively to people with midwifery skills, for example, doctors, midwives, nurses who have been trained to be proficient in the skills necessary to manage normal delivery and diagnose or refer obstetric complications.

Combined skilled attendants, according to Townsend (1998), live in and are parts of the community they serve. They must be able to manage normal labour and delivery, recognize the onset of complications, perform essential

interventions that are beyond their competence or not possible in the particular setting.

In his study, Chickerell (1981) agreed that depending on the setting, other health care providers such as auxiliary nurse/midwives, community midwives, village midwives and health visitors may acquire appropriate skills if they have been specially trained. These individuals frequently form the backbone of maternity services at the periphery, and pregnancy and labour outcome can be improved by making use of their services, especially if they are supervised by well trained midwives.

Ovellet (1998) stated that skilled care delivery is usually provided in a health facility. However, birth can take place in a range of appropriate place from the home to tertiary referral centre depending on availability and needs. Home delivery may be appropriate for a normal delivery, provided that the person attending the delivery is suitably trained skilled and equipped. Such as skilled attendants has referral to a higher level of care as an option.

Scheetz (1998) in his study on community midwifery, concluded that a skillful attendant support women in their social and family context through a major life event. The care she offers is flexible and adapted to individual circumstances through her work patterns are constantly modified by changes in maternity care provision.

Getting to the end of his study, Scheetz (1998) agreed that community midwife becomes involved after pregnancy is confirmed, a skilled attendant may work in family planning or pregnancy clinics and so follow a couple through the

whole continuum of childbearing by providing antenatal care, often sharing this responsibility with general practitioners and of consultant obstetricians.

According to Hopson (1978), a skilled attendant undertakes monitoring of high-risk pregnancies at home in addition to attending home births, accompanying women in their care to hospital for delivery. In this way there is continuing care of the women and also help to maintain attendant's skills and increase his job satisfaction.

District Midwifery

The work of the midwife in the community involves antenatal education and preparation for parenthood and extends to certain areas of gynecology, family planning and children. The midwife may practices in hospitals, clinics, health units, domiciliary conditions or any other services. The study further confirmed that district midwifery in practice of maternity care based on the women's own environment taking into consideration her social and cultural norms.

In a subsequent study Disert and Goldenberg (1995) reported that district midwifery training curriculum contributed to the students' professional growth. This gave them the opportunity to gain experience outside the hospital setting a feel of what the community practice entails. Rittman (1992) in her interpretive approach to studying district midwifery also discovered the richness and complexity of district midwifery. From this, she concluded that student midwives do not only interact with clients in the maternity homes but they also visit clients in their homes, assess puerperal mothers, dress babies cord and give immunization.

Ferguson (1994) recommended district experiences to prepare the students for practice after the completion of their programme. He incorporated this in the evaluation given by the clients and supervisors on the student midwives.

Townsend (1988) in his pilot study, in which student midwives in their final year, worked with community midwives for eight weeks, claimed that the reduction in the length of postnatal stay in the hospital had led to a corresponding increase in the workload of community midwives.

During the student midwives with the community midwives, Townsend (1998) established that social and ethnic background are associated with inequalities not only in health but also in the health care provision notably delivery and family planning. Reasons given by Townsend (1998) for these inequalities include the attitude of care giver, a women's own perception of needs end privities and difficulties in communication and obtaining information. Sullivan and Smith (1996) referred to domiciliary midwifery as indispensable including living and working with the community members to recognize possible health problems, identify the problems, generate alternative solutions to the problems, implement the chosen solutions and evaluate the solutions. They added that in addition to acquiring knowledge and skills needed to assist individual families and communities to meet their physical. Psychological and social needs the student midwife also has to equip herself with knowledge and skills necessary to assist individual and couples to plan their families to achieve their reproductive health goals. The nurse-midwife's preparation for the birth, according to Norton (1994), includes:

1. Frequent screening to ensure that the woman satisfies the criteria for normalcy
2. Plans for transfer option should this become necessary including contact with the referral centre (hospital), and preparation of the nursing staff
3. A home visit during the thirty-six week of gestation
4. Ensuring adequately and functioning of the supplies and equipment the midwife need for the home birth.

Nurse Preparation for the Birth

Jakarta (1984) recommends that preparation required for a home birth very from practitioner to practitioner. All the same certain things are constant and these she gives as:

a) Compliance with the care plans including childbirth education classes and making of an emergency plan
b) Purchasing of supplies
c) Positive attitude towards the capabilities of the women's body
d) Appropriate psychological motivation for a home birth
e) Compliance with practice standards regarding smoking, drugs use and nutrition

The nurse-midwife remains observant for any other clues that the woman or couples are (or are not), psychological able to attend to a home birth. Westar and Graziano (1994) stated that plans for transfer to the hospital include the procedure to be used if transfer should become necessary. The physician consultant is contacted and arrangement made for meeting him or her at the

designated backup hospital. However, it has been recommended that a prepared and involved nursing staff can greatly facilitate the goals of the home birth woman or couple to be accepted, to keep the family together and to leave the hospital as soon as possible.

Rogers and Myrick (1998) suggested that embarking on home visits as part of preparation towards birth serves as a number of purposes which enables the nurse-midwife to:

a) Familiarize herself with the layout of the house and its facilities for birth (bedroom, bathroom, kitchen, telephone and etc),

b) Check that all supplies are purchased and ready for use

c) Ensure that the emergency plan and telephone numbers are posted by every telephone in the house. Rogers and Myrick (1998) puts forward certain advantage of good preparation for birth that the nurse-midwife will need.

In the same view Scheetz (1998) is able to:

a) Assess the arrangement for pet control and where the animals will be during the birth

b) Discuss the completed arrangement plans with any siblings, especially the toddler.

Scheetz (1998) further stressed that the nurse-midwife is able to assess the preparations for having a baby in the family, that unless there are ethnic or cultural beliefs to the country, by the thirty-sixty week, names for the baby are selected, baby's clothes and care supplies purchased and plans made for the

baby's place in the home. Scheetz further emphasizes that the nurse-midwife must look for signs of life and nurturing in the house, such as plants, music, fish and animals as a reflection of the attitudes of the woman or couple towards bringing new life into their home. Myrick and Barrette (1994) also recommended that the home visits are also part of the continual screening for naming and appropriate preparations for a home birth.

The Woman's or Couples Preparation for the Birth

Young and Trojan (1994) in their study of couples' preparation for the birth discovered that preparation involves considerable time, thought, energy, planning and activity. Some of which are keeping parental care appointments, complying with the agreed upon plan of care and keeping the nurse midwife informed of any life changes.

Myrick and Barrette (1994) emphasized education and knowledge as essential for a home birth couple. They explained that the couples need to know as much as the place of birth and what they can do to help themselves. Part of the preparation involves provision of books on pregnancy, birth and early prevention of complications for the couple to read. Myrick and Barrette continues that some women express the need for knowledge as knowledge dispels fears. Dick-Read explained that fear cause tension which in turn causes pain which results in more fear and thus a vicious cycle is established.

In Royal Conwell Hospital in England, Jacksons (1996) organized an educational session for couples nearing their term. The study reported that childbirth education for home birth couples include an open discussion,

confrontation and subsequent dispelling of fears about having a home birth complications, emergencies and dealing with other people's negative reactions the study session exposes what problems can occur and what can and cannot be done about each possible situation in the home setting. At the end of the study session, the recognition that the hypothetical complications envisioned were not normal and that their own history was one of normalcy which gave the couples reassurance and strength.

Hseih and Knowles (1990) who studied childbirth preparation for couples, recommended that the woman and couple should make "practice run" (p.250), to their backup hospital to learn the fast route, where to park, where to enter the building in case this should become necessary. To them a cardinal rule of emergency transportation is always at least half full or the car tank must contain more than enough fuel for the distance.

Blachard and Caesar (1998) after studying families' reaction to birth stressed that, preparation is required for those who will be present for the birth. If there are children, not only do they need preparation but also an adult needs to be designated as primarily responsible for them. This adult needs preparation for the labour and birth. Sibling preparation classes should be attended together by parents and other participations of the birth.

The selection of participants should be made with great care and thought as Hopson (1978) emphasized. Hopson realized that apart from all the reasons that a woman or couple may have for inviting someone to participate in this

experience, the attitude of these individuals toward out of hospital birth might convey fear to the labouring mother.

Developing a Partnership

According to Chcikerell (1981) the relationship of a birth couple and a nurse-midwife is essentially that of partnership in which the woman or couple first makes the decision to deliver at home. Chickerelle went on further to state that this decision influences the birth couple to first make the decision or deliver at home. Chickerelle added that this is a decision in which influence may be exerted by family members especially mothers and mothers-in-laws, though the greatest amount of influence is exerted by the partner or husband. To Checkerell (1981) this is important because it is to the husband that the woman will turn for support and strength when she feels vulnerable or weak.

Townsend (1998) stated that the husband as a partner must be family committed and be a full participant in the process; but not more committed than the woman as this can lead to a difficult and poor situation during the home birth. As such there needs to be an equal commitment by both partners, by the time the woman sees the nurse fill term.

Briteain (1999) explained that nurse-midwife partnership facilitates the efforts of the woman or couple in their childbirth experience and sets the clinical standards and expectations of the relationship. The setting of clinical standards and expectations classifies the partnership and the responsibility of partnership.

Delivery/Home Birth

Young (1986) in his descriptive survey on pregnant women indicated that couples choose home birth for a variety of reasons. Thus, it is essential that the nurse-midwife ascertains exactly what they experience in order to determine if these expectations are realistic and if they within the nurse-midwife's clinical standards and expectations.

Considering the factors given by couples for choosing home birth Briteain (1999) indicated normalcy of the pregnancy, previous hospital experience, availability of alternatives both in and out of hospital as the major reasons.

A study done by Ovellet (1998) on home births showed that to understand home birth, one needs to go into different families' home to appreciate the fact and really understand how different each family's environment is valued. Priorities and even the ways in which family members relate to each other all reflect in the home. So much information about people is possible when they are seen in their own environment.

Bun (1982) defined home birth as a birth that takes place in the woman's own territory to which the midwife goes. This fundamental difference involves different responsibilities for the couple and different planning, approaches and methods of providing care by the midwife.

Then term normal delivery, according to Myles (1996) is a spontaneous delivery in a healthy mother. Whereas deliveries are accepted readily in cities, in most rural areas there is reluctance to act and the cord stump, or beliefs about the placenta, handling of the baby by strangers and in some cases, even fear

concerning the separation of the baby from the mother. These make most rural mothers pray to be delivered in the traditional way at home. By relaxing the rules at the maternity homes, for example, by allowing the relation to take away the placenta and other products of conception for disposal in the traditional manner and allowing free visiting, these fears can be allayed and home delivery can be made more acceptant.

During his study on home birth Hopson (1978) found that the advantage of being at home becomes obvious where courtesy prevails. It is the woman's or couples' home and the midwife is a guest in their home. As such, each likes it. Hopson explained that the couple having their own unconfined space and control in their own surroundings and facilities promotes confidence, pride and capability.

Another study done by Myrick (1988) also examined the advantages of home birth findings of this study indicate that, the intimacy and the ability to cope with labour in her own setting foster the woman's reliance upon herself and her partner. Being able to have the persons they want with them is both their decision and a means of sharing and enhancing family bonds.

An older study done by Herber (1990) examined the impact of midwives on home births and concluded that the midwife brings into the births situation not only clinical knowledge, skills and judgment but also a positive attitude of confidence and believe in the birth process and the capability of the woman's body, mind and spirit. The study also revealed that with the woman's and participants' help, the midwife sets her supplies and equipment in readiness and the birth transpires.

Home Health Care

Private companies and public agencies may provide home health care services, which are important to protocol clients and to other clients after discharge from the health care facility. Young (1986) carried out a descriptive survey to investigate the advantage of home health care. He asserted that follow-up home care for protocol client and her neonates are randomly assigned to two groups. One group is discharging according to normal protocol at an advantage weight of 2,200 gram and the other group discharged about 11 days earlier at approximately 2,000 grams. The latter group received follow-up home care by a clinical nurse specialist which cost an average of 76 pounds per neonate, $18.560 less than the average cost per neonate in the first group. Young found out that there was no difference in the neonates' physical problems after discharge between the two groups.

In a subsequent study, Brooten and Caesar (1998) also discovered home care cost advantage to not only health clients and neonates, but also to other clients such as clients who had undergone unscheduled caesarian birth and those whose home had hysterectomy done.

In the study of York and Brown (1989) clients discharge one to two days early that usual receives follow-up care at home and by telephone for up to eight weeks after discharge. The study finds that clients receive more support and education under this system than was the norm in hospitalized client. They also indicate that follow-up home care is satisfactory to clients because it allows for individualized attention.

Nacion and Abramson (1980) contended that when follow-up home care is properly provided it offer psychological support and increase client's control over health care, which can benefit the client. The study indicates that parents who received follow-up during the first fourth weeks after discharge benefit because they are able to ask the midwife questions on a one-on-one basis. Again low-income clients and neonates benefit when home care follows early discharge because the home visits ease the clients concerns and use health care resources effectively.

On the same note Cohen and Rubin (1980) stressed that the trend toward early postnatal discharge and home care is consonant with the consumer's increasingly active participation in health care. The client can select her provider and obtain the information she desires. On the other hand Robinson (1988) examined the impacts of early discharge for home health care and discovered factors such as the client being sent home too sick to receive sufficient self-care information and many suffer from this lack. Kenner (1978) also stated that home health care increase client's responsibility and anxiety and that the parent becomes worried about their ability to provide care for their ` neonates who are discharged early from the Neonatal intensive Care Unit (NICU), These clients admitted that they did not listen to or understand the discharge because they believe that their neonate may not live to be discharged. A further study by McBride (1992) on home health's revealed that these clients were afraid to leave their neonate with other caregivers. They felt they needed to provide care themselves. The anxieties experienced by these clients led to social isolation lace

of social support and increased stress for the client. Mcbride concluded that the nurse must discuss with antepartal and postpartal client who lacks sufficient support and determine her concerns and needs.

A study by Wallace and Rudb (1991) indicates that psychosocial support may be overlooked if home health care is the burden of the care itself. Support from a partner, family or friends must be available to the parent under stress or the postpartal client.

Family Planning

According to Rose-Field and Wrary (1982), "the maternal and child health problems that exist in many developing countries today are indeed enormous. However programs which can make substantial improvement are possible right now. One of these is family planning. They stated that family planning can help prevent many unnecessary deaths among women of childbearing age, and children. Few public health measures can have so great an effect in a relatively short time as the implementation of a family planning providing easy access to effective methods of contraception.

Jakarta (1984) commented at the International Conference on Family Planning that the family planning is an essential component of any broad-base development strategy that seeks to improve the quality of life for both individual and communities.

Nevertheless, two obstacles to the use of modern family planning have been identified in a study by the Health research Unit (Ministry of Health, Ghana 1992). The first is the misconception that exists in the community leading to fear

and rejection of family planning methods. The second is related to accessibility and socially inappropriate setting for family planning service.

In the same vein Clark (1981) identified certain constraints to be addressed. These include culturally appropriate information, education and communication services as well as the need to train service provides to provide a wider range of family planning services in even health stations and outreach communities.

Counselling Service in Family Planning

According to Herber (1981) counselling is a very important task in family planning service provision. Through counselling, these nurses help clients to choose and continue to use correctly the family planning method(s), they have chosen. Herber added that counselling assists the client to understand the available family planning and reproductive health choices. Also counselling minimizes rumours and misconceptions about family planning, guides the clients to make an informed choice, which leads to correct and consistent use of chosen method(s). Herper (1990), (1992) gives indicators when counselling services are provided as below clients' expectations. These indicators are:

1. Persistent or increased rumours in the community even though the programme has tried to dispel them.
2. Many clients do not return for post counselling services
3. Frequent change of mind about contraceptive methods.

Jakarta (1984), investigating the effects of counselling on clients, distinguished counselling from other activities which are sometimes confused

with counselling. From the investigation he found out that family planning counselling helps clients to make informed and voluntary decision about their reproduction. He stated that the role of the service provider is therefore, to ensure that clients know the benefits and risks of all family planning methods available and to help them to consider their needs, options and feelings so that they can make up their own minds regarding what they want to do about their fertility. Jakarta concludes that counselling is the greatest means of assuring clients satisfaction in choosing and continuing to use the method.

Jacobs and Jones (1995) in their study into the midwifery curriculum stated that midwifery students do acquire and understand the theoretical aspects of counselling and family planning, but applying skills and decision making in real life situation is a different thing. Jacobs and Jones emphasized that decision making comes with experience and on serving a practitioner who has decision making skills. Manipulating and practical skills cannot be learned merely from lectures or books.

Reduction of Risk through Birth Prevention

Myrick's (1988) pilot study into contraceptive indicated that family planning may reduce maternal mortality by reducing exposure to pregnancy and therefore to risks associated with unwanted pregnancy. Myrick added that contraceptive use has no direct effect on the risks of death once pregnant. Therefore, if all women are equally likely to adopt effective methods of contraception, prevalence will change the risk of death from pregnancy. Subsequent studies by Middem and Benson (1995) into the use of contraceptive

suggest that contraceptive prevalence often rises among older, higher parity women or those at greatest risk of abortion which means that family planning can help reduce maternal mortality. In the same vein Stevenson's (1995) study revealed that more educated women with better accesses to services often have disproportionately high rates of contraceptive use and how mortality ratio. A decline in fertility indicates that first births which are riskier will increase as a proportion of all births.

In a successful Matlab MCH-FP project, Sevenson (1995) observed that the project primarily reduced maternal mortality rate in Matlab by reducing the number of women who become pregnant.

Trends in Contraceptive Usage

In a survey of developing countries, Konig and Meng (1988) stated that family planning allows women to delay motherhood, space births and avoid unwanted and unplanned pregnancies. Family planning programme have raised contraceptive use throughout the developing world. Koening and Meng found that, at least ten percent and as many as forty percent of married women of reproductive age want to avoid a birth but are not using contraceptive. A considerable unmet need for contraception remains, however.

Meng and Conti (1995) conducted a survey into the use of family planning which suggests that family planning choices are often the first element of primary health care that can be made available in a resource setting. It is mostly the provision of basic non-clinical contraceptive is in favour of nearly all women in such a setting and a variety of cost-effective distribution system can be set up

from social marketing to community-based distribution programme focused on vulnerable groups.

Bulato's (1992) research into contraceptive use revealed there has been a gradual shift toward more effective and more long-term methods, especially sterilization Bulato's research indicates that worldwide female sterilization is the leading method and now accounts for about half of all contraceptive use, but regional comparison show substantial variation in method acceptance. From the research, the most popular method in China is the IUD, in Northern Africa, the pill, and female sterilization in Latin America. International methods account for over ten percent of users.

Benefit of Contraceptives

Methods vary in their clinical effectiveness and couples vary in the degree to which they make proper use of them. Bike and Hayes (1994) identified certain risk in contraceptive method; they contended that the risks tend to be small, balanced by some health benefits which considerably outweigh the risk of pregnancy, childbirth and the risk of unsafe abortion.

Bulato (1992) explaining the benefits of contraceptives also added that IUD is associated with pelvic inflammatory disease mainly in women who are at risk of developing sexually transmitted disease. Barrier methods are not as effective as some other methods in preventing pregnancy, but they have an important non-contraceptive benefit by protecting against HIV infection and sexually transmitted diseases.

Effectiveness of Family Planning Programme

Kankel and Pussier (1994) discussed factors making family planning programmes effective and have suggested the following as input:

1. Accessibility to services
2. Services must be provided in both public and private health facilities and through community-based distribution network.
3. There must be contraceptive diversity to meet varying family needs throughout the life cycle for both women and men.

Rittman and Sella (1995) support the findings of Kankel and Russier but add that counselling must be offered by health care providers trained to respect client concerns and sensibilities. They also identify two other factors which promote family planning programme effectiveness. First, strategic management must take into account contraceptive demand, public and political support, service, delivery, infrastructure and the logistical supply system.

Secondly, collaboration with the private sector for the correction of blood pressure measurement (to help detect hypertensive disorders of pregnancy), and the diagnosis and treatment of reproductive tract infections and urinary tract infections. Some of the emerging issues in the literature review are nurse preparation for the birth. It is the duty of the nurse/midwife to educate the pregnant mothers to prepare themselves during pregnancy, labour and peurperium. This will help the labouring women to cope well with the assisting midwife so that at the end of the delivery, a life healthy baby will be delivered by a healthy mother.

On the issue of developing a partnership, Chickerell (1981) has indicated that the relationship of birth couple and a nurse-midwife is essentially that of a partnership in which the couple or the woman decides as to whether she will deliver in the home or in hospital.

Home health care is another relevant area that needs to be considered. This is because the woman has to be educated on how to take care of herself and of the baby to prevent puerperal infection which, if neglected, can lead to maternal and neonatal mortality. The present study was interested in finding out the perceptions private midwives and their clients had about the suitability of student midwives in providing services relating the issues discussed in the review of literature.

CHAPTER THREE

METHODOLOGY

The purpose of the study was to identify the challenges faced by private midwifes in performing deliveries and providing family planning services in the Berekum District. The study investigated the extent to which clients and private midwives had interest in the midwifery students and assessed the relationship of students with clients.

This Chapter describes the approach used in conducting the study. It explains in detail the type of design and how instruments used in data gathering were administered. It also talks about the population under study and the procedure in selecting a sample from the population. The chapter ends by describing the procedure for collecting data and how the collected data were analyzed.

Research Design

A descriptive survey design was used for this study. This type of design describes a situation with an already existing problem. Descombe (2003) stated that the notion of a survey suggests that the researcher intends to get information 'straight from the horse's own mouth' and is purposeful and structured. He maintained that surveys are associated with large scale research covering many

people. McMillan (1996) also states that the use of the descriptive design ‘’is a report of the way things are what is or what has been’’

The study involved an existing problem in a particular location involving the perceptions of clients and supervisors about the student midwives in the communities. The descriptive survey design had the potential of enabling a researcher to find what an actual problem is and how a community perceived the problem to be.

The descriptive survey was therefore employed to help produce information from a wide range of clients, midwives and their ward assistants from the various maternity homes in the Berekum District. It was therefore expected to facilitate the collection of enough data to determine the nature of the problem as it exists at the time of the study. The design allowed the use of questionnaire and interview schedule which generated large volumes of data that existed.

Population

The study was conducted at the five maternity clinics in Berekum District in Brong Ahafo Region of Ghana. These clinics serve five communities with a total population of 10,632 and a growth rate of three percent (Berekum District Health Administration, 2000). The study area is largely a rural area. There are poor road network, most of which are impassable especially during the rainy season. The inhabitants are generally poor. Their main economic activity is farming especially cassava and plantain, vegetables and corn, though there are few cocoa, palm and citrus plantations. The timber industry is causing

considerable deforestation in the area. The communities are about 5km away from each other.

Each of the five maternity clinics had one professional midwife and two or three ward assistants. The clinics have outpatient departments for receiving antenatal, postnatal and family planning clients. An unassisted delivery took place at the labour wards. Antenatal and postnatal clients were admitted in the same ward. Each clinic had a bed capacity of four in the main ward while the labour ward had two beds. A part of the consulting room was used for family planning services. Antenatal, postnatal and family planning services were provided five days in a week. In-patient care included activities in maternity services as well as deliveries. On the average each clinic got 20 deliveries in a month. Preventive and public health services were provided. Immunizations are conducted on every Tuesday. The midwives visited postnatal mothers in their homes every evening until the babies' cords came off.

Sample and Sampling Technique

The sample size for the study was 80. This comprised 60 clients, 15 ward assistants and 5 professional midwives. The client-respondents' sample for the study was randomly selected from the postnatal mothers who delivered in the clinics and outside the clinics in the five communities and had their names booked in the maternity clinics antenatal books. Clients who had received family planning from the clinics as well as those who were still receiving the services were also randomly sampled. The clients-respondents were selected from the communities around the five maternity homes using the stratified random sampling technique.

Also three ward assistants were sampled from each of the maternity clinics using the simple random sampling technique. Where the assistants were only three, all of them were selected. All the five midwives in the five maternity clinics were purposively sampled for the study.

Data Collection Instrument

The instrument used in this study was a questionnaire due to the advantages it was over other instruments. By using the questionnaire, respondents were free to express their opinions because of the assurance of anonymity. However, the questionnaire was administered to some of the clients because majority of them could not read and write. Labour and delivery formed one section while family planning formed the other section.

The labour and delivery section had 8 closed and 12 opened-ended questions. These sought to find out from the clients and the supervisors, the students' attitude towards them and the work that the students had to perform. The key issues mentioned here included students' reception of clients, how students behaved themselves in front of clients and how the community members patronized the maternity clinic.

Altogether 82 questions were asked eliciting information on students' approach to handling clients. The questions were rated on the likert scale. The responses to the items in the questionnaire were scored using a five-point scale and weighted depending on whether the items were constructed positively or negatively statement that are positive like "I like students comportment of self during procedures" were scored as follows:

Strongly Agreed (SA), - 5

Agreed (A), - 4

Undecided (U), - 3

Disagree (D), - 2

Strongly Disagreed (SD), - 1

The procedure was reversed for statements that are negative such as "I hate the presence of students during delivery" for these negative statements, the scoring were as follows:

Strongly Agreed (SA), - 1

Agreed (A), - 2

Undecided (U), - 3

Disagree (D), - 4

Strongly Disagreed (SD), - 5

Pilot-Testing of Instrument

The instruments were pilot-tested in a selected clinic in Berekum District. The selected clinic was not one of the clinics under study. Twenty clients, one professional midwife and two ward assistants took part in the pilot-test. In all 23 respondents were selected for the pilot-test. All the respondents responded to the same questionnaire. However, the questionnaire was read to the clients in the form of interview because they could not read. The content validity of the instruments was established by subjecting the instruments to perusal tutors in midwifery and the researcher's supervisor. The validators corrected all the ambiguities, correct spellings and made sure items had been placed at the

appropriate sections. Cronbach's coefficient alpha, a measure of the internal consistency, was used to determine the reliability of the instruments. The reliability coefficient for the instrument was .82. After administering the questionnaires, an analysis of the responses obtained indicated that there were no ambiguities in the instrument.

Data Collection Procedure

Five letters of permission were collected from the District Health Directorates and a copy was sent to each of the private midwives in charge of the maternity homes requesting their permission to use the clients and explaining the purpose of the study to them in order to win their approval and co-operation in aiding the selection and interviewing of the respondents who were clients of their clinics.

Two days were spent in the communities, two days in each community interviewing ten postnatal mothers, four women receiving family planning services, one ward assistant and a private midwife. Apart from the midwives and the ward assistants who completed a questionnaire in the clinics, the remaining respondents were interviewed in their homes.

On meeting the respondents, rapport was first established by way of greetings and self introduction. The declaration of the purpose of the exercise was made known. Since the private midwives could read and write, they were given the questionnaire to answer under the supervision of the researcher so that they could not communicate with the selected ward assistants who also would serve as respondents later. However, the ward assistants and the other respondents had

their instruments read to them and their responses were recorded. The researcher solely administrated the interview questionnaire.

Data Analysis

Data were analyzed by the use of frequencies and percentages. The results were presented in tables, grouping responses together and finding out percentage of similar and different opinions**.**

For each specific research question, a frequency count of the extent of agreement or disagreement on each issue was taken. The frequencies were then summarized and presented as described in the first paragraph of this section.

CHAPTER FOUR

RESULTS AND DISCUSSION

The purpose of the study was to identify the challenges faced by private midwifes in performing deliveries and providing family planning services in the Berekum District. The study investigated the extent to which clients and private midwives had interest in the midwifery students and assessed the relationship of students with clients. This chapter presents the results of the study and discusses them. Tables 1-4 provide background information about the respondents.

Table 1: Age of Respondents

Age group (Yrs),	Number of Respondents	Percentage (%)
18-20	7	8.75
21-30	13	16.25
31-40	55	68.75
Above 40	5	6.25
Total	**80**	**100**

From the results presented in Table 1, it can be seen that most of the respondents 55(68.75%) were between the ages of 31 and 40 indicating that most of them were grown up mothers. Only 7(8.75%) were between the ages of 18-20 years old while 5(6.25%) of the respondents were also above 40 years old.

Table 2: Number of Years Spent In the Community

Number of years	Number of Respondents	Percentage (%)
1-2	14	17.5
3-5	18	22.5
6-10	40	50
Above 10 years	8	10
Total	**80**	**100**

Table 2 shows that majority of the respondents 40(50%) had lived for 6-10 years in the community 18(22.5%) had stayed 3-5 years in their communities. 10 Only 8(10%) indicate that they have stayed for over 10 years in the communities. This indicates that almost all the respondents had spent long years in the community.

Table 3: Place of Given Birth/Delivering Babies

Place of delivering babies	No. of Respondents	Percentage (%)
Home	15	18.75
Clinic	3	3.75
Hospital	17	21.25
TBC	45	56.25
Total	**80**	**100**

The results in Table 3 shows that 45(56.25%) of the antenatal mothers delivered at the traditional birth attendants' place. Only 3(18.75%) respondents indicate that they deliver at clinics while 17(21.25%) indicate that deliver at

hospitals. This implies that majority of antenatal mothers patronize the services of traditional birth attendants in the communities.

Table 4: Highest Educational Qualification

Educational qualification	Number	Percentage %
Non formal	15	18.75
JSS	10	12.50
MSLC	16	20.00
SSCE	4	5.00
Total	**80**	**100**

The Table 4 indicates that 15(18.75%) had of the respondents did not have formal education while 10(12.5%) completed only JSS. The results revealed that and on 4(5%) of respondents had completed Senior Secondary School education.

Research Question One: How do the clients and the midwifery supervisors perceive the student midwives performance in the community?

The sought to find answer the perception of clients and midwifery supervisors' about students' performance in the communities in the Brekum District. The results that emerged were presented in Tables 5-9.

Table 5: Responses on the Perception of Student Midwives Performance in the Communities

Responses	Frequency	Percentages (%)
Strongly agree	10	12.5
Agree	49	61.5
Undecided	3	4
Disagree	8	10
Strongly disagree	10	12
Total	**80**	**100**

As seen in Table 5 majority of the respondents 59 (74%), agreed to the statement that "Student midwives do not perform well during delivery" while 18 (22%) disagreed to the statement. Therefore, it is assumed that students' midwives did not perform well during delivery. This supports Hopson (1978) preference for a skilled attendant who undertakes monitoring of high-risk pregnancies at home in addition to attending home births, accompanying women in their care to hospital for delivery. In this way there is continuing care of the women and also help to maintain attendant's skills and increase his job satisfaction.

Table 6: Responses on Whether Student Midwifes are Inexperienced

Student midwives are inexperienced

Students midwifes are inexperience	Frequency	Percentages (%)
Strongly agree	49	61.25
Agree	5	6.25
Undecided	8	10
Disagree	0	0
Strongly disagree	18	22.5
Total	**80**	**100**

As shown in Table 6, majority of the respondents 54 (67.55%), agreed with the statement that "Student midwives are inexperienced" while 18 (22.5%) disagreed with the statement that student midwives are inexperienced. Therefore, it is the perception of the private midwives, clients and the ward assistants that student midwives are inexperienced. This is supported by Ferguson (1994) who recommended district experience to prepare the students for practice after the completion of their programme. He incorporated this in the evaluation given by the clients and supervisors on the student midwives. Furthermore Townsend (1988), in his pilot study in which student midwives in their final year, worked with community midwives for eight weeks, claimed that the reduction in the length of postnatal stay in the hospital had led to a corresponding increase in the

workload of community midwives. This implies that the students lacked the experience to share the work load of the midwives.

Table7: Students explain procedures to clients in labour well

Students explain procedures to clients in labour very well	Frequency	Percentages (%)
Strongly agree	0	0
Agree	3	3.75
Undecided	11	13.
Disagree	47	58.75
Strongly disagree	19	25.75
Total	**80**	**100**

The results in Table 7 shows that majority of the respondents 66(84.5%), disagreed with the statement that "Student explain procedures to clients in labour well" while 3(3.75%) agreed with the statement that student explain procedures to clients in labour well. From the results it is perceived by the clients, ward assistants and the private midwives that student do not explain procedures to clients in labour very well. This is contrary to Shaman and Inhaler (1985) who stated that midwifery attendants must explain procedures to clients adequately for clients to know their rights. Clients' rights as persons form part of the basis of midwifery care and must be upheld as such in midwifery practices. Myles (1996) also claimed that clients in labour come to the clinic entertaining all sorts of fears. These fears can only be allayed by the attendant who has to build confidence in

herself and in the clients. Clients have their own ways of assessing attendants' self comportments in whatever they are doing.

Table 8: Student midwives do not approach clients well

Responses	Frequency	Percentages (%)
Strongly agree	18	22.5
Agree	40	50
Undecided	6	7.5
Disagree	16	20.0
Strongly disagree	0	0
Total	**80**	**100**

In Table 8 it can be seen that majority of the respondents 58 (72.5%) agreed with the statement that "Student midwives do not approach clients" well while 16 (20%) disagreed. It is therefore concluded by the clients and the midwives that student midwives do not approach clients well. This is contrary to Rogers and Myrick (1998) who summarized the role of a midwife as empathetic. As such, the midwife needs to be able to put aside her own thought, feelings and experiences and "be with' someone in their experiences. Being empathetic also implies that the midwife responds to a new mother and father from where they are in their difficulty or distress rather than from the place where the midwife thinks they ought to be.

Table 9: Student midwives are lazy

Responses	Frequency	Percentages (%)
Strongly agree	14	17
Agree	48	60
Undecided	0	0
Disagree	8	10
Strongly disagree	10	13
Total	**80**	**100**

As seen in Table 9 majority of the respondents 62 (77%) agreed with the statement that "Student midwives are lazy". However, 3 (3.75), disagreed with the statement. From the results it can be concluded that client and midwives perceived student midwives as being lazy. This is in disagreement with Pierce (1998) who pointed out that during the district experience, the student is exposed to the community. Initially the student and the midwife work closely together. Emphasis in the beginning is to orient the student to develop greater confidence and competencies in order to be more independent.

He further acknowledged that district experience prepares students towards future roles as midwives by providing feedback to the students regarding clients care, organizational skills, psychomotor skills and problem solving. The student midwife does eight weeks attachment of domiciliary midwifery under the supervision of a registered midwife. This gives her the opportunity to gain experience outside the hospital setting.

From the foregoing it may be concluded that clients, ward assistants and midwife supervisors perceive student midwives as: incapable of performing well during delivery, inexperienced, unable to explain procedure well to clients in labour, unable to approach clients well, and lazy.

Research Question Two: What are the reasons for the periodic reduction in service delivery at the maternity homes? Tables 10-14 provide the answer to this question.

Table 10: Students midwives scare clients of, that is why they deliver in their homes

Responses	Frequency	Percentages (%)
Strongly agree	56	70
Agree	5	6.25
Undecided	1	1.25
Disagree	10	12.50
Strongly disagree	8	10
Total	**80**	**100**

In Table 10 majority of the respondents 61 (76.25%), agreed with the statement that students midwives scare clients and, that is why they deliver in their homes/TBA. while 18 (22.50%) disagreed. The results show that clients, assistants and midwives are saying that student midwives scare clients, making them prefer to deliver in their homes with TBA assistance. This was mentioned by Young (1986) in his descriptive survey on pregnant woman which indicated that

woman/couples choose home birth for a victory of reactions. Thus it is essential that the nurse-midwife ascertains exactly what they experience in order to determine if these expectations are realistic and if they are within the nurse-midwife's clinical standards and expectations. Considering the factors given by couples for choosing home birth, Briteain (1999) stated that normalcy of the pregnancy, previous hospital experience, availability of alternatives both in and out of hospital as the major reasons.

Table 11: Older women will not allow student midwives to touch their private parts therefore they deliver in their homes

Responses	Frequency	Percentages (%)
Strongly agree	30	37.5
Agree	25	31.25
Undecided	5	6.25
Disagree	20	25
Strongly disagree	0	0
Total	**80**	**100**

As shown in Table, 11 majority of the respondents 55 (68.75%) agreed with the statement that "Older women will not allow student midwives το touch their private parts and therefore they deliver in their homes", while 20 (25%) disagreed. From the results clients, ward assistants and midwives are saying that older women will not allow student midwives to touch their private parts therefore they deliver in their home with the assistance of TBAs who are usually old

women. Home delivery is supported by Myrick (1988), indicate that, the intimacy and the ability to cope with labour in her own setting foster the woman's reliance upon herself and her partner. Being able to have the persons they want with them is both their decision and a means of sharing and enhancing family bonds. Therefore, clients are not shy when delivering in their home/TBA. In addition Huber (1981) concluded that the midwife brings into the births situation not only clinical knowledge, skills and judgment but also a positive attitude of confidence and believe in the birth process.

Table 12: Students are not competent conducting second stage of labour

Responses	Frequency	Percentages (%)
Strongly agree	60	75
Agree	5	6.25
Undecided	2	2.5
Disagree	10	12.5
Strongly disagree	3	3.75
Total	**80**	**100**

Table 12 shows that majority of the respondents 65 (81. 25%), agreed with the statement that "Students are not competent conducting second stage of labour" while 13 (43.25%) disagreed. It is seen from the result that clients, ward assistants and midwives were of the view that students were not competent in conducting second stage of labour. This is contrary to Chickerelle (1981) who held the view that to ensure a holistic training of students, opportunity is provided for each

student in the course of her training to understudy a professional midwife based in the community. This way she experiences day-to-day interaction with community members. The aim of the district practice is to develop students' level of competence beyond the traditional education and provide opportunities for students to resolve inaccuracies in midwifery role concepts to integrate selected aspect of midwifery education and practice in the actual community setting.

Table 13: Confidence reposed in students is just little regarding Antenatal clinic

Responses	Frequency	Percentages (%)
Strongly agree	40	50
Agree	30	37.5
Undecided	0	0
Disagree	5	6.25
Strongly disagree	5	6.25
Total	**80**	**100**

Table 13 shows that majority of the respondents 70 (87.5%), agreed with the statement that "Confidence reposed in students is just little regarding Antinatal clinic" while 10 (12.5%) disagreed. From the result, it is assumed that clients, ward assistants and midwives agreed that confidence reposed in students is just little regarding ANC. This is in agreement with Sullivan and Smith (1996), who referred to domiciliary midwifery as indispensable including living and working with the community members to recognize possible health problems,

identify the problems, generate alternative solutions to the problems, implement the chosen solutions and evaluate the solutions. They add that in addition to acquiring knowledge and skills needed to assist individual families and communities to meet their physical. Psychological and social needs the student midwife also has to equip herself with knowledge and skills necessary to assist individual and couples to plan their families to achieve their reproductive health goals.

Table 14: Student midwives do not respect the rights of client during labour

Responses	Frequency	Percentages (%)
Strongly agree	45	56.25
Agree	30	37.5
Undecided	0	0
Disagree	0	0
Strongly disagree	5	6.25
Total	**80**	**100**

Table 14 shows that majority of the respondents 75 (93.75%), agreed with the statement that "Student midwives do not respect the rights of clients during labour" while 5 (6.25%) disagreed. The result suggests that clients, ward assistants and midwives agreed that student midwives do not respect the rights of client.

The results discussed suggest that the reasons for the periodic reduction in service delivery at the maternity homes appear to be that: students midwives scared clients; the older women would not allow student midwives to touch their private parts; students were not competent in conducting second stage of labour, confidence reposed in students is just little regarding Antenatal clinic; and students do not respect the rights of client during labour.

Research Question Three: How do the clients and supervisors perceive the students relationship with them? Tables 15-19 provide the answer to this research question.

Table 15: Student midwives are rude to clients and their relatives

Responses	Frequency	Percentages (%)
Strongly agree	40	50
Agree	25	31.25
Undecided	3	3.75
Disagree	12	15
Strongly disagree	0	0
Total	**80**	**100**

In Table 15 majority of the respondents 65 (81.25%) agreed with the statement that "student midwives are rude to clients and their relatives". while 12 (15%) disagreed. From the results clients, ward assistants and midwives are claiming that student midwives are rude to clients and their relatives. This was

mentioned by Myrick and Barrette (1994) who emphasized education and knowledge as essential for a home birth couple. Couples need to know as much as the place of birth and what they can do to help themselves. Part of the preparation involves provision of books on pregnancy, birth and early prevention of complications for the couple to read. Therefore, midwives should be cautious when dealing with clients during pregnancy and child birth.

Table 16: Student midwives do not communicate well with clients and their relatives

Responses	Frequency	Percentages (%)
Strongly agree	29	36.25
Agree	32	40
Undecided	0	0
Disagree	9	11.25
Strongly disagree	10	12.5
Total	**80**	**100**

In Table 16 majority of the respondents 61 (76.25%) agreed with the statement that "student midwives do not communicate well with clients, and their relatives", while 19 (23.25), disagreed. The results show that clients, ward assistants and midwives thought student midwives did not communicate well with clients and their relatives. This makes relevant Jacksons (1996) advice that childbirth education for home birth couples should include an open discussion,

confrontation and subsequent dispelling of fears about having a home birth complication, emergencies and dealing with other people's negative reactions.

The study session should expose what problems can occur and what can and cannot be done about each possible situation in the home setting. At the end of the study session, it should be recognized that the hypothetical complications envisioned are not normal and that their own history is one of normalcy which gives the couples reassurance and strength. Therefore, it is important for midwives to give feedback to their clients after attending to them.

Table 17: Student regards clients as inferior people who beg for health services

Responses	Frequency	Percentages (%)
Strongly agree	52	65
Agree	0	0
Undecided	0	0
Disagree	9	11.25
Strongly disagree	19	23.75
Total	**80**	**100**

In Table 17, majority of the respondents 52 (65%) agreed with the statement that "student midwives regards clients as inferior people who beg for health services" while 34 (25%) disagreed. The results show that clients ward assistants and midwives felt that student midwives regard clients as inferior people who begged for health services. This was mentioned by Blanehand and

Caesar (1994) after studying families reaction to birth, stressed that, preparation is required for those who will be present for the birth if there are children, not only do they need preparation but also an adult needs to be designated as primarily responsible for them.

This adult needs preparation for the labour and birth. Sibling preparation classes should be attended together by parents and other participations of the birth. The selection of participants should be made with great care and thought as Hopson (1978) emphasized. Hopson realized that apart from all the reasons that a woman or couple may have for inviting someone to participate in this experience, the attitude of these individuals toward out of hospital birth might convey fear to the laboring mother.

Table 18: Student midwives are not applying courtesy of midwives

Responses	Frequency	Percentages (%)
Strongly agree	30	37.5
Agree	36	45
Undecided	0	0
Disagree	14	17.5
Strongly disagree		0
Total	**80**	**100**

As seen in Table 18, majority of the respondents 66 (82.5%), agreed with the statement that "Student midwives are not applying courtesy of midwives" while 14 (17.5%) disagreed. This finding violates the clinical standards advocated by Briteann (1989) who explained that the setting of clinical standards and expectations classifies the partnership and the responsibility of partnership. In this

regard the student midwives are expected to encourage the husband of the labouring client to be present to give moral support to his partner. This will facilitate easy delivery.

Table 19: Clients and relatives do not trust Student midwives on family planning services

	Frequency	Percentages (%)
Strongly agree	16	20
Agree	40	50
Undecided	0	0
Disagree	11	13.75
Strongly disagree	13	16.25
Total	**80**	**100**

Table 19 shows that majority of the respondents 56 (70%) agreed with the statement that "Clients and relatives do not trust student midwives on family planning services" while 24 (30%) disagreed. As Jakarta (1984) commented at the International Conference on Family Planning, family planning is an essential component of any broad-based development strategy that seeks to improve the quality of life for both individual and communities. So midwifery students should be knowledgeable enough to win the trust of clients. However, Jacobs and Jones (1995) in their study into the midwifery curriculum, stated that midwifery students do acquire and understand the theoretical aspects of counselling and family planning, but applying skills and decision making in real life situation is a

different thing. Manipulating and practical skills cannot be learned merely from lectures or books.

In the same vein Clerk (1981) identified certain constraints to be addressed including culturally appropriate information, education and communication services as well as the need to train service providers to provide a wider range of family planning services in even health stations and outreach communities.

From the discussion it can be concluded that clients, ward assistants and midwife supervisors do not trust student midwives on family planning services. They also felt student midwives were not courteous and did not communicate well with clients and their relatives. In addition, student midwives are rude to clients. Moreover, the student midwives, were perceived as inferior people who begged for health services.

Research Question Four: To what extent do the communities and the clients' benefit from the students' district practical. Tables 20 - 24 provide the answer to this research question.

Table 20: Student midwives are interested in socialization thus defeating the purpose of their presence

Responses	Frequency	Percentages (%)
Strongly agree	5	6
Agree	55	69
Undecided	2	3
Disagree	0	0
Strongly disagree	18	22
Total	**80**	**100**

Table 20 shows that majority of the respondents 60 (75%), agreed with the statement that "Student midwives are interested in socialization, thus defeating the purpose of their presence" while 18 (22.25%) disagreed. This was mentioned by Chickerell (1981), who stated that some of the emerging issues in the literature review are nurse preparation for the birth. It is the duty of the nurse/midwife to educate the pregnant mothers to prepare themselves during pregnancy, labour and peurperium.

This will help the laboring women to cope well with the assisting midwife so that at the end of the delivery, a life healthy baby will be delivered by a healthy mother. The relationship of birth couple and a nurse-midwife is essentially that of partnership in which the couple or the woman decides as to whether she will deliver in the home or in hospital.

Table 21: Students criticize the routines laid down in the maternity homes

Responses	Frequency	Percentages (%)
Strongly agree	40	50
Agree	3	4
Undecided	8	10
Disagree	0	0
Strongly disagree	29	36
Total	**80**	**100**

Table 21 indicated that majority of the respondents 43 (54%), agreed with the statement that "Students criticize the routines laid down in the maternity homes. while 18 (29.36%) disagreed. The result suggests that student midwives in the opinion of the clients and mid wives tended to disagree with laid down routines in the maternity homes. York and Brown (1989) indicated that that clients discharged one to two days early should usually receive follow-up care at home and by telephone for up to eight weeks after discharge.

The study finds that clients received more support and education under this system than was the norm in the case of hospitalized client. They also indicate that follow-up home care was satisfactory to clients because it allowed for individualized attention. In addition, Nacion and Abramson (1980) contended that when follow-up home care is properly provided it offers psychological support and increases client's control over health care, which can benefit the client. Such were the routines that the student midwives in my school ignored.

Table 22: Student midwives helps in delivery of children in the community

Responses	Frequency	Percentages (%)
Strongly agree	30	38
Agree	23	28
Undecided	0	0
Disagree	0	0
Strongly disagree	27	34

Table 22: Student midwives helps in delivery of children in the community

Responses	Frequency	Percentages (%)
Strongly agree	30	38
Agree	23	28
Undecided	0	0
Disagree	0	0
Strongly disagree	27	34
Total	**80**	**100**

Table 22 shows that majority of the respondents 53 (68%) agreed with the statement that student midwives help in delivery of children in the community. while 27 (34%) disagreed. This is similar to the findings by Myles (1996) who stated that midwifery is a very important professional vocation. A competent midwife renders useful services to her clients and the community in which she lives. In a subsequent study by Disert and Goldenberg (1995) district midwifery training curriculum, indicates that, a great satisfaction is having contributed to the students' professional growth. In the study, the student midwife in the community. This gave them the opportunity to gain experience outside the hospital setting, a feel of what the community practice entails. Ritman (1992) in her interpretive approach to studying district midwifery, also discovered the richness and complexity of district midwifery. From this she concluded that student midwives do not only interact with clients in the maternity homes but they

also visit clients in their homes, assess puerperal mothers, dress babies cord and give immunization.

Table 23: Students midwives help in counseling and teaching family planning in the community

Responses	Frequency	Percentages (%)
Strongly agree	60	75
Agree	7	9
Undecided	0	0
Disagree	13	16
Strongly disagree	0	0
Total	**80**	**100**

As Table 23 shows majority of the respondents 67 (84%) agreed with the statement that "Students midwives help in counseling and teaching family planning in the community" while 13 (16%) disagreed. The results show that clients, ward assistants and midwives felt that student midwives were helpful in counseling and teaching family planning in the community.

This is in line with Huber's (1981) postulate that counselling is a very important task in family planning service provisions. Through counselling, nurses help clients to choose and continue to use correctly the family planning method(s), they have chosen. Huber added that counselling assists the client to understand the available family planning and reproductive health choices. Counseling dispels rumors and misconceptions about family planning, guides the

clients to make an informed choice, which leads to correct and consistent use of chosen method(s).

Table 24: The presence of students midwives serves its purpose (to observe and assist)

Responses	Frequency	Percentages (%)
Strongly agree	15	18
Agree	50	62
Undecided	5	7
Disagree	10	13
Strongly disagree	0	0
Total	**80**	**100**

Table 24 shows that majority of the respondents 65 (80%) agreed with the statement that "The presence of students midwives serves its purpose (to observe and assist)". while 18 (22.25%), disagreed. This finding is important because, according to Chickerelle (1981) to ensure a holistic training of students, opportunity is provided for each student in the course of her training to understudy a professional midwife based in the community. The trainee midwife experiences day-to-day interaction with community members. The aim of district practice is to develop students' level of competence beyond the traditional education and provide opportunities for students to resolve inaccuracies in midwifery role concepts to integrate selected aspect of midwifery education and practice in the actual community setting. The experiences are designed to

enhance both academic and organizational role and socialization for the students through additional learning. Therefore, the presence of the students' midwives serves its purpose.

From the discussion it can be concluded that the presence of students' midwives serves some purpose. Student midwives help in counseling and teaching family planning in the community. Student midwives also help in delivery of children in the community. However, student midwives criticize the routines laid down in the maternity homes and they are interested in socialization, thus defeating the purpose of their presence. They are also perceived as incompetent in conducting deliveries, lacking in courtesy and tended to scare away clients, especially the older clients, who felt embarrassed granting the student midwives access to their private parts.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The purpose of the study was to identify the challenges faced by private midwives in conducting deliveries and providing family planning services in the Berekum District when student midwives are on practice. The study investigated the extent to which clients and private midwives had interest in the midwifery students and assessed the relationship of students with clients. This Chapter provides a summary of the research report. It also makes some conclusions and recommendations in the light of the findings.

Summary

Chapter One provided a background of the study, the statement of the problem, purpose of the study, research questions and objectives, the significance of the study, delimitation, and limitations.

Chapter Two reviewed related literature on issues such as: The role of the midwife, Skilled attendants; District midwifery; the nurse-midwife's preparation for the birth; the women's/couples preparation for the birth; developing a partnership; delivery/home births; home health care; family planning; counseling services in family planning; reduction of risk through birth prevention; trends in contraceptives usage; benefits of contraceptives and effectiveness of family planning programmes. Chapter Three describes the research design, techniques

and procedures employed in the study. It further describes population, sample and sampling procedure, the instrument and procedures used for analyzing data collected.

Chapter Four is devoted to the presentation of results and discussion of findings.

Key Findings

The study revealed that:

Clients, ward assistants and midwife supervisors perceived student midwives as; incapable of performing well during delivery, inexperienced, unable to explain procedure well to clients in labour, unable to approach clients well and lazy

The reasons for the periodic reduction in service delivery at the maternity homes are that: students midwives scare clients; the older women would not allow student midwives to touch their private parts; students are not competent conducting second stage of labour; confidence reposed in students was little and students did not respect the rights of client during labour.

Clients and midwife supervisors did not: trust student midwives on family planning services with regards to applying courtesy of midwives and communicating well with clients and their relatives. In addition, student midwives were perceived to be rude to clients and their relatives and that they regarded clients as inferior people who begged for health services.

The presence of student midwives was serving some purpose in that students midwives were helpful in counseling and teaching family planning in the community, student midwives helped in delivery of children in the community.

However, student midwives often criticised the routines laid down in the maternity homes and they are interested in socialization thus defeating the purpose of their presence.

Conclusions

Based on the results of the study it can be concluded that:

1. Clients were not satisfied with the performance of the student midwife in the community. Therefore, the students should learn the type of language to use while dealing with the clients.
2. Clients, ward assistants and midwife supervisors had a low opinion about the level of professionalism students midwives
3. Deliveries at the clinics were adversely affected by the presence of the student midwives
4. Clients frowned upon receiving family planning from the student midwives who were younger than them.

Recommendations

Based on the conclusions of the study the following recommendations are made:

1. The Berekum Midwifery Training College should ensure that the student midwife has mastery of the practical areas in the demonstration room before going out in the community to practice.
2. The College authorities should make it a policy to visit the maternity homes prior to the period of sending students for domiciliary midwifery to assess the clinics and prepare the clients to receive the student.

3. The supervisors of the maternity homes should be counseled to accept the students and be ready to teach them to become useful instruments in the country.
4. Student midwives must be cautious about when and where to pass comments about the routines of the maternity homes.
5. It is not always easy to effect a change in every life situation. Therefore, the students should allow themselves to be corrected by learning new ideas from the maternity homes.
6. Students must also be counseled regarding both verbal and non-verbal communications with clients. Students should not feel bossy and idealistic towards clients.
7. The tutors of the midwifery school should pay a surprise visit to the students to see things for themselves during students' domiciliary midwifery practices.
8. Policy makers should have a periodic stake holders meeting to give a feedback to the school authorities about students' behaviour, performances and attitudes during their domiciliary midwifery practices and also submit reports on the students to the college.

REFERENCES

Abado, R. (1971). Appraisal of the comprehensive midwife programe. *Midwife Journal,* 2, 100-104.

Akiwumi, A. (1988). *Midwifery education contemporary Ghana*. A key note address at 10th Annual Conference of the Nurse Education Group Koforidua ,Ghana

Bennet, S. C. (1993). An innovative model for community practice. *Nursing Education,* 19 (3), 23-25

Berekum District Health Administration (2000) Annual Growth rate Ministry of Health (MOH).

Bike, A. G. & Hayes, W. R. (1994). *Midwifery practice. Textbook on district midwifery.* New York: Reven Press Limited.

Blanehand, M. W. & Caesar, L. L (1994). *Introduction to midwifery*. Cambridge: Medical Publishers.

Briteain, M. A. (1999). *Nurse-midwife partnership*. London: Uunwin Hyman Limited.

Brooten, K. & Caesar, W. (1998). *Home health care* .Toronto: Bailliere Tindal.

Bun, L. M. (1982). Domiciliary midwifery education. *Nurse Education Today,* 14(66), 66-69

Chickerelle, B. G. (1981). Professional nurturance community midwifery for undergraduate midwives. *American Journal of Nursing,* 6(4), 37-39

Clerk, P. (1981). *Partners in family planning*. Edinburgh: Longman Group Limited.

Cohen, K. R. & Rubin, C. W.O. (1980). *Family planning methods*. New York: JB Lippincott Company.

Disert, C. & Goldenberg, D. (1995). Clients perception of benefits and Commitment of attendants in midwifery practice. *Journal of Advanced Nursing,* 19(4), 23-32

Descombe, M. (2003). *The good research guide for small-scale social research projects.* Maidenhead Philadelphia: Open University Press

Ferguson, L. M. (1994). Reproductive health (1997). *Ghana Journal on Woman's Health,* 5(23), 6-8

Graziano, M. (1994). Mentors and preceptors in the nursing profession. *Contemporary Nurse,* 3(3), 121-126.

Herper, D. (1990). A one to one relationship with clients. *Midwifery Forum,* 23(1), 10-15.

Hopson, D. B. (1978). The ideal history and the history of ideas. *Journal of Nursing Scholarship,* 25(6), 25-255.

Hseih, N. L. & Knowles, D. W. (1990) Instruction facilitation of students' relationship in Midwifery education. *Journal in Midwifery Education*, 29(6), 250-268.

Jacksons, L. L. (1996). Family planning programmes. *Nursing outlook,* 37(4), 167-171.

Jakarta, N. (1984). The effect of a midwifery attendant in the community. *Journal of Nursing Education*, 30(6), 24-25

Kankel, M. G. & Pusslen, M. (1994). *Counselling services in the community*. London: Group Limited.

Kenner, J. B. (1978). *Family planning counselling services in the community*. London: Longman Group Limited.

Koenig, F. R & Meng, J. (1988). Community Midwifery. *Nurse Education*, 27(7), 45-54.

McBride, C. A. (1992).*Choice in reproductive Health*. Los Altos, Large Medical Publishers.

McMillan, J. H. (1996). *Educational research: Fundamentals for the consumer*. New York: Harper Collins Publishers Inc.

Meng, J. & Conti, A. (1995). *Psychology in midwifery*. London: Bailliere Tindall

Middem, D. & Benson G. M. (1995). Relationship between a midwifery attendant and client. *Journal of Nursing Education*, 21, 127-134

Myles, M. (1985). A Textbook for midwives. (13th ed.). Hong Kong: Churchill Livingstone.

Myles, M. (1996). A Textbook for midwives. (14th ed.). Hong Kong: Churchill Livingstone.

Myrick, F. (1988) Preceptorship. Is it the answer to the problems in clinical teaching? *Journal of Nursing Education*, 27(3), 136-138. Myrick, F. & Barrett, C. (1994) Selecting clinical preceptors for basic baccalaureate nursing students: a critical issue in clinical teaching. *Journal of advanced Nursing*, 19, 194-198.

Nacion, C. F. & Abramson, H. H. (1980). *Family planning handbook for community workers*. Jamaica: Macmillan press limited.

Norton, J. S. (1994). A collaborative framework for domiciliary midwifery. *Journal of Midwifery Staff Development,* 10(2), 94-98.

Ovellet, L. (1998). *Conducting home birth*. Toronto: Macmillan Pubishing Company

Pierce, E. (1998). *Obstetric for ten teachers*. London: Butter & Tanne Limited.

Rittman, R. C. & Sella, E. R. (1995). *Counselling session in family planning.* London: Bailliere Tindall.

Rittman, M. R. (1992). An interpretative analysis of receipting an unsafe student. *Journal of Nursing Education,* 34(5), 21-22.

Robinson, M. M. (1988). *Family planning for Tropics*. London: Churchill Livingstone

Rogers, S. & Myrick, F. (1998). Clinical teaching association with Models creating effective BSN/Midwifery Student. *Journal of Nursing Education,* 33 (9), 422-425.

Roncoli, N. A. (1989). Introduction to counselling sessions. Edinburgh: Longman's Group Limited.

Rose-Field, N. A. & Wrary, A. (1982). *Contraceptive Usage*. New York: Oxford Press.

Scheetz, L. J. (1998). *Community midwifery*. London: Macmillan Press Limited.

Sullivan, E. G. & Smith, P. A. (1996). The effect of an innovative midwifery student and critical thinking skills. *Journal of Midwifery Education*, 35(1), 23-28.

Tounge, A. (1956). *Psychology of childbirth*. New York: Wesley Longman. Inc.

Townsend, I. B. (1998). *Family planning counselling*. Sydney: J. B. Lippincott Company.

Wallace, W. Z. & Rubb, S. (1991). *Family planning programmes*. Geneva: Health Link Publishers

Wesstar, R. J. & Caraziano, M. J. (1992). *Counselling services in the community.* Cambridge: Medical Publishers.

York. E. S. & Brown, E. J. (1989). *Handbook on family planning*. Los AHOS: Longe Medical Publishers.

Young, K. M. (1986). Effects of prenatal and infancy home visitation by nurses on pregnancy outcome, childhood injuries and repeated childbearing. *Scholarly Inquiry for nursing practice,* 1, 5-19

Young, A. & Trojan, L (1994). *Domiciliary midwifery in rural communities*. Geneva: Ravan Press.

APPENDICES

APPENDIX A

UNIVERSITY OF CAPE COAST
FACULTY OF EDUCATION
INSTITUTE FOR EDUCATIONAL PLANNING AND ADMINISTRATION

Tel. No. : 03321-30571
Fax No. : 03321-30588
E-mail : iepa@ucc.edu.gh

University Post Office
Cape Coast
Ghana
July 31, 2011

Our Ref. EP/144.1/V.2/83

……

……

……

……

LETTER OF INTRODUCTION

The bearer of this letter, **Halima Opoku-Ahmed** is a graduate student of the Institute for Educational Planning and Administration of the University of Cape Coast. She requires some information from your outfit for the purpose of writing a Dissertation as a requirement of M.Ed degree programme.

We would be grateful if you would kindly allow her to collect the information from your outfit. Kindly give the necessary assistance that **Halima Opoku-Ahmed** requires to collect the information.

While anticipating your co-operation, we thank you for any help that you may be able to give her.

Thanking you for your co-operation.

Mr. Robert Appiah
Principal Administrative Asst
for: DIRECTOR

APPENDIX B

QUESTIONNAIRES

Demographic information

Please tic [√] where applicable

1. Name of maternity home…….

2. Age

   18-20 [ ]

   21-30 [ ]

   31-40 [ ]

   Above 40 [ ]

   Others ……..please specify

3. Heights educational qualification

   Non-formal [ ]

   JSS [ ]

   MSLC [ ]

   SSSCE [ ]

4. How long have you been in the Community?

   1-2 [ ]

   3-5 [ ]

   6-10 [ ]

5. Where have you been Given Birth/Delivering your Babies

   Home [ ]

   Clinic [ ]

Hospital [ ]

TBA [ ]

How do the clients and the midwifery supervisors perceive the student midwives performance in the community?

6. Student midwives do not perform well during delivery

SD [ ] D [ ] U [ ] AS [ ] A [ ]

7. Student midwives are inexperience

SD [ ] D [ ] U [ ] AS [ ] A [ ]

8. Student midwives do not explain procedures to clients in labour well

SD [ ] D [ ] U [ ] AS [ ] A [ ]

9. Student midwives do not approach clients well

SD [ ] D [ ] U [ ] AS [ ] A [ ]

10. Student midwives are lazy

SD [ ] D [ ] U [ ] AS [ ] A [ ]

What are the reasons for the periodic reduction in service delivery at the maternity homes?

11. Students midwives scare clients of, that is why they deliver in their homes.

SD [ ] D [ ] U [ ] AS [ ] A [ ]

12. Older women will not allow student midwives to touch them so they deliver in their homes.

SD [ ] D [ ] U [ ] AS [ ] A [ ]

13. Students are not competent conducting second stage of labour

SD [ ] D [ ] U [ ] AS [ ] A [ ]

14. Confidence reposed in students is just little regarding ANC

SD [ ] D [ ] U [ ] AS [ ] A [ ]

15. Student midwives do not respect the rights of client during labour

SD [ ] D [ ] U [ ] AS [ ] A [ ]

How do the clients and supervisors perceive the students interfered relationship?

16. Student midwives are rude to clients and their relatives

SD [ ] D [ ] U [ ] AS [ ] A [ ]

17. Student midwives do not communicate well with clients and their relatives

SD [ ] D [ ] U [ ] AS [ ] A [ ]

18. Student regards clients as inferior people who beg for h

SD [ ] D [ ] U [ ] AS [ ] A [ ]

19. Student midwives are not applying courtesy of midwives

SD [ ] D [ ] U [ ] AS [ ] A [ ]

20. Clients and relatives do not trust Student midwives on family planning issues

SD [ ] D [ ] U [ ] AS [ ] A [ ]

To what extent do the communities and the clients' benefit from the students' district practical

21. Student midwives are interested in socialization while defeating the purpose of their presence

SD [ ] D [ ] U [ ] AS [ ] A [ ]

22. Students criticises the routines laid down in the maternity homes

SD [ ] D [ ] U [ ] AS [ ] A [ ]

23. Student midwives helps in delivery of children in the community

SD [ ] D [ ] U [ ] AS [ ] A [ ]

24. Students midwives help in teaching family planning in the community

SD [ ] D [ ] U [ ] AS [ ] A [ ]

25. The presence of students midwives serves its purpose (to observe and assist),

SD [ ] D [ ] U [ ] AS [ ] A [ ]

APPENDIX C

Data Analysis

Item 1: **Age of Respondents**

Age range	FREQUENCY	PERCENTAGE
18-20	7	8.75
21-30	13	16.25
31-40	55	68.78
Above 40	5	6.25
Total	80	100

Item 2: number of years spent in the community

Range	FREQUENCY	PERCENTAGE
1-2	14	17.50
3-5	18	22.50
6-10	40	50.00
Above 10 years	8	10.00
Total	80	100

Item 3: Place of Given Birth/Delivering Babies

	FREQUENCY	PERCENTAGE
Home	15	18.75
Clinic	3	3.75
Hospital	17	21.25
TBC	45	56.25
Total	80	100

Item 4: Heights educational qualification

	FREQUENCY	PERCENTAGE
Non formal	15	18.75
JSS	10	12.50
MSLC	16	20.00
SSCE	4	5.00
Non formal	15	18.75
Total	80	100

Item 5: Where have you been Given Birth/Delivering your Babies

	FREQUENCY	PERCENTAGE
HOME	15	18.75
CLINIC	3	3.75
HOSPITAL	17	21.25
TBA	45	56.25
Total	80	100

Item 6: Student midwives do not perform well during delivery

	FREQUENCY	PERCENTAGE
STRONGLY AGREE	10	12.50
AGREE	49	61.50
UNDECIDED	3	4.00
DISAGREE	8	10.00
STRONGLY DISAGREE	10	12.00
Total	80	100

Item 7: Student midwives are inexperience

	FREQUENCY	PERCENTAGE
STRONGLY AGREE	49	61.25
AGREE	5	6.25
UNDECIDED	8	10.00
DISAGREE	0	0
STRONGLY DISAGREE	18	22.50
Total	80	100

Item 8: Student midwives explain procedures to clients in labour well

	FREQUENCY	PERCENTAGE
STRONGLY AGREE	0	0
AGREE	3	4.00
UNDECIDED	11	14.00
DISAGREE	47	58.00
STRONGLY DISAGREE	19	24.00
Total	80	100

Item 9: Student midwives do not approach clients well

	FREQUENCY	PERCENTAGE
STRONGLY AGREE	36	45.00
AGREE	25	31.00
UNDECIDED	9	46.00
DISAGREE	5	46.00
STRONGLY DISAGREE	5	46.00
Total	80	100

Item 10: Student midwives are lazy

	FREQUENCY	PERCENTAGE
STRONGLY AGREE	14	17.00
AGREE	48	60.00
UNDECIDED	0	0
DISAGREE	8	46.00
STRONGLY DISAGREE	10	13.00
Total	80	100

Item 11: Students midwives scare clients of, that is why they deliver in their homes.

	FREQUENCY	PERCENTAGE
STRONGLY AGREE	56	70.00
AGREE	5	6.25
UNDECIDED	1	1.25
DISAGREE	10	12.25
STRONGLY DISAGREE	8	10.00
Total	80	100

Item 12: Older women will not allow student midwives to touch them therefore they deliver in their homes.

	FREQUENCY	PERCENTAGE
STRONGLY AGREE	30	37.50
AGREE	25	31.25
UNDECIDED	5	6.25
DISAGREE	20	25.00
STRONGLY DISAGREE	0	0
Total	80	100

Item 13: Students are not competent conducting second stage of labour

	FREQUENCY	PERCENTAGE
STRONGLY AGREE	60	75.00
AGREE	5	6.25
UNDECIDED	2	2.50
DISAGREE	10	12.50
STRONGLY DISAGREE	3	3.75
Total	80	100