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The development of a community-based, problem-based learning curriculum in the undergraduate degree in nursing with special emphasis on the child-bearing women in women's health

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2014-05-23
http://hdl.handle.net10539/14710

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contribution to the development of nursing knowledge and nursing practice;

- demonstrate professional and personal behaviour consistent with a commitment to lifelong learning, accountability in practice, and the promotion and development of the nursing profession;
- fulfil the role of the nurse as a manager of health care delivery; and
- where relevant, incorporate principles of teaching and learning into nursing practice.

While the curriculum is an integrated one, the core of woman's health is taught in the third and fourth years of study. Thus, the level goals for the third and fourth years are included.

Level III

At the end of level III, the student should be able to:

- identify and describe common health problems with reference to gender issues;
- describe and manage women's health issues;
- describe and manage psychosocial health issues;
- apply knowledge from pharmacology and the psychosocial sciences to selected health\illness situations;
- demonstrate competence in psychomotor and affective skills in the provision of normal antenatal, intrapartum and postpartum care;
- demonstrate therapeutic skills in relation to psychosocial nursing;
- function, under supervision, in specialised multidisciplinary teams;
- support a professional caring approach to clients with special health needs;
- demonstrate proficiency in the use of communication skills in various community and clinical settings;
- be responsible for own learning and begin to apply principles of learning in client and group education;
- function within an ethical and legal framework, and
- demonstrate and apply knowledge of the research process.

Level IV

At the end of level IV, the student should be able to:

- use a comprehensive approach in the management of women's health issues and problems;
- use a comprehensive approach in the management of psychosocial health issues and problems;
- integrate knowledge from the natural, biological, social and nursing sciences in professional practice;
- competently select and implement the appropriate skills to facilitate health care delivery in community and hospital settings;
- work effectively as a member of a multidisciplinary health care team and in intersectoral situations;
- integrate professional caring in nursing practice and engender a culture of caring within the profession;
- demonstrate positive self-esteem and appropriate leadership abilities in the health care team;
- demonstrate the basic functions of management and its application to nursing practice in all settings;
- conduct and critically analyse research and other writings relevant to nursing practice;
- apply the principles of group work to enable communities to take responsibility for their own health;
- demonstrate professional behaviour consistent with the legal and ethical codes governing and influencing the profession, and
- critically evaluate own practice and assume responsibility for life long learning.

7.8 CURRICULUM FOR WOMEN'S HEALTH

7.8.1 PHILOSOPHY FOR WOMEN'S HEALTH

In providing midwifery and nursing care, recognition is given to the uniqueness of women's

health and the influence of her status in the family and community on her health. The need to provide holistic care is acknowledged and includes empowering women in self-care and health promotion. In so doing, the nurse-midwife is culture sensitive. Her caring is evidenced in her competence and skills, attitudes and communication and respect for human life. To this end, the needs of others supercede her own. Through the student's own learning experiences she is empowered to improve the quality of life of women in her care. The graduand's continuing personal and professional development continue to provide her with the abilities and skills to promote the health of women. During this period of learning the graduand's own self-image as a nurse-midwife is developed and nurtured.

7.8.2 CURRICULUM MODEL

This is developed on the four concepts of the conceptual framework, viz. environment, registered midwife, curriculum and outcome, and on the themes which were identified in 5.5.3, (p 259) viz. nursing/midwifery, communication, teach \ learn, growth and development, health issues and determinants, profession and health care system. In order to better incorporate issues which affect women's health the concept registered midwife will become registered nurse-midwife.

7.8.2.1 DEFINITION OF CONCEPTS

environment - this is used in its broadest sense and refers to the learning environment as well as to the environments of the community, family and individual. It also refers to the environment of the unborn child. The learning environment will include a variety of settings, such as small group tutorials, community and hospital settings.

registered nurse-midwife - development of a professional nurse and midwife will be based on an understanding of legislation which governs her practice and other legislation which may influence her decisions. An understanding of the multidisciplinary team in relation to her practice is fundamental to the provision of holistic care. Her roles of care-giver, manager, teacher and researcher must be developed.

curriculum - core knowledge is presented in such a way as to allow for self-directed learning. Dialogue is encouraged in small group work. Through dialogue, problem-solving and lateral thinking are promoted. Content is needs based - both at the community level and at the learner's level. Thus it is student driven and the teacher assumes the role of facilitator. The teacher-learner relationship is one of learner-learner in which knowledge and experiences are shared.

outcome - evaluation of learning is continuous through the discussions. Self and peer evaluation are encouraged. Formal evaluation is through contextual, clinical situations. These may be in either the written or the verbal format. A clinical study of a woman through her pregnancy, labour and delivery contributes to both the theoretical and the practical evaluation of the student.

7.8.2.2 DEFINITION OF THEMES

nursing / midwifery - refers to the art and science of caring for women across the lifespan. Care is founded on knowledge relating to factors which influence women's health. Thus nursing / midwifery is both knowledge and practice based. Care provided is professional, skilled and empathic. It is client-centred and seeks to facilitate care. In so doing it is collaborative and is "being with". Being client-centred, it is culture sensitive and considers the woman's values and beliefs.(Refer to the philosophy of the department 7.4.2, p 280, for the definition of caring.) It is a dynamic process. The knowledge and practice of nursing / midwifery is research based and thus scientific in its approach. Universal core values which should be evident in practice are the provision of information, demonstration of professional knowledge and skill, assistance with pain, touch, sensitivity, respect and calling by name. (These are values which were expressed by women in this research (vide 5.1.2.5, 5.1.2.8 and 5.1.2.7 pp 156, 170 and 167 respectively. These values are in common with Brown's(1986) themes (vide 5.1.2.9 p 178) and Wolf's (1986) caring behaviours (vide 5.1.2.9.1.2 p 184).)

communication - this includes both verbal and nonverbal communication. Nonverbal

communication includes attitudes and behaviour. It includes written communication which may be used in client referrals and the writing of records and reports. Communication must be effective in that it must consider level of understanding, culture and context. It includes the development of the skill of active listening. It is an interactive process which is non-judgemental.

teach / learn - learning is student-centred and the teacher's role is one of co-learner. Teaching and learning draw on experiences and reflection. There is sharing of information with peers, teacher-as-learner and women in need of health care. It seeks to meet the needs of the community and therefore learning is contextually based. Teach refers to the health promotion of women and to peer teaching. In the process empowerment takes place. The learner is empowered through the acquisition of knowledge and the client through the sharing of knowledge to improve her health status. Learning is self-directed in which the learner accesses experts and the information technology.

growth and development - refers to the individual's personal growth and development both physically and emotionally. It includes the woman's growth and development across the lifespan. The family and community are included in their maturational stages. Growth and development are consistent with the process of "ever-becoming."

health issues and determinants - health issues refer to conditions which are most commonly experienced by the women in the community. They include the health issues which have been identified in the National Health Plan. Health determinants are factors which have an influence on a woman's health, e.g. lifestyle, nutrition, genetics, culture, social, psychological, environmental, and political factors.

profession - refers to the nursing profession and the factors which influence its status as a profession, viz. legislation, standards of practice, ethics and research. It is a knowledge-based, practice-based profession and thus a research based profession. It includes the ethos of the

profession. It renders a service to the community which is based on effective management, leadership and decision making. Successful socialization of the learner into the profession is enhanced by experts or role models. The professional recognizes the importance of collaborative practice with other health care professionals in seeking to optimise the provision of quality health care.

health care system - refers to the health system which has been adopted by the country. Primary health care refers to care that is accessible, affordable and acceptable to the community. It includes secondary and tertiary care and methods of referral. It includes non-governmental health care facilities. The influence of global organizations, such as the World Health Organization, is recognized. Qualities which define health structures such as politics and legislation, policy development, demographics and statistics are included. Financial influences on the health care system apply, as does the issue of labour relations in being able to offer and maintain the system.

7.8.2.3 INTEGRATION OF CONCEPTS AND THEMES INTO A MODEL

The curriculum embraces the concepts and themes. It encompasses the philosophy of a problem-based curriculum in its approach to learning and the philosophy of community-based education in its preparation of practitioners. It considers the community, family and individual with particular reference to the women in each of these domains. The themes define the curriculum input in order to address the needs of women within each of these domains. The outcome is the registered nurse-midwife who is capable of meeting the needs of women through effective health care. Dialogue and context are significant factors in the implementation of the curriculum. In the health care setting, within any given context the woman and the nurse-midwife enter with their own experiences. Through dialogue these experiences are shared and the woman's needs are identified. Dialogue, being interactive, enables and empowers the woman to become an active participant in her care. Figure 7.2 illustrates the coming together of the woman and the nurse-midwife. Dialogue marks the point of interaction in which experiences and information are shared. In the teaching / learning

situation the learner and the facilitator enter the situation with their own experiences and interpretations. Dialogue marks the point at which the learner and the facilitator share their experiences. Figure 7.3 illustrates dialogue in the learning situation. Figure 7.4 illustrates the point at which facilitator and learner may learn from each other and thus teacher-as-learner and learner become co-learners in a situation. The sharing of information through dialogue is not consistent. There may be occasions when the nurse-midwife learns more from the woman in her care than the woman learns from her. The same may happen in the teaching / learning situation, when there may be occasions when the facilitator learns more than she imparts. It is through dialogue, in either situation, that knowledge and information flow in a dual interaction. In giving meaning to the dialogue, the nurse-midwife must recognise and attempt to understand the context to which it refers.

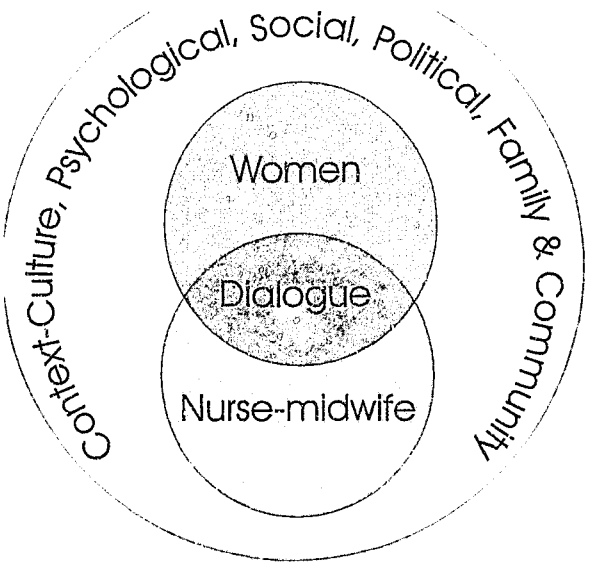


Figure 7.2 Relationship of dialogue to interaction between woman and nurse - midwife

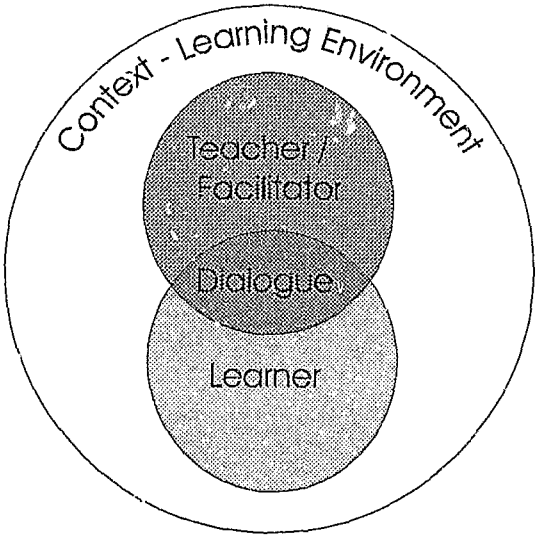


Figure 7.3 Relationship of dialogue to interaction between teacher / facilitator and learner

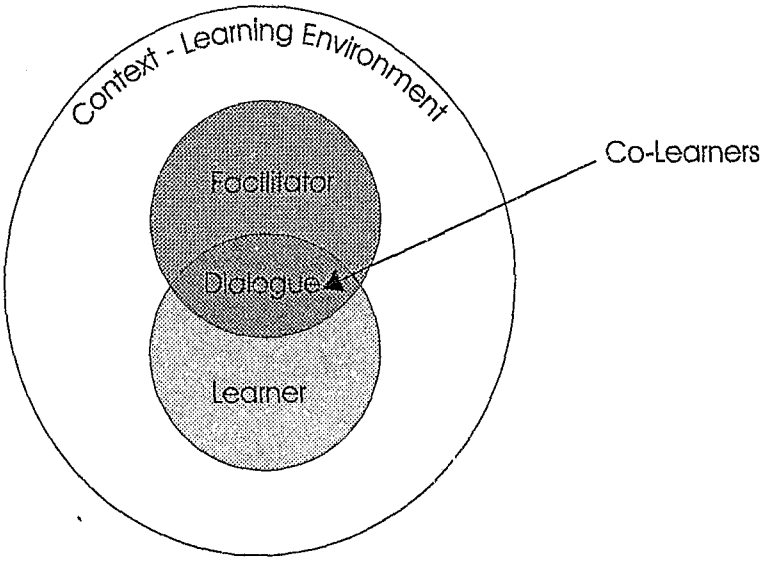


Figure 7.4 Diagrammatic representation of point at which facilitator and learner become co-learners

7.8.2.4 DESCRIPTION OF THE CURRICULUM MODEL

The curriculum model draws on the concepts context, input and process from Stufflebeam's educational model (vide 3.3.2 p 80) and the conceptual framework of this study (vide 3.4 p 87). Stufflebeam's context refers to the environment in which the curriculum exists. In this model context is used to describe the broader, national environment in which the curriculum exists. Input, as described by Stufflebeam, refers to actual and potential resources, facilities and strategies available. In this model, input is provided by the conceptual framework and the strategies, viz. problem-based learning and community-based education. Stufflebeam's concept of process, which he describes as the actual functioning of the system, encapsulates the concepts of the conceptual framework, viz. environment, registered midwife and curriculum. Stufflebeam's concept of product is replaced by that of the conceptual framework. Product refers to the outcome of the objectives of the study. In this model outcome refers to the practitioner, i.e. it refers to the human element rather than to the objective element.

The model has as its beginning point the concept of context. Context describes the setting and the boundaries within which learning takes place. These boundaries have been identified and described above (vide 7.2 p 275) as the Department of National Education, the Department of National Health, the South African Nursing Council and at a local level, the university, faculty and the nursing department, itself. However, teaching / learning and the provision of health care are not without reason and can only be meaningful if they meet the needs of the recipients of health care and therefore, the health needs of women must be contextualised. The boundaries of the context give definition to the input which is required in order to prepare practitioners to meet women's health needs. The strategies used to provide input are the conceptual framework, problem-based learning and community-based education. These strategies define the process. The conceptual framework is described by the environment, registered nurse-midwife, curriculum and outcome. Each of these concepts can be applied in the acquisition of nursing knowledge and practice of nursing.

Environment This describes the environment and the needs of the environment in which learning and practice take place. Its focus is the needs of women. However, it is realised that

their needs cannot be viewed in isolation and thus practice must take cognisance of the woman in relation to family and community. This concept also defines the philosophy and goals of the learning environment. The principles on which problem-based learning are founded (vide 2.1.4 p 17) provide the background to this philosophy and goals of the learning environment.

Registered nurse-midwife The registered nurse-midwife should be capable of decision-making, problem-solving and critical thinking. However, these are qualities which through her practice of nursing she imparts to learners, and therefore the model proposes a learner-centred input from experienced nurse practitioners and midwives.

Curriculum The curriculum content is based on the real world, i.e. it focuses on the world around us in order to identify essential knowledge needed by the learner in order to prepare him / her for competent practice. The themes of the curriculum, viz. nursing / midwifery, teach / learn, communication, growth and development, health issues and determinants, profession and health care system guide the concepts which need to be acquired relevant to the real world needs. In translating this information into the practice of nursing, students need to be able to problem solve, think critically and make effective decisions. (See tables 7.1 and 7.2 pp 297 and 298 respectively, for application of themes to knowledge of women's health.)

Throughout there is interaction and dialogue between nursing knowledge and nursing practice. We live in an interactive world and therefore communication and dialogue are essential. Interaction can be extended to the use of the library, peers (both locally and internationally), experts in the field and the internet.

Stufflebeam's last concept, viz. product equates with outcome of the conceptual framework. Stufflebeam describes product in objective terms whereas this model describes the outcome as a competent practitioner. This has a subjective element and therefore the term outcome is used to equate with product. Competency has been assessed through comprehensive and varied assessment strategies and is evidenced in practice by a reflective and action oriented practitioner. Vide figure 7.5 for a diagrammatic representation of the curriculum model.

Table 7.1 Application of themes to Women's Health I

WOMENS HEALTH I
FOCUS : WOMAN'S HEALTH - THE HEALTHY WOMAN

Nursing	Communication	Teach/Learn	Growth/ Development	Health Issues & Determinants	Profession	Health Care Systems
• Needs approach and assessment of women of all ages • Needs approach and assessment of pregnant women • Needs approach and assessment of neonate	Non-verbal Verbal Family relationships Stress management	Self assessment for client Self care Neonatal care	Pregnancy • Foetus • Abortion Fertility control Breast feeding Teenage pregnancy Empowerment • Abuse Parenting • Family • Single woman Menopause	Psycho - social • Economic • Political • Culture Lifestyle • Sexually transmitted diseases Nutrition Mature woman	Professional practice Scope of practice World Health Organization Safe motherhood National Health Plan Child Act Abortion Act Transcultural care	• Primary health care • Alternative health practices • Woman's rights

Table 7.2 Application of themes to Women's Health II

WOMENS HEALTH II
FOCUS : WOMAN'S HEALTH - HIGH RISK GROUPS

Nursing	Communication	Teach/Learn	Growth/Development	Health Issues & Determinants	Profession	Health Care Systems
Need approach: • Problem pregnancy • Older woman • High Risk neonate	Non-verbal Verbal Feminist issues Family relationships	Health promotion at all ages of womanhood	Carcinomas: • Cervix • Breast Impaired foetal and neonatal development Impaired pregnancy pathology in: • Middle-age • Older women	Psycho - social: • Culture • Political • Economical Nutrition Abuse	Scope of practice Legislation application to Midwife Midwife as change agent	National policies: • Primary health care • Referral systems • Adoption

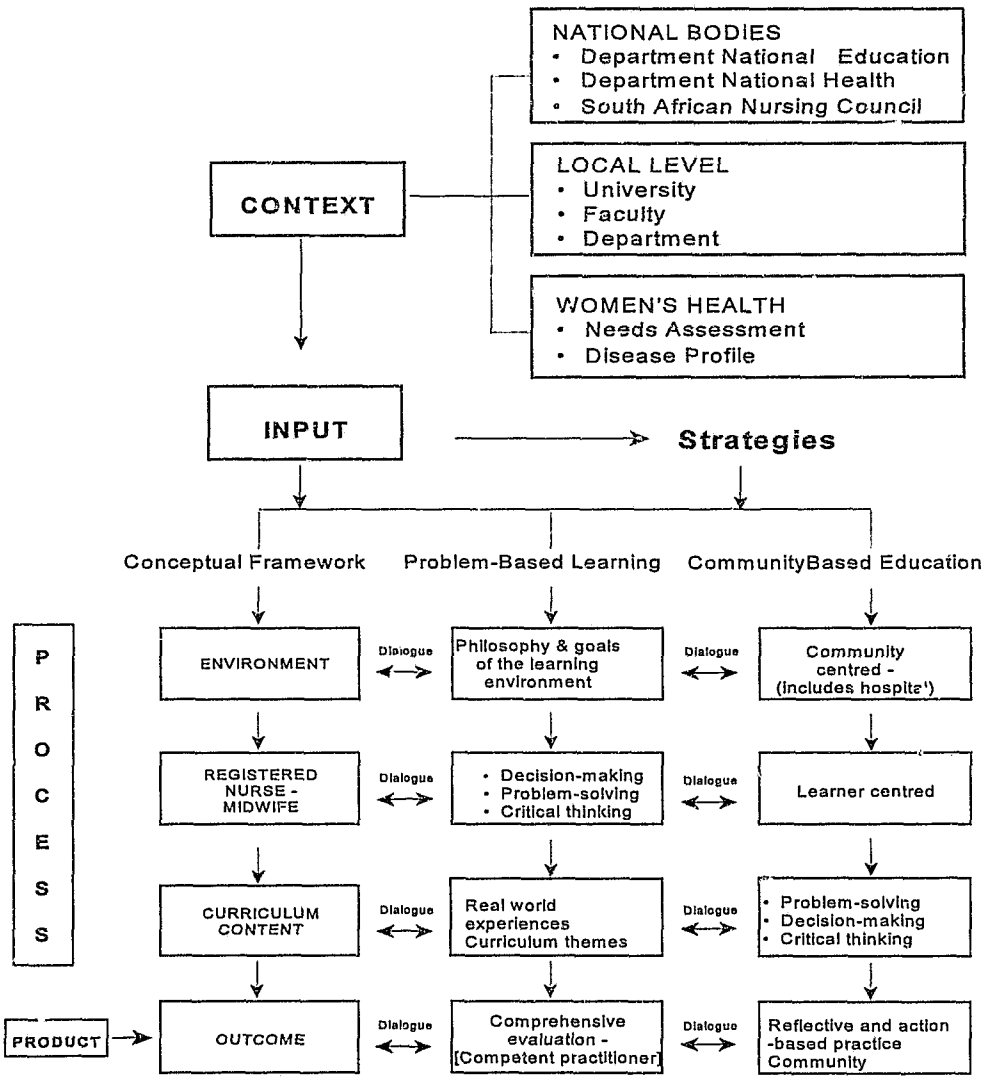


Figure 7.5 Diagrammatic representation of curriculum model

7.9 IMPLEMENTATION OF THE MODEL

The implementation of the curriculum is guided by Stufflebeam's CIPP model (vide 3.3.2 p 80) and the conceptual framework of this study. The context is defined by the environment in which the curriculum is implemented, i.e. South Africa and more particularly the province of Gauteng. The target population for which this curriculum is developed is women and women's health. Thus the content is prescribed by the health needs of this particular group and is identified through a needs assessment. The curriculum model is process driven and founded in the teaching / learning strategy of problem-based learning. The content focuses on the real world needs of women and therefore incorporates the characteristics of community based education (vide 2.4.2 p 43). Thus the characteristics of these strategies are to be implemented in the form of small group learning and practical learning experiences in a variety of community settings, including the hospital which is part of the community. The process is guided by the teacher whose role becomes one of a facilitator and co-learner. The key concept in this process is dialogue, where attention is given to the learner's needs. It is therefore, learner centred. However, being learner centred does not mean that needs of the learner are the sole focus off the process. Learners' prior learning and life experiences are recognised and developed through the sharing of previous experiences, reflection of past experiences and the empowerment of learners to take responsibility for their own learning and self-development. The process is enabled through the use of learning resources, such as the library, computers and clinical facilities. Learners are encouraged to be active in the assessment of their learning through self-assessment, peer assessment and formal assessment that is comprehensive and outcomes-based. The outcome of the curriculum is a competent practitioner. The concepts which drive the implementation of the process are dynamic with constant interaction between them.

Figure 7.6 illustrates the implementation of the model and the variables which are significant in its implementation. The models which describe the curriculum and its implementation are both linear because they attempt to demonstrate the dynamic nature of the model and the constant interaction between the concepts. The constant interaction is facilitated through dialogue.

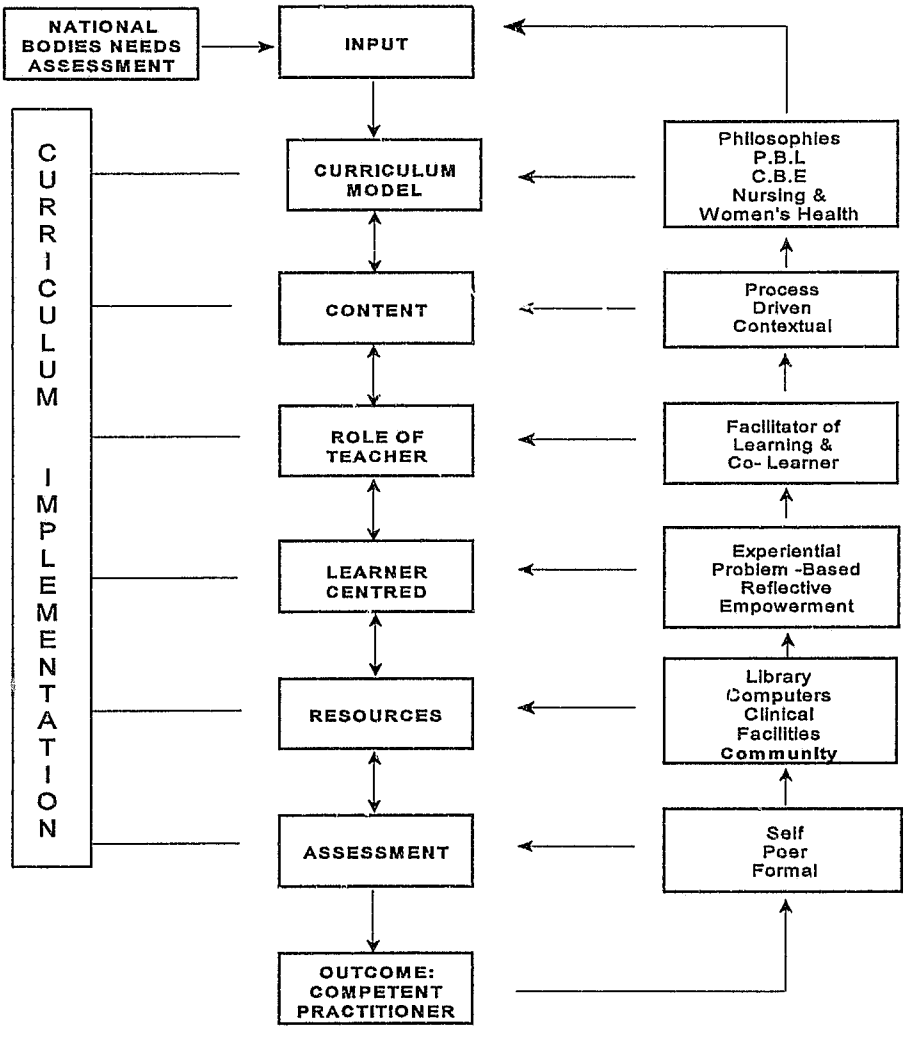


Figure 7.6 Diagrammatic representation of curriculum implementation

This model will be implemented in the third and fourth years of study. The philosophy for the women's health curriculum was born out of a revision of the macro curriculum for the undergraduate nursing degree. (See Annexures S and U and 5.5 p 254).

7.10 PEER GROUP EVALUATION OF MODELS

The researcher presented her models for peer group evaluation to nurse researchers who have expertise in the fields of research, education and women's health. Two members of the group have doctoral degrees in nursing and two have Masters degrees. The conceptual framework, curriculum model and curriculum implementation model were presented and discussed. The researcher followed the presentation up with a short questionnaire which requested the participants to comment on the models. Chinn and Kramer (1991:137) identify five points which need to be answered in forming a complete critical reflection of a model. These are:

- is it clear ? This refers to the clarity and consistency of the presentation. Clarity and consistency may be both semantic and structural.
- is it simple ? This refers to the number of structural components and relationships within in the theory. Simplicity implies fewer relational components.
- is it accessible ? This refers to whether the concepts are grounded in empirical research.
- is it general ? Generality infers that a wide scope of phenomena are covered by the model.
- is it important for nursing and nursing education ?

The researcher requested the participants to evaluate the framework and the models against these five characteristics. The four participants all responded to the questionnaire.

7.10.1 THE CONCEPTUAL FRAMEWORK

All the participants felt that the framework is clear, simple, accessible and important for nursing and nursing education. Only one participant felt that it is not general. One respondent stated that "the combination of the different theoretical frameworks make it very applicable in both nursing and education." Another stated that it is maleable, "allowing definition with reference to specific context \ situation as categories are broad and inclusive."

7.10.2 THE CURRICULUM MODEL

All the participants felt that this model is simple, clear, general, accessible and important to nursing and nursing education. There was some discussion as to whether "dialogue" should be illustrated in the vertical as well as in the horizontal planes as bi-directional. The person who was invited for her education expertise did not subscribe to this suggestion. On further reflection and discussion the researcher has not adopted this suggestion because she feels that the model describes the development of the curriculum. The person with education expertise commented that this model illustrated the relationship between nursing theory and nursing practice and she felt that the model attempts to bridge the gap between theory and practice. She went on to say that she felt that it was important that this model be presented to the relevant persons at government level so that preparation of practitioners for primary health care can be implemented appropriately. Another participant has described the model as " comprehensive yet clear ... I am sure that nurse educators can benefit by using it."

7.10.3 MODEL FOR CURRICULUM IMPLEMENTATION

All the participants felt that this model is simple, clear, general, accessible and important to nursing and nursing education. It was suggested that process could be indicated by creating a reflective loop so that outcome feeds back on the contents of the right hand side of the model and back into "input". This would create a loop within the model. The researcher has adopted this suggestion. This loop is consistent with Stufflebeam's circular model between context, input, process and product (vide figure 3.1 p 82).

7.11 APPLICATION OF THE MODEL TO A WOMEN'S HEALTH CURRICULUM

Name of the course: Women's Health

Duration of the course: Two academic years

Aim of the course.

The aim of the course in women's health is to provide the student with the understanding of

the conditions which affect her life across the life span.

7.11.1 WOMEN'S HEALTH I

The purpose of the course.

To provide the student with an understanding of the issues which affect women's health.

Goals of the course.

At the end of the course the student should be able to:

1. Discuss factors which affect women's health.
2. Discuss woman's needs in terms of sexuality and contraception.
3. Describe the needs of the working woman and the mature woman.
4. Describe how you would attempt to meet the health needs of women in a multi-cultural society.
5. Describe the importance of antenatal care and manage care for normal antepartum women.
6. Understand the processes affecting the intrapartum period and manage this period.
7. Describe the factors influencing the postpartum period and relate their influences to care of the postpartum woman.
8. Describe the relationship between the development of the foetus and maternal health needs.
9. Describe and meet the needs of the neonate.
10. Understand the concept parenting and use this knowledge to facilitate this function in new parents.

In order to meet these goals problem development would need to include the healthy woman, the antenatal client, the intrapartum period, postpartum needs and management, the normal neonate and the needs of the mature woman. Thus learning packages should be developed for the following:

- The Healthy Woman

- Becoming a Mother
- The Birthing Experience
- The New Mother
- Baby and the New Family
- The Mature Woman

Clinical Learning Opportunities and Requirements.

By the end of the first course you will have obtained practical learning in the academic hospital. During this period you will nurse and care for women during their pregnancy, labour and puerperium. You will also nurse women who have been admitted to the gynaecology wards for reasons such as a hysterectomy. This means that you will be caring for women across the lifespan and women who come from many different cultures and beliefs. It is important that you remember this because many aspects of womanhood have strong cultural values. Therefore remember that you are not only giving physical care to these women. You need to relate physical care to cultural beliefs, e.g. some women cannot be examined by a male nurse or doctor. So if your care is to be meaningful you will need to familiarise yourself with some of the common cultural beliefs of the women of the community. Remember though not to stereotype!

Some suggestions for learning about cultural beliefs include:

- each member of the group should interview a woman of a different culture from his / her own. Bring what you have learnt to the problem-based tutorial session. Each group member tells her story of what he / she has learnt and how this differs from her own culture.
- doing the same as the above, but instead of presenting to your group only, we set up a display. You could illustrate your findings by showing pictures or artifacts that pertain to cultural beliefs surrounding womanhood. We could share this with the entire student body and thus facilitate the learning of culture more broadly. This could be extended to include alternative health practices.

Parenting forms an important aspect of this course. To help you understand what all this implies you will "go shopping" one morning. During your outing you must identify and select what you think you would buy if you were a first-time mom. You will need to decide what you really need; how you are going to feed your baby, where the baby will sleep. These are just a few examples - you will decide what else you need to consider that morning. Once we have done this we will come together and look at what you've "bought" and do a costing exercise of what getting ready for a baby implies. During the course of this module you should also interview some first time moms and find out what the first six weeks at home were like. This could include visiting some support groups in the community and finding out what they offer and how they operate.

Please remember that the above are only suggestions - you can contribute suggestions for your learning needs at any time.

As part of your self assessment you will be expected to keep a journal. You should write up at least one experience you have had in each of the clinical placements to which you have been allocated. You may keep your journal as you like - i.e. **be creative!** In order to help you get started, here are a few suggestions:

- reflect on an incidence which has occurred during the particular clinical placement;
- how was it managed?
- what was the outcome?
- what could have been done to improve the situation and possibly the outcome?
- what was the effect of the incidence on the woman?
- what was the effect of the incidence on you?
- What have you learnt from this incidence?

Assessment

As part of your continuous assessment you will need to keep a portfolio of your learning. Your portfolio should reflect all that you have learnt or discovered in relation to the situation

or problem. It should be clearly illustrated by your notes, references which you have used, journal articles, pamphlets or brochures which you have found useful and experts who you have consulted. Don't forget to include information which you may have obtained from the internet or from nursing student colleagues in other countries.

You should develop your portfolio over the next two years. Please remember, that you can always add information to a section which you may have considered "complete"!

7.11.2 WOMAN'S HEALTH II

The purpose of the course

To provide the student with an understanding of factors or conditions which result in deviations from health in women.

Goals of the course

At the end of this course the student should be ab' to:

1. Explain and plan care for conditions which cause pregnancy, labour and the puerperium to deviate from the norm.
2. Identify and plan care for a neonate which is considered to be "high risk".
3. Identify and manage conditions which cause health problems in women.
4. Identify and manage common health problems in children.

Thus learning packages will be developed for the following:

- My complicated pregnancy
- Experiences of complicated labours
- When being a mother became too much
- My baby was lying the wrong way
- When mothers ask: Will my baby live?
- After childbearing (this package would include carcinomas which are prevalent in the

community, e.g. carcinoma of the cervix and carcinoma of the breast.)

- Living with a chronic illness (this package could include women with HIV or diabetes. It would emphasize the need for the nurse-midwife to give attention to rehabilitation in the care she rendered. The student would be required to identify community support groups and the services which are available.)

Clinical Learning Opportunities and Requirements

By the end of the second course you will have obtained clinical learning experience in a community clinic, voluntary organisations, a secondary hospital and the academic hospital. By now you will have met a number of women from many different cultures and backgrounds. You will experience different feelings at what some women have been through - e.g. abuse in the form of rape or harassment, financial difficulties and no work, denial of educational opportunities and many others. Learn from these women's stories as you carry out your health assessments - how do their experiences affect their health and more importantly - what can you the nurse do about it?

Evaluate the primary health care clinic as to how it meets the needs of the women of the community which to serves. What efforts are made to promote the health of the women? How do the women feel about "their clinic"?

You should also look at the system of referral from the clinic to secondary or tertiary care. Consider lines of communication, are they effective? What happens when the woman returns home? How are issues such as contraception, the sexually transmitted diseases and HIV managed at the various levels of care. Consider any outreach programmes or projects which aim to uplift and empower the women. You should attend a meeting of a group of community women - find out what they want for themselves, what is the purpose of their group?

Please continue to keep your journal and your portfolio that you started last year.

7.11.3 SUGGESTED LEARNING PACKAGE FOR WOMEN'S HEALTH I

In developing a learning package for this course, consideration needs to be given to the use of a problem. The focus of this course is the normal - the well woman, the normal pregnancy and labour and the term, healthy neonate. Thus the use of "problems" is inappropriate. The use of learning situations is more appropriate. This does not negate the help or interventions of the nurse and midwife because every situation can be improved upon or interventions implemented to maintain optimal health. Thus for this course the scenarios do not necessarily make use of "problems" in the strictest sense of the word. Alternate means of presenting this package to students could be through the use of a video portraying women in different cultures or through a magazine article on female circumcision. Students could also be encouraged to bring current newspaper clippings which report on the status or achievements of women locally.

LEARNING PACKAGE FOR THE MEANING OF "WOMEN'S HEALTH"

Being a woman

Have you ever thought about what it means to be a woman? From birth social, cultural, environmental, religious and financial pressures influence her life. By the time that she reaches puberty many factors will have affected her growth and development. The very nature of her sex exposes her to risks associated with childbearing. Furthermore, many women report feelings of anxiety and depression. While women appear to use the health care services more frequently than men, these services are not always suitable for meeting her needs. In later life, her life experiences, lifestyle and culture impact on her health. Despite the many adverse factors which may affect a woman's health, women appear to have biological advantages over men and have a longer life expectancy than that of men. This leads us to ponder then, is women's health important?

Suggested Approach

1. Analyse the above scenario.
2. Identify important concepts.
3. Describe how these concepts influence a woman's health.
4. Conduct a focus group interview with women in your community. Attempt to obtain their opinions regarding the status of women in the community and factors which contribute their state of health.
5. Based on your own personal and professional experiences, evaluate the cognisance taken of women's health in the health care services.
6. Review the group process.

Key concepts which should be identified

Female circumcision

Gender differences

Women's multiple roles as homemaker, breadwinner and care-giver

Nutrition

Education

Communicable diseases

Sanitation

Rape

Sexual abuse

Abortion

Haemorrhage

Health workers attitudes

Alcohol abuse

Smoking

Violence

Status of older women

Menopause \ osteoporosis

Protective nature of female hormones

Male foetus \ female foetus

Economic status \ political status

Empowerment.

Skills related to the scenario:

No clinical \ physical skills need be learnt in this package.

Communication and interviewing skills.

Skills which should be implemented are those of the problem based learning process, information seeking and experiential learning through reflection and critical thinking.

Resources

Students may access experts in the department itself

Staff in the Women's Health Project

Staff in both the ante-natal and gynaecology clinics

Facilitator's notes

The goal of this package is to create an awareness in the student of the factors which relate to women's health. The aim is to generate broad discussion about the factors and not to go into the details of the factors. The discussion should develop in such a way that the student gains understanding of what should be included in history taking and assessment of women.

Assessment

Learning that has taken place in this package will be assessed through its application of knowledge in the remainder of the course.

LEARNING PACKAGE FOR THE ANTENATAL CLIENT

This package could be presented through a video portraying a registered nurse-midwife interviewing a client at the booking visit or alternately a mother held card which reflects a

history could be used as trigger material.

Situations related to ante-natal care

SARAH JONES

Part I

You have just started your midwifery practica and have been allocated to work in the ante-natal clinic of the community health centre. It is your first morning in the clinic and the charge sister allocates staff to "bookings", "the cubicles", "urine room" and "blood room". You are allocated to Sister Xaba who will orientate you to the clinic. During the orientation, she explains the meanings of and duties related to the above allocations. After orientation you are allocated to bookings where you meet Sarah Jones. Sarah is a primigravida and has come to "book in". The midwife you are working with asks Sarah whether she is sure that she is pregnant and she replies that her pregnancy test was positive. Together with the midwife, you book Sarah. At the end of the interview she is given a date for her next visit. The midwife tells Sarah that this visit will be slightly longer than the others to follow because it is in some senses a continuation of today's visit. It will include a full physical examination. It requires that she has some blood and urine tests done today before she goes, so that they are available for the next visit. She advises Sarah that she is welcome to bring a companion with her to clinic. It can be anybody she chooses, her mom, husband, sister or a friend. She also tells Sarah that the clinic offers classes to prepare her for labour and the birth of her baby. These classes also provide her with information that will benefit her health and that of her unborn baby. You accompany Sarah to the blood room and on the way she tells you "all this" makes her feel very nervous - "Is it really necessary to come again, now that I've booked my bed?"

Suggested approach

1. Analyse the above scenario.
2. Identify key concepts.
3. Discuss issues related to these concepts.

4. Discuss how you will access this information.

Key concepts which should be identified.

Ante-natal care - its aims and objectives

Diagnosis of pregnancy - subjective and objective signs; biophysical tests

Assessment data - demographic data

- age
- marital status
- occupation
- culture and religion
- lifestyle and social habits
- reproductive history
- menstrual history
- contraceptives used
- last menstrual period
- obstetric history
- expected date of delivery
- family history - genetic disorders
  multiple births
  diabetes, cardiac disease or blood disorders
  - history related to respiratory, haemodynamic, metabolic, nutritional and elimination needs
  - musculo-skeletal function - previous injuries
  - mental status - previous problems, attitude towards pregnancy, support system.
  - history related to surgical interventions especially of breast, uro-genital, cardiac tolerance of anaesthetic

Biophysical tests related to scenario:

Pregnancy tests

urine tests - dipstix and midstream urine for microscopy, culture and sensitivity;

blood tests - haemoglobin, blood grouping and rhesus, RPR and HIV status.

Skills related to the scenario:

Interviewing skills;

Ability to test urine and obtain a midstream specimen from client;

Ability to take blood specimens and handle correctly;

Ability to obtain informed consent in relation to testing HIV status;

Ability to reassure and inform client where necessary.

Resources

Staff in the antenatal clinic and antenatal ward

Experts in the nursing department

Obstetricians

Part II

The next day you are working in the cubicles where the women are seen for their antenatal visits. The morning is busy and working with the registered midwife you see a number of women. However, one young woman makes an impression on you. She is single and has come to the clinic alone. You note that this is her first baby. The registered midwife notes that she is looking despondent and asks her whether something is worrying her. She tells her that her mother disapproves of her boyfriend, the father of her baby. He is very supportive of her and does not intend leaving her. She has always had a good relationship with her mother and this friction is disturbing her. She very much wants this baby. At the moment she is still working and living at home, but she doesn't know how much longer she can take it there. Her boyfriend's parents have said that she is welcome to go to their home, but she doesn't want to cause her mother any further hurt. The registered midwife helps her to explore her feelings

further. She then continues with the physical assessment. Mary, the young woman, states that she has been keeping well. However, the midwife is concerned because Mary's weight gain is below the acceptable limit. On abdominal examination foetal growth appears to be satisfactory, the symphisis-fundus measurement shows increase since the last measurement and the foetal heart rate is good. Mary, does however, say that there are some days when the baby doesn't seem to move much. The midwife queries Mary's daily nutritional intake. Mary admits to not having much of an appetite. Mary's blood pressure and urinanalysis are within the normal limits. There is no oedema of the ankles and she does not have any problems relating to vaginal discharge, constipation or heartburn. The midwife provides Mary with information regarding her diet and diet in relation to foetal movement. She tells Mary that she would like to do a non-stress test before Mary goes home. She says that she is advising this as a precautionary measure. You are asked to take Mary to the NST (non-stress test) room.

Suggested Approach

1. Analyse the above scenario
2. Identify key concepts and the information you need.
3. Discuss issues related to these concepts.
4. Discuss how you will access this information.

Key concepts which should be identified

Details of physical examination - norms for pregnancy
Diet and nutrition in pregnancy
Psycho-social status and health information
Foetal movement - quickening, patterns of, sleep patterns
Non-stress tests and measures of foetal well-being
Minor disorders of pregnancy

Skills related to the scenario:
Ability to perform a physical examination.

Ability to perform an abdominal examination.
Ability to provide health information.
Ability to perform a non-stress test.

Facilitator's notes

In relation to the themes, the facilitator must probe and ensure that the following concepts are identified in the discussion:

nursing/midwifery - assessment of needs. Be able to relate these to physiology and other basic sciences.

communication - ability to communicate effectively with the client through the appropriate use of terminology; sensitivity to client's verbal and non-verbal communication and awareness of cultural values and beliefs. The promotion of the relationship of women with significant others.

Teach\learn - identifies own learning needs and objectives, is able to group these needs and identify means of meeting these needs; identifies concepts which may require information for self-care by the client and aspects in which the client may be empowered.

Growth and development - of the pregnancy and methods of assessing this growth, growth and development of the foetus, psycho-social influences on the pregnancy.

Health determinants - culture, lifestyle, occupation, economic status, drugs, alcohol, genetics and physical status.

Profession - scope of practice of the registered midwife, rules and regulations for the registered midwife, relevant legislation, e.g. the abortion act, legislation in relation to medication. Transcultural care.

Health care system - primary health care - midwife obstetric unit; referral system. Use of mother held card.

Assessment

Possible methods of assessing learning that has taken place in this package include multiple choice questions, modified essay questions and objective structured clinical evaluation. The researcher is not in favour of the use of multiple choice questions for this course. Her reason for this is that they tend to fragment the learning material and one is not really able to assess whether the student has encapsulated the concepts and whether lateral thinking is taking place. For this reason, the researcher prefers the use modified essay questions for evaluating the cognitive and some of the attitudinal aspects of learning. Wales and Skillen (1998:260) state that scenarios are "directive." They describe this as meaning that the clinical situation described in the scenario directs the student's thinking and response. They go on to note that "scenarios facilitate the identification of course strengths and weaknesses.

Multiple choice questions, however, may be useful for the students to evaluate their own learning. This form of self-assessment can be achieved through the use of pre and post-tests.

An example of a modified essay question for the above learning package is as follows.

Modified Essay Question

Scenario

Mary Kau is a twenty-two year old primigravida. She is married to John, a twenty-four year old salesman. Mary does domestic work. She is currently employed in a full time position. Her employer has agreed to give maternity leave and she plans to go back to work when the baby is two months old. Her last normal menstrual cycle was 17 February 1998. Mid-March she spotted for two days.

1. Identify the concepts which could impact on Mary's health during the pregnancy.
2. Calculate Mary's expected date of delivery (show your calculations.)
3. Explain a possible cause of her spotting mid-March.
4. Name three tests which could be done to confirm her pregnancy.
5. Identify further information you would obtain during the ante-natal assessment. Explain the significance of this information.
6. Name the blood tests you would expect to be ordered for Mary.
   - 6.1 Explain the significance of these tests in relation to Mary.
   - 6.2 Relate your actions to your professional practice.
7. Explain the significance of monitoring the following parameters during pregnancy:-
   - 7.1 blood pressure
   - 7.2 weight
   - 7.3 vaginal discharge.
8. Describe how you would seek to promote Mary's health through the following concepts:
   - 8.1 nutrition
   - 8.2 exercise
9. Describe the influence which culture may have on pregnancy outcome. Describe how you would seek to provide culture sensitive care to Mary.
10. During her pregnancy Mary complained of the following problems:
    - 10.1 nausea at 10 weeks
    - 10.2 constipation at 24 weeks
    - 10.3 vague headaches at 18 weeks
    - 10.4 tenderness on the right side at 30 weeks

    State possible causes and interventions for each.
11. Identify four means of assessing foetal well-being clinically before 30 weeks of pregnancy.
12. Describe the information you would give Mary to enable her to monitor her baby's well-being after 30 weeks of pregnancy.
13. List the medications which the midwife should prescribe for Mary. Explain why these

are necessary and the legislation which empowers the midwife to prescribe these medications.

14. Explain the rationale of the patient-held record. How do you believe this may help to empower women in their health care?
15. Where in the health care structure do you believe that Mary's pregnancy is best managed? Motivate your answer.

An alternate form of assessment for this package would be a case study. Students could be required to present a case study of an antenatal client, preferably who they'd assessed. This could either be presented verbally to their small learning group and facilitator or it could be written and handed in. The former presentation has the advantage that it provides opportunity for dialogue and questioning from the group. However, this would be time consuming.

Skills which could be assessed in this package are interviewing skills, abdominal palpation and / or a physical examination of the woman. Students should be given opportunity to practise these skills and to book a date for an assessment when they feel competent to be assessed.

7.11.4 SUGGESTED LEARNING PACKAGES FOR WOMEN'S HEALTH II

These packages are more consistent with problems in the true sense of the word. An alternate means of presenting the following package could be through the use of records - client notes, laboratory and x-ray reports and referral letters.

LEARNING PACKAGE FOR COMPLICATIONS OF PREGNANCY
JULIA NKOSI

You are the registered midwife in charge of the antenatal ward of a referral maternity hospital. Julia Nkosi is admitted into the ward when you are on duty. Her history and reason for admission are as follows:

Julia Nkosi is a 31 year old P0G3 (Para nought and gravida three. Thus despite three pregnancies she has no alive children. This information would not be given to the student. It would constitute an aspect of self-directed learning.) She has a history of a previous miscarriage at 12 weeks gestation and an ectopic pregnancy at 8 weeks.

Julia had rheumatic mitral valve disease as a child (she can't remember exactly how old she was when she became ill.) This left her with mitral stenosis. In June of this year she had a balloon valvotomy. She is currently on the following medication:
Hydralazine 10mg b.d.
Ismo 10 mg b.d.
Lasix 40 mg daily
Slow K ii b.d.
Pregamal ii daily

Julia has no allergies and no harmful habits, however, her HIV status is positive.

She is now 27 weeks pregnant by dates.

When she attends the clinic for a routine visit she states that she has been coughing for the last two weeks and she is short of breath. She experiences dyspnoea when she walks 500 m. She also reports that she has a sharp pain in the chest. This has been present for the last two weeks.

On examination she is found to have ++ oedema. She does not have palpitations. Her B.P. is 100/65 mm Hg and her heart rate is 80 per minute. Liver and spleen are not enlarged. Breath sounds are equal. Auscultation of her heart reveals S1✓ S2✓ with systolic murmur.

Abdominal palpation reveals a pregnancy that is consistent with the period of gestation.
Julia is to be considered for the AZT trial.

Suggested approach

1. Analyse the above scenario.
2. Identify further information which you may require.
3. Suggest a plan of management for Julia's immediate health status.
4. Discuss ethical issues which relate to her history.
5. Suggest a plan of management for the remainder of her pregnancy.
6. Identify members of the health team who may be significant in the management of Julia's pregnancy.
7. Speak to a pregnant cardiac patient.
8. Seek information from health professionals who have expertise in related fields.
9. Consult literature from journals.

Key concepts which should be identified

Effects of pregnancy on cardiac status

Pharmacology and effects on the foetus

HIV - ethical considerations

Pneumonia

Care of the cardiac patient during pregnancy

Biophysical tests which may be required:

- chest x-ray
- sonar
- echogram
- urea and electrolytes
- full blood count
- blood culture
- sputum for culture

Scope of practice of the registered midwife - referral

Skills which are required in relation to the above scenario:

Interviewing and counselling skills

Ability to measure and record blood pressure and pulse accurately

Ability to auscultate heart and lungs

Ability to palpate abdomen

Ability to administer and control medication

Communication skills - members of the interdisciplinary team involved in care

Ability to provide appropriate health information

Ability to perform a non-stress test

Facilitator's notes

In relation to the themes, the facilitator must probe and ensure that the following concepts are raised in the discussion:

Nursing\midwifery - assessment and care of the woman; assessment and care of the neonate. Students should probe for results of x-ray, blood results, because Julia in fact has pneumonia and requires active management with antibiotics.

Communication - health information through effective communication; awareness of patient's non-verbal communication for evidence of anxiety; communication with the family in relation to patient's health status.

Teach\learn - ability to identify own learning needs; ability to teach the patient about her condition, the clinical manifestations of the condition and the possible outcomes of the condition. Ability to assess own learning and patient's understanding of the condition.

Growth\development - influence of the condition on the growth and development of the foetus, measures of foetal well being. Possibility of intra-uterine growth retardation in response to maternal condition

Health determinants - culture, social habits, age, parity, nutrition, economic status.

Professionalism - scope of practice of the registered midwife; rules and regulations governing the practice of the registered midwife. Transcultural care. Ethical aspects related to the problem.

Health care systems - referral from primary health care to secondary care; referral to an obstetrician.

Assessment for a problem\ s related to a complicated pregnancy

Motivation for possible methods of student assessment are as above. However, in this instance an appropriate method of assessment would be a research based essay, e.g.

Write an essay on the most common complications of pregnancy which are encountered in your community.

Your essay should demonstrate evidence of research, i.e. you should refer to statistics and recent journal articles. You should state how you identified the most prevalent conditions. You should state the implications of these conditions and their effects on the pregnancy and what this means for your nursing care. Describe the interventions which the nurse-midwife could implement in order to prevent or to limit the consequences of these conditions. You may illustrate your essay with your own experiences of women you may have nursed with these problems.

An alternate method of assessment for this package would be a triple jump. Students could be shown a video. The video could portray a registered nurse-midwife examining a antenatal client who she suspects is presenting with pre-eclamptic toxaemia. In the video the nurse-midwife would be shown measuring the blood pressure, assessing for oedema and asking questions relating to the occurrence of headaches, epigastric pain and blurring of vision. The

students would be required to state a provisional diagnosis and ask for further information. In the final stage students would be required to write an essay related to the management of this client for the remainder of her pregnancy. The essay should include possible complications that this client could develop, e.g. intra-uterine growth retardation and / or abruptio placenta, and how the nurse-midwife would monitor for their occurrence.

A skill which could be assessed in this package is the determination of foetal well-being. This could include carrying out a non-stress test. Again the student should be allowed to book a date for the assessment when she feels competent to be assessed. The assessment should be comprehensive, in that the student should be able to justify the reasons for performing such a test, be able to interpret the result and relate the procedure to the woman's comprehensive care.

LEARNING PACKAGE FOR WOMEN'S HEALTH II - NOT RELATED TO PREGNANCY

An alternate means of presenting this package could be through the use of statistics for relevant conditions for the country or the province. Presenting the trigger material in such a manner would have the added advantage that it would create an awareness in the students of the value and use of statistics in health care as well teaching / learning interpretation thereof.

Mary Long

Mary Long has had a "Pap" smear done at the primary health clinic where you are working as a registered nurse-midwife. She is devastated by the results. The results reveal a cervical intraepithelial neoplasia type III. She says that she "doesn't really know what this means, but I know that it's bad news."

Suggested approach

1. Analyse the above scenario.

2. Identify key concepts.
3. Identify issues related to these concepts.
4. Discuss how you will access this information.
5. Identify further information you would require from Mary Long in order to be able to explain her condition to her.
6. Describe methods of management of her condition which may be considered for Mary Long. Explain the factors which may influence the choice of treatment for her.
7. Describe the impact which this condition may have on the health care services.

Key concepts which should be identified

Papanicolaou smear - analysis of cervical cells for abnormalities

Classification of stages of carcinoma of the cervix

Primary factors in aetiology of the disease

- age at first coitus
- age at first pregnancy
- number of sexual partners
- marital status

Secondary factors in the aetiology of the disease

- nutrition and diet
- culture and religion
- sexually transmitted diseases
- circumcision
- socio-economic status
- sperm and the possibility of high risk male
- geographic distribution
- hormones and the use of oral contraceptives
- social habits, e.g. smoking.

Treatment modalities

- carbon dioxide laser
- surgery - hysterectomy \ pelvic clearance
- chemotherapy

Psycho-social care of the client

Skills related to the scenario:

Inter-personal skills

Communication and interviewing skills

Crisis intervention

Health information

Decision making skills

Examination of the cervix and ability to take a cervical smear. Handling of the specimen.

Pre and post operative care

Care of the woman receiving chemotherapy

Support measures and promotion of rehabilitation

Ability to apply measures which serve to prevent the condition, viz. health promotion and cervical screening

Resources

Staff in the gynaecology clinic and ward

Gynaecologists

Visit the histology laboratory

Part II

Mary Long returns to the primary health care clinic three months later. She has come to see you and to tell you that she underwent a hysterectomy two and a half months ago. She is feeling well and is relieved to know that there was no evidence of spread of the abnormal

cells. She has really come to ask you whether there are any support groups for women such as herself in the community. You tell her that you are not aware of any for women who have had or have carcinoma of the cervix. There is a group for women who have had a mastectomy. The group is called "Reach for Recovery". She tells you that her experience was "awful". Her husband was not supportive and couldn't understand why she was "making such a fuss about getting rid of her womb." She wonders whether she couldn't help other women who may be going through something similar. The two of you discuss the possibility of staring a support group for women who have had hysterectomies, or who have carcinoma of the cervix.

Suggested Approach

1. Analyse the above scenario.
2. Identify key concepts.
3. Identify issues related to these concepts.
4. Suggest ways in which this discussion could be taken further.
5. Identify further information you would require and how you could obtain this information.

Key concepts which should be identified

psycho-social implications of hysterectomy
counselling
possibility of post-operative depression
use and value of community support groups
organization of support groups
need for rehabilitative measures.

Skills related to the scenario:
interpersonal skills
communication and interviewing skills

decision making skills.

Facilitator's notes

In relation to the themes, the themes, the facilitator must probe and ensure that the following concepts are raised in the discussion:

nursing / midwifery - caring in relation to a woman diagnosed with a malignant condition.

communication - assess verbal and non-verbal communication. Determine whether the woman has a support structure. Determine her coping methods.

teach / learn - ability to identify own learning needs, ability to explain the condition, its implications and methods of treatment to the woman.

growth and development - progression / regression of the disease. Impact of the condition on the body.

health determinants and issues - carcinoma of the cervix is a health priority for the country's health care plan. Lifestyle and its relationship to the disease.

profession - scope of practice of the registered nurse-midwife. Transcultural care.

health care systems - policy with regard to routine Papanicolaou smears and screening. Health informatics and carcinoma registers. Methods of referral.

Assessment

The cognitive aspects of this package could be tested through multiple choice questions. However, decision making and critical thinking abilities would be better evaluated through a modified essay question.

Modified essay question for carcinoma of the cervix

Martha Mazibuko is a 46 year old woman who is diagnosed as having stage II carcinoma of the cervix he is a known hypertensive and is on medication for this problem. Her obstetrical history reveals that she is a para 4 gravida 6.
Martha Mazibuko is referred to the district hospital from the community clinic.

1. Explain the factors in her history which are consistent with the aetiology of the disease.
2. What may be the effect of these occurrences on her hypertension?
3. Identify the factors which will be considered in choosing the most appropriate treatment for her.
4. What would you consider to be her most important needs on admission to the hospital? Describe how you attempt to meet these needs.
5. Martha Mazibuko is advised to have a pelvic clearance. Describe the impact which this advice may have on her socially and culturally.
6. Post-operatively, Martha Mazibuko returns for chemotherapy. Describe the chemotherapy regime used in such instances.
7. Describe nursing interventions you would implement in the care of these women.

Skills which could be assessed in this package could include the complete physical assessment of the woman. This could include the ability to perform a vaginal examination and to visualise the cervix.

7.12 IMPLEMENTATION OF THE LEARNING PACKAGES

The learning packages will be implemented through the use of small group discussion. The size of the groups will vary from nine to fifteen students. The learning problem or situation will be managed in the groups using the seven jump procedure described in chapter two (vide p 22). Students will be encouraged to access information from inter alia, textbooks, journals

and clinical experts. Credit will be given to students who optimise the use of learning resources other than textbooks.

Learning packages will vary in their length, i.e. some will be dealt with in two weeks, while others will require several weeks. Tutorial sessions will last three to four hours, once a week. The session will be used for discussion, further study and core lectures. Students may bring to the session items which they have found relevant to the problem, e.g. magazine articles, pamphlets or video cassettes.

Practical learning experiences will begin at the beginning of the course as students will be encouraged to include practical learning experiences in the process of working through the learning package. Formal hospital and community experiences will extend over six months, beginning at the end of the third year of study, so that three months will be in the third year of study and three in the fourth year of study. This offers opportunity to consolidate the practica, but still complies with requirements of the South African Nursing Council, that the course shall extend over two years of study. Credit will be given for any practical or community experience which the student initiates in the course of his / her learning.

7.13 CONCLUSION

In this chapter the curriculum approach and model for courses in women's health were described. Considerations which impact on the curriculum development were explained. The philosophy of the department and for the course are included. The programme and course goals are described. Means of achieving these goals are illustrated through the learning packages which are included. The results of a peer group evaluation of the conceptual framework and the curriculum models are described.

CHAPTER EIGHT

A SERIES OF REFLECTIONS

Your joy is your sorrow unmasked.
(Gibran 1997:36)

This chapter presents the summary, limitations, recommendations and conclusions in a series of reflections. Guba (Bailey 1997:18) states that "any process of formal inquiry is said to be guided by a set of 'basic beliefs'." These reflections have become the lived experiences of the researcher.

8.1 Reflections on the past

This study evolved over a period of five years. During this period of time four stages can be identified. (Vide figure 1.1 p 11).

Stage one. This was a stage of concept clarification, identification of the context and describing and defining the problem. During this stage the researcher was a learner in the fields of problem-based learning, community-based education and qualitative research. To meet her learning needs she attended a workshop in Egypt on community-based education and problem-based learning. She also visited schools of nursing in Canada and Australia which utilise this teaching approach. The literature was reviewed for problem-based learning, community-based education and curriculum evaluation. Stakeholders in the curriculum who needed to be included in the research were identified and this led to the concept of a combined qualitative / quantitative approach. This stage concluded with the problem being established, aims and objectives of the study were identified and a possible approach to analysis beginning to formulate, resulting in the development of the conceptual framework.

Stage two. In this stage the methodology was formulated. Methods of data collection were selected within the qualitative / quantitative approach. This was a stage of preparation with the necessary consents being sought and acquired. Pilot studies were conducted for the quantitative data. Review of the literature and discussions with experts in the fields guided this stage. This stage extended over a period of approximately one year.

Stage three. This stage extended over a period of four years. It was the period of data collection and analysis. Review of the literature was on-going.

Stage four. This stage extended over a period of two years. It focused on collation of the data and the literature into a meaningful report. The main objective of the study - to develop a curriculum for women's health - was achieved in the development of a curriculum approach, a curriculum model and examples of means of implementation. The implications of the study and the recommended curriculum were submitted for peer review and critique.

In reflecting on these stages, the following aspects of the study come to mind:
Stage one. This was an exciting period of self-directed learning, as the researcher strove to learn more about the key concepts of the study. The opportunity to critically evaluate the possibility of transposing these concepts to the South African nursing context led to the reading of innovative and inspiring stories from nurse educators across the world. During this stage the researcher was struck by the similarity of our problems, despite our diversities in culture and language! A strength of this stage of the study was the opportunity to meet and to have dialogue with educators who had experience in the use of problem-based learning. In the evolution of the conceptual framework, the researcher was struck by the close affiliation which appears to exist between a nursing framework and an educational model. It was apparent that in meeting the needs of nursing, the concepts of an educational model may guide the content of a nursing curriculum. This emphasises the need for nurse educators to have a broader understanding of teaching and learning than the narrow confines of nursing education.

Stage two. Using a selection of the stakeholders in a women's health curriculum allowed opportunity for the curriculum to be evaluated from different perspectives and experiences. Cross analysis of the viewpoints provided opportunity to validate the data through the comparison of experiences. The quantitative / qualitative approach proved to be a useful strategy. The focus groups gave respondents opportunity to express themselves freely, out of the confines of the quantitative data collection methods. Conversely, the structured methods, facilitated the collection of data from women who could not express themselves clearly. It furthermore enabled the researcher to obtain information on the specific areas which she required.

Stage three. This was the period of data collection and like many researchers in this stage of the study, the researcher experienced periods of frustration. Reflection on this stage brings to mind the four parts which formed the study, viz. the environment, the registered midwife, the curriculum and the outcome.

Reflections of the environment. During this part of the study women were interviewed in two settings - the hospital setting and the community setting. Interviewing the women in the hospital setting required the use of a research assistant. While this did overcome the communication difficulties, there were instances where greater probing of responses would have been useful. These instances were not recognised by the assistant because she was not a nurse. However, if she had of been a nurse, the women may not have spoken as freely as they did to her. When reporting back daily to the researcher, she often made reference to "stories" that the women had told her. Very often these related to care. The interviews were carried out conscientiously and the research assistant appeared to be committed to the study because it was an attempt to do something about the care of women. Reflection brings to mind a greater limitation in this part of the study, viz. that the structure of some of the questions did not test knowledge or understanding, e.g. question 16 asks whether health information was given after delivery. Answers required only "yes" or "no". Given the high positive response rate to the question, it would have been useful to have assessed understanding of the

information given. A limitation in this aspect of the study is that only women in the maternity unit of the hospital were interviewed. It may have been useful to interview a sample of women in the medical and surgical units of the hospital. However, this aspect can be addressed through further research.

Interviewing women in the community focus groups gave women opportunity to express their opinions freely - and this many of them did. Women shared their experiences and told their stories with a range of feelings and emotions. This may have been facilitated by the neutrality of the environment in which the groups were conducted, e.g. church halls. For the researcher the groups provided opportunity for her to become a researcher-as-learner. The researcher became aware how inappropriate and useless our health information is for so many of these women. While many of these women have rich experiences to share, the limitation of this part of the study related to the women's inabilities to express themselves clearly in English. The researcher made extensive use of reflection and clarification in an attempt to overcome this drawback. The requests for information and teaching and the references to care stand out as the major highlights of the discussions.

Reflections of the registered midwife This part of the study revealed in some measure the state of nursing. The midwife appears to be lacking in job satisfaction, in some instances dissatisfied with the care that she is rendering and low in self-esteem. While she acknowledges her teaching responsibilities, she does not appear to be enthusiastic about this aspect of her work.

Reflections on the curriculum Students appeared to answer both sets of questionnaires honestly. In the first questionnaire that was distributed to the entire student body, this was evidenced by the use of names of teachers. This applied to both positive and negative comments. In the questionnaire given to the final year students, students described both the positive and negative learning opportunities. Their use of words to describe these experiences suggest that they have been honest and frank in their responses. An aspect which could have

received greater attention in the initial questionnaire was the need for a women's health curriculum. At the time that this questionnaire was being developed the concept of a women's health curriculum had not fully evolved. A limitation of this part of the study is that the small student numbers do not allow for statistical analysis.

Reflections on the outcome This part of the study consisted of two parts - the focus groups with past graduands and the focus group with nursing supervisors.
Reflection of the groups with the graduands brings to mind how willing they were to participate in the study. This willingness was evident in the discussions, where graduands described their experiences and related them to their teaching and learning. Aspects of their needs e.g. culture had been discussed in lectures, but it became evident that the emphasis on these concepts had suggested the "nice to know" and they had not seen the relevance of them to nursing practice. The small size of the focus groups may be a limitation. A larger group may have generated a wider range of discussion about curriculum content and implementation.

Reflection of the groups with the nursing supervisors supports the feelings generated by the questionnaires given to the registered midwives. The groups appear to reveal the state of nursing. The understanding of the role of the student and her needs, the meaning of holistic care and the lack of empowerment of the midwife are aspects which stand out as highlights from these discussions.

Stage four. This stage was a period of "bringing it all together." This was not an easy stage. The researcher had great difficulty in being creative and using her "new" self-directed knowledge. This was frustrating. As she reflected on her inability, childhood memories stirred. The researcher had been known to have an imagination as a child. What had happened to this? and why couldn't she draw on this ability. Reflection allowed her to recognise what formal education and learning had done to this quality. When last had it really been used? When had it really been encouraged during the years of learning to be a nurse and midwife,

and more recently a nurse educator? It was not easy "to let go" and to draw on techniques which do not appear to fit in "scientific" education. Furthermore, she also realised that she had always used an interactive teaching strategy in her lecturing. She had always told stories from her experiences. This was a strength from the past and needed to be kept, but had to be extended to encourage students to tell their stories as well. Once this was recognised, it became easier - the role of teacher-as-learner was beginning to form!

On reflecting on this period of curriculum development the researcher recognised the constraints imposed on her by the regulating body. Its regulations are so prescriptive that they preclude the development of a more comprehensive curriculum for women's health. In trying to meet the regulations relating to pregnancy, labour and the puerperium the curriculum becomes weighted towards the childbearing woman. Curriculum overload would result if the curriculum were to do justice to all the other issues relating to women's health. This limitation needs to be further addressed.

A final reflection on this period is that to the researcher's knowledge this study forms a body of new knowledge. It is the first attempt at a curriculum which attempts to bring issues in women's health into one discipline for undergraduate nursing students in this country.

8.2 Reflections on the future

As the researcher reflects on the future, it is evident from the study that reflections relate to practice, action and teaching / learning. These will be considered separately.

8.2.1 Reflections for practice

The need to produce caring, thinking practitioners who are capable of taking care of their own learning needs is necessary if they are to take care of the lives of others. This is not being facilitated through role-modelling. Nurses and midwives need to be made aware of the perceptions that the community have of the image which they portray. Nursing practice needs to be re-focused so that caring is put back into nursing. Nurses and midwives need to be made

aware of actions that constitute the meaning of caring to women. Nurses and midwives need to be encouraged to reflect on their own care - to analyse their actions and responses. A means to achieving this may be support groups or audits of quality of care. Registered nurses and midwives need to participate more actively in the teaching of students. They should be involved in more than the bedside teaching of students.

In teaching situations, students need to be supported and recognised as learners. Practise areas need to become areas which foster the promotion of learning and information for both the student and the woman. Graduands should be encouraged to continue to participate in the programme as teacher-learners and to teach from their learner-learner experiences. Nurses and midwives need to consider their own skills and knowledge and review these in the light of the demands made on the practitioner in primary care settings. Furthermore, they need to appreciate the opportunity for learning that the learner does experience in these settings. An attempt needs to made to re-focus the position of hospital-based care. There appears to be an attitude that it is only in hospital settings that quality care is possible and where learning can take place.

8.2.2 Reflections for action

This led the researcher to reflect on the four parts of the study and to consider areas which require further research.

Environment - further research needs to be done to determine the actual knowledge of women regarding information given. Studies should probe the information which has been given through either pre and post information "tests", or by simple question and answer type of assessment. This aspect is important given the diversity of cultures and languages. Research in this area should also seek to determine methods of information dissemination that are the most acceptable to women, e.g. workshops, demonstrations, use of models or audio-visual talks. Women in this study asked for the use of models and charts to illustrate concepts relevant to the talk. Ongoing research needs to be done to determine the changes related to health care needs, e.g. the incidence of the number of women testing positive for HIV is increasing monthly and this will influence the disease patterns of the future. Women will be

succumbing to different diseases at an earlier age and this will shift the morbidity and mortality patterns. Thus, the demands made on nursing for care will change and unless nursing practice moves with these changes, needs will not be met.

Registered midwife - nurses and midwives need to become more research-orientated in their thinking and in their practice. They need to be encouraged to take action to improve their own working situations. It would appear that they allow policies to be imposed on them. They should be part of the policy-making decisions and should be encouraged to do so through research-based enquiry. Further research is necessary to validate this impression.

Curriculum - the "new" paradigm needs to be evaluated to facilitate ongoing curriculum planning and implementation. Nurse educators need to reflect on what they are doing, evaluate the impact of the differences, keep what is good and worthwhile and change what is not meaningful. In the process of evaluation it is essential that all the stakeholders are considered. Community-based education calls for intersectoral research. Thus students and experts across the disciplines should plan research which could be meaningful to the community. In this way the community can benefit and students can learn the science of research. The researcher plans to modify the appropriate sections of the questionnaire given to the final year students and administer it to the first group of students completing a problem-based learning curriculum at the end of 1998. This will allow a comparative study to be made of students in a traditional curriculum with those in the "new" curriculum. Six months after graduation, the researcher plans to hold a focus group with students who are graduating in 1998. Further research which needs to be undertaken is into the development of critical thinking skills. A longitudinal study will be planned to assess the development of these skills over the four years of study.

Outcome - graduands of the programme should be encouraged to maintain contact with their teachers and feedback strengths and weaknesses of their programme. Teachers need to monitor graduands progress by communicating with nurse managers. Teachers need to evaluate and monitor outcome standards through ongoing research, reflection and dialogue.

8.2.3 Reflections for teaching / learning.

Both teachers and learners need to adopt a philosophy of continuous learning. The world around us is changing rapidly and both need to be aware of changes that are brought about through new knowledge. The knowledge explosion is so great that teachers and learners need to find new ways to access the information. Currently, this means the ability to utilise the information technology. However, this is not sufficient, for one cannot absorb it all - nor is it necessary to do so. Teachers and learners need to be able to choose the information they want and that they need. This requires critical thinking within the realm of self-directed learning. Given the above, another guide to teaching and learning, is relevancy of information. Learning should be relevant to the context in which practitioners work. In the developing countries, teaching needs to be for that country and not for the first world. Likewise, students need to be encouraged to further their education in their own countries and not in countries that are highly technical and whose communities have very different needs from the those of their own countries. This means that educators need to be creative in their teaching styles and in their approach to content, so that students study in their home countries and are enabled to utilise their learning to maximum effect on completion of their formal studies. This process can be facilitated by developing contacts with women in the community so that students gain understanding of the specific needs of the women. They would also benefit from attending women's groups where other issues relevant to women's health are debated and discussed, for example literacy classes. The need to teach and learn with experts and learners from other disciplines is another strategy that will enable learning within the knowledge explosion. At the same time this approach can only benefit the service offered to the community. Currently the community is a victim of specialisation, as individuals and families are referred from one care-giver to another, with little or no coordination of care given. Intersectoral teaching and learning can also benefit team work as we learn the roles and functions of others and hence again quality of care may be improved as we learn to draw on the expertise and skills of others. Thus the development of primary health care teaching sites where women's health is managed comprehensively would greatly enhance the teaching / learning process. Such sites would also enable the teaching of aspects of women's health

across the lifespan, whilst being sensitive to the changing needs of the women in the community.

8.3 Conclusion

The objectives of this study were to:

1. design a curriculum model for women's health, with emphasis on the childbearing woman, utilising the concepts of community-based education and problem-based learning.
2. develop problem-based learning packages for a woman's health curriculum and in particular for the childbearing woman.
3. develop a conceptual framework for the curriculum evaluation and development processes.
4. assess the needs of the women in the community, by:

4.1 describing the perceptions of women in hospital and community settings;

4.2 identifying the perceptions of midwives regarding the needs of childbearing women and their role and function in that regard;

5. describe students' perceptions of the current curriculum, by

5.1 determining the perceptions of students currently in the curriculum;

5.2 determining the perceptions of graduands regarding their preparedness for midwifery practice on completion of their degree;

6. obtain the perceptions of nursing supervisors regarding the midwifery curriculum and the beginning midwifery practitioner.

Thus the objectives of the study have been met and it has been shown that a curriculum utilising problem-based learning and community-based education can be implemented in a curriculum for women's health for the teaching of nursing students in a Baccalaureate programme.

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THE DEVELOPMENT OF A COMMUNITY-BASED, PROBLEM-BASED LEARNING CURRICULUM IN THE UNDERGRADUATE DEGREE IN NURSING WITH SPECIAL EMPHASIS ON THE CHILD-BEARING WOMEN IN WOMAN'S HEALTH.

Patricia Anne-Marie Mc Inerney

A thesis submitted to the Faculty of Health Sciences, University of the Witwatersrand, in fulfilment of the requirements for the degree of

Doctor of Philosophy

Johannesburg, 1998.

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ANNEXURE A

University of Limburg, the Netherlands

The "Seven Jump"

1. Clarify terms and concepts in the problem description unknown to you
2. Define the problem. That is: list the phenomena to be explained
3. Explain the problem; try to produce as many different explanations for the phenomena as you can think of. Use prior knowledge and common sense
4. Arrange the explanations proposed; try to produce a coherent description of the processes that, according to what you think, underlie the phenomena
5. Formulate learning goals
6. Attempt to fill the gaps in your knowledge through individual study
7. Share your findings with your group and try to integrate the knowledge acquired into a comprehensive explanation for the phenomena. Check whether you know enough

ANNEXURE B

INTERVIEW SCHEDULE TO DETERMINE THE PERCEIVED NEEDS OF PREGNANT WOMEN DURING PREGNANCY, LABOUR AND THE PUERPERIUM.

HOSPITAL CLASSIFICATION:
DEMOGRAPHIC DATA:

1. AGE

12 - 14	
15 - 17	
18 - 21	
22 - 24	
25 - 27	
28 - 31	
32 - 34	
35 - 37	
38 - 41	
42 and more	

2. Is this pregnancy your

first	
second	
third	
fourth	
fifth	
sixth	
more than six	

3. Is this baby your

first	
second	
third	
fourth	
fifth	
more than five	

3.1 Are they

alive	
dead	
cause of death	

PREGNANCY DATA:

(you may answer to more than one)
4. Where did you have your previous baby\ies

4.1 at this hospital	
4.2 another maternity hospital	
4.3 at home	
4.4 a clinic	
4.5 not applicable (first baby)	
4.6 other please specify	

5. Why have you chosen to have your baby at this hospital?

5.1 How many weeks pregnant were you when you booked into the clinic?

6. What care did you expect to be given during your pregnancy?

7. During your pregnancy did you feel that you were given sufficient information regarding the following:-

	yes	no
7.1 your physical condition		
7.1.1 your emotional health		
7.2 your baby's condition		
7.3 danger signs of pregnancy		
7.4 breastfeeding		
7.5 signs of labour		
7.6 what to expect during labour		
7.7 preparation for labour		
7.8 your choices during labour		
7.9 your diet		
7.10 sexual needs and responses		
7.11 development of the baby and birth defects		
7.12 personal hygiene (e.g. are baths safe)		
7.13 emotional changes and stress		
7.14 Aids virus and other infections and how they can affect the baby		
7.15 parenting - how to cope with being a mother		
7.16 caring for your baby		
7.17 social services for pregnant women e.g. maternity benefits \ free services		

7.2 Did you understand the information that was given to you?

yes	
no	

8. Did you attend ante-natal classes?

yes	
no	

8.1 If yes, how many classes did you attend?

8.2 Which class did you attend?

8.2.1 on the day of your clinic visit	
8.2.2 Monday evening	
8.2.3 Wednesday afternoon	

8.3 Were these times suitable for you?

yes	
no	

If not, what would have been the most suitable tome for you?

8.4 Did you find these classes helpful \ useful?

yes	
no	

Please describe aspects of care that were good and aspects that could be improved.

9. What kind of care did you expect to be given during labour?

10. During labour, what did the midwife do or say that was helpful?

11. During labour, what did the midwife do or say that was unhelpful?

12. What could have been done that you think would have been more helpful?

13. With reference to your labour, were the following aspects met in the care you were given:-

	yes	no
13.1 pain relief		
13.2 support and comfort from midwife		
13.3 support and comfort from companion		
13.4 respect for culture		
13.5 respect for you as a person		
13.6 respect for your labour requests		
13.7 information about progress of labour		

14. After the birth of your baby, what care did you expect to be given?

15. How are you feeding your baby?

15.1 breastfeeding	
15.2 bottle-feeding	
15.3 combination of both	

16. Were you given health information in the following aspects:-

	yes	no
16.1 breast care		
16.2 vaginal discharge		
16.3 hygiene needs		
16.4 sexual needs		
16.5 burning on micturition		
16.6 bowels		
16.7 pain in the legs		
16.8 breastfeeding		
16.9 care of bottles\ bottle-feeding		
16.10 baby bathing \hygiene		
16.11 nappy changing \ stools		
16.12 immunization		
16.13 registration of birth		
16.14 danger signs - self		
16.15 danger signs - baby		
16.16 well baby clinics		
16.17 post-natal support groups		

17. To what extent were your expectations met:-

17.1 During pregnancy

17.1.1 completely	
17.1.2 almost completely	
17.1.3 hardly at all	
17.1.4 not at all	
please comment	

17.2 During labour

17.1.1 completely	
17.1.2 almost completely	
17.1.3 hardly at all	
17.1.4 not at all	
please comment	

17.3 After delivery

17.1.1 completely	
17.1.2 almost completely	
17.1.3 hardly at all	
17.1.4 not at all	
please comment	

18.1 If you could have had your baby anywhere, which would you have chosen?

18.1.1 at home with a midwife	
18.1.2 another hospital	
18.1.3 at home with a traditional birth attendant	
18.1.4 community clinic	
18.1.5 this hospital	
18.1.6 other please specify	

18.2 Please give reasons for your preference.

19. Is there anything that we could have done to improve the care that you have had?

Thank you for taking time to answer these questions.

UHLELO NEMIBUZO NOKU NQUMA KWEZIDINGO ZABE SIFAZANE ABAKHULELEWE BENGAKA BELETHI NOMA BESAKHULELWE SEBEZOBELETHA.

UHLELO KWASESIBHEDLELA:
UMNININGWANE OWAZIWAYO:
1. Ubudala \ iminyaka

12 - 14	
15 - 17	
18 - 21	
22 - 24	
25 - 27	
28 - 31	
32 - 34	
35 - 37	
38 - 41	
42 kuya phezulu	

2.Lokukhulelwa kwakho okwesingaki (noma unamasu kmangaki)

okokuqala	
okwesibili	
okwesithathu	
okwesine	
okwesihlanu	
okwesithupha	
noma ngaphezulu	

3. Lomtwana nqowesingaki

ngowokuqala	
ngowesibili	
ngowesithathu	
ngowesine	
ngowesihlanu	
noma ngaphezulu kwesihlanu	

3.1 Ubathola

Bephila	
Noma sebeshonile	
Into edala ukuthi bashone	

UMNININGWANE OWAZIWAYO NGOKUKHULEIWA
(Ungaphendula izimpendulo eziningi)

4. Wamutholelaphi umtwana wakho noma ubelethelaphi abantwana bakho

4.1 kulesi isibhedlela
4.2 noma kwesinye isibhedlela sokubelethela
4.3 ekhaya
4.4 emtholampilo
4.5 yingane yokuqala
4.6 abanye chaza

5. Yini edale ukuthi uzobelethe la kulesibhedlela

5.1 Ngesikhathi uzofuna indawo kumtholampilo wawuna masonto amangaki na?

6. Ububheke impatho enjani ngesikhathi ukhulelwe na?

7. Ngesi khathi ukhulelwe ucabanga ukuthi bakunika imininingwane eyanele naqondana naloku okulandeyo :

	yebo	cha
7.1 isimo sempilo yakho 7.1.1 babekuzwela ngempilo yakho		
7.2 isimo somtwana		
7.3 izimpanu zobungozi usakhulelwe		
7.4 ukuncelisa		
7.5 impawu zomusiko		
7.6 wawubhekeni ngesikhathi sezinseka		
7.7 wazilungisela kanjani ngesikhathi sezinseka		
7.8 wakhethani ngesikhathi usikwa\ izinseka		
7.9 wake wa nikezwa imininingwane ngo kudla		
7.10 wezanjani kwezochansi kanye nempendulo		
7.11 ukukhula komtwana osezelwe		
7.12 ukuhlanzeka ngokwakho (njengokugeza umtwana okuphephile)		
7.13 ukuzizwa uphansi emoyeni unama (moods) nokuxineka		
7.14 izifo ezithathelwanayo njenge AIDS nezinye ezithathelwanayo zinga ngena kanjani emtwaneni		
7.15 umzali - ungaziphatha kanjani njengomama		
7.16 ekuphatheni umtwana		
7.17 ukuthola ulwazi lokulashwa mahala kwabantu abakhulelwe nolwazi mayelana nemali etholakala uma ungasasebenzi (UIF)		

7.2 Uyakuzwisisa loku esikwazisangako?

yebo	
cha	

8. Uyaya kwizifundo zaba khulelwe?

yebo	
cha	

8.1 Uma uya, usuyekwizifundo ezingaki? njengoba ukhulelwenje.

8.2 Waya kwiziphi izifundo?

8.2.1 Ngosuku oyangalo emtholapho	
8.2.2 ngomsombuluko ebusuku \ ekuseni	
8.2.3 ngolwesithathu ntambama	

8.3 Lezikhathi ziyavumelana nawe?

yebo	
cha	

Uma ungalitholi ithuba isiphi isikhathi esikulungele wena na?

8.4 Uzithola ziwusizo lezifundo?

yebo	
cha	

Wena ngokwakho ufuna senzenjani yiza no mbono wakho

9. Isikhathi isokubeletha sinzima uzwa nenhlungu ungathanda wena uphathwe kanjani na?

10 Lona owayekusiza ubeletha unesi washo, wenza okulusizo kuwena?

11. Bakusho onesi ababelethisayo noma bakwenza okungelona usizo kuwena.

12. Nifuna yi phi impatho, eyonisiza uma nizothola abantwana, ngethuba elilandelayo?

13. Yiluphi usizo oludingayo uma usiykwa, lokhu okulandelayo kuzozwana nempatho yenu?

	yebo	cha
13.1 ukwhliswa kwezinhlungu		
13.2 usizo lukanesi obelethisayo		
13.3 usizo lomyeni wakho		
13.4 ukuhlonipha amasiko emvelo		
13.5 ukuhlonishwa wena njengo muntu chaza kabanzi ngalokho		
13.6 uzome leukuzihloniphe uma uzwa zinhlungu zomtwana ozayo noma kungelula		
13.7 ulwazi olu banzi ngokuqhubeka kwezinhlungu zokufika komtwana		

14. Uma umtwana esekhona, ufuna impatho enjani kuwe amele uyithole?

15. Umnika kanjani ukudla umtwa na wakhona?

15.1 uyamuncelisa ebelenilakho	
15.2 noma umupha ubisi lwebhodiela	
15.3 noma ukusebenzisa kokubili	

16. Wathola ulwazi olubanzi ngempilo ngaloku okulandelayo ?

	yebo	cha
16.1 ukuthi ungawagcina kanjani amabele ehlanzekile		
16.2 nokuphuma ngaphambili \entombazaneni		
16.3 inhlazeko eyanele efunekayo kuwena		
16.4 uma ulalanowesilisa		
16.5 nokushisa komchamo		
16.6 nokuqhunjelwa		
16.7 ukuqhaqhamba kwemilenze		
16.8 ngokuncelisa ngebele lobisi luka mama		
16.9 amabhodlela agcinwa kanjani\ ehlanzekile okupha umtwana ubisi		
16.10 umtwana ugezwa kanjani\ ngokwempilo		
16.11 ukushintshwa kwamanapakeli omtwana\ uma ekakile		
16.12 ukugonywa		
16.13 ukubhaliswa komtwana emabhukwini kahulumeni		
16.14 izimpawu eziyingozi - kuwe		
16.15 izimpawu eziyigozi- kumtwana		
16.16 umtwana makasiwe emtho lampilo ngezinsuku ezikhethiwe		
16.17 abakusiza uma usuthole umtwana		

17. Wawubhekeni ngesikhathi uzothola umtwana zafezeka izifiso
17.1 ngesikhathi ukhulelwe

17.1.1 ngokupheleleyo	
17.1.2 cishe kuphelele	
17.1.3 okuncane	
17.1.4 nakunye okwafezeka siza uchaze	

17.2 ngesikhathi usikwa

17.2.1 ngokuphelelelyo	
17.2.2 cishe kuphelele	
17.2.3 okuncane	
17.2.4 nakunye okwafezeka siza uchaze	

17.3 emva kokuthola umtwana

17.3.1 ngokuphelelelyo	
17.3.2 cishe kuphelele	
17.3.3 okuncane	
17.3.4 nakunye okwafezeka siza uchaze	

18.1 Uma ungakhulelwa ungathanda ukuthi umtholelekuphi umntwana?

18.1.1 ekhaya nosizo lomhlengikazi obelethisayo	
18.1.2 kwesinye isibhedlela	
18.1.3 noma usizo lwesangoma noma yimuphinje ophatha amakhambi okushunqisi	
18.1.4 kumtholampilo wesizwe	
18.1.5 kusona lesibhedlela	
18.1.6 okunye siza uchaze	

19. Bungcono buni ongasiza ngabo ukukhuphula izinga lesimo sababelethayo?

Ngiyabonga ngokusebenzisa isikhathi sakho ukuthi uphendule nemibuzo yami.

ANNEXURE C

INFORMATION SHEET FOR INTERVIEWER

Good Morning / Afternoon

My name is Nokwazi Gumbi. I am acting as a research assistant to Trish Mc Inerney, who is collecting information for her research. She is studying for a higher degree. She wants to collect information so that she can educate or prepare students better to meet the needs of women. In order to do this she needs to find out how women experience care that nurses and midwives give them.

Your name has been selected to answer some questions. Would you mind answering them? It will take approximately 20-30 minutes to answer all of the questions. You may refuse. If you do, you will still receive the same care in this ward as if you had answered the questions. If you choose to answer the questions, and then change your mind, you may say so and I will stop asking you the questions. The care given to you will not be influenced by your decision. If you decide to answer all the questions you will be contributing to the care given to women and to the education of student nurses. You are not required to tell me your name and if you do, I will not be writing it on the sheet of paper. Are you willing to answer these questions? (Verbal response / consent obtained.)

ANNEXURE D



Areas in which focus groups were conducted and their relationship to the academic hospital

ANNEXURE E

INFORMATION SHEET FOR FOCUS GROUPS HELD IN THE COMMUNITY

Good Morning / Afternoon

My name is Trish Mc Inerney. I am a senior lecturer in the Department of Nursing Education at the University of the Witwatersrand.

The purpose of this meeting is to collect information for my research. I am studying for a higher degree and am looking at what students in the undergraduate nursing degree should be taught in order to prepare them to meet women's health needs.

The research has shown that a useful way of helping women to meet their health needs is to meet with women in groups. In this way I hope to find out how you have experienced the health services and the health professionals especially the nurses. I am also interested to know what conditions you think women experience most.

Should any of you wish to withdraw from the discussion at any stage, you must please feel free to do so. At no time will your identities be revealed. I do however ask your permission to tape the discussion so that I can analyse it later.

(Verbal permission was obtained from all the group members.)

ANNEXURE F

Nursing Education

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Medical School, 7 York Road · Telegrams 'Witsmed' · Telephone: (011) 488-4272 · Fax: (011) 488-4195
Parktown, Johannesburg 2193

Dear Colleague,

The attached questionnaire forms part of the data being collected in developing a curriculum for students in an undergraduate nursing programme. To facilitate this, the opinions of registered midwives are being sought. The data collected will also be used for the purpose of research for a higher degree.

It would be very much appreciated if you would contribute to this by giving your opinions and thoughts to the questions posed. The questionnaire will take approximately 10 minutes to complete. Your opinions, as expressed in this questionnaire, are anonymous and will remain confidential. Should you wish to withdraw from the study you are free to do so.

Please complete the questionnaire before 8 December 1995 and return to the Charge Sister of the area in which you are working. Should you need clarification about any of the questions, please contact me at Ext 4270 (w) or 442 7008 (h).

Thanking you in anticipation for sharing your opinions and for taking time to answer this questionnaire.

Yours faithfully,

Trish McInerney

The University of the Witwatersrand rejects racism and racial segregation. It is committed to non-discrimination particularly in the constitution of its student body, in the selection and promotion of its staff, and in its administration.

QUESTIONNAIRE TO DETERMINE THE BELIEFS OF MIDWIVES REGARDING NEEDS OF PREGNANT WOMEN AND THEIR PERCEPTIONS OF THEIR ROLES IN MEETING THESE NEEDS.

DEMOGRAPHIC DATA
(please put a "x" in the appropriate square.)
1. AGE

18 - 21	
22 - 25	
26 - 29	
30 - 33	
34 - 37	
38 - 41	
42 - 45	
46 - 49	
50 - 53	
54 - 57	
58 and over	

2. I obtained my midwifery registration through the

2.1	one year diploma	
2.2	three and a half year diploma	
2.3	four year diploma	
2.4	four year degree	
2.5	other	
	please specify	

3. Please state where you obtained your practical midwifery experience as a student.

_____

_____

4.1 I have practised as a registered midwife for

4.1.1	0-3 years	
4.1.2	4-7 years	
4.1.3	8-11 years	
4.1.4	12-15 years	
4.1.5	16-19 years	
4.1.6	20 years or more	

4.2 Where was **most** 0f your experience gained?

4.2.1	hospital practice	
4.2.2	community practice	
4.2.3	clinic practice	
4.2.4	as a private practitioner	

PERCEPTIONS PATIENT NEEDS

5. I perceive the needs of the **pregnant** woman to be

_____

_____

_____

6. I perceive the needs of the woman in **labour** to be

_____

_____

_____

7. I perceive the needs of the woman during the puerperium to be

_____

_____

_____

8. To what extent do you as a midwife believe that these needs are being met? (please put a "x" in the appropriate square.)

8.1 During pregnancy

8.1.1	completely	
8.1.2	almost completely	
8.1.3	hardly at all	
8.1.4	not at all	
	Please comment	

8.2 During labour

8.2.1	completely	
8.2.2	almost completely	
8.2.3	hardly at all	
8.2.4	not at all	
	Please comment	

8.3 During the puerperium

8.3.1	completely	
8.3.2	almost completely	
8.3.3	hardly at all	
8.3.4	not at all	
	Please comment	

PERCEPTION OF THE ROLE AND FUNCTION OF THE MIDWIFE.

9. I believe that the role and function of the midwife includes that of:- (Please rate these in order of importance to you, with one (1) being the most important)

	Importance
9.1 care giver	
9.2 teacher	
9.3 administrator	
9.4 researcher	
9.5 policy maker	
9.6 role model	
9.7 independent practitioner	
9.8 any other roles	
please specify	

10. With regard to the role/function which you regard as being most important, are there any factors which prevent you from fulfilling this role adequately? if so, please state these:

_____ _____

_____

_____

11. With reference to the education of the student midwife, please indicate your awareness of the following:-
(please put a "x" in the appropriate square.)

	Always	almost always	sometimes	never
11.1 year of study				
11.2 knowledge of curriculum				
11.3 teaching responsibility				

12. To what extent do you think midwives can function as change agents, in the following:-

	always	almost always	sometimes	never
12.1 policy making at national level				
12.2 policy making at regional level				
12.3 policy making at local level				

14. Any other comments

Thank you for taking time to answer this questionnaire.

ANNEXURE G

Nursing Education

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3, WITS 2050 South Africa · Telegrams Univits · Telephone: (011) 488-4272 · Fax: (011) 488-4195

Reference: PMcI/dg
Tel No. 488-4270
3 October 1994

Dear Student

The medical faculty is currently evaluating all its undergraduate degrees. In order to do this the opinions of students are needed and therefore we need your help. You are asked to complete the attached questionnaire. You are not required to write your name anywhere. Your replies are confidential and will be treated as such. In order to make this study meaningful and introduce appropriate changes, you are asked to answer the questions as honestly as you can. Please read the questions carefully and make an "X" over the number you choose or in the appropriate box. Some questions require two responses and in others you can mark more than one.

Thank you for participating in this study. We will give feedback when the data has been analysed.

Yours sincerely

B. Robertson

Pat McInerney (Miss)
Senior Lecturer
Department of Nursing Education

The University of the Witwatersrand rejects racism and racial segregation. It is committed to non-discrimination particularly in the constitution of its student body, in the selection and promotion of its staff, and in its administration.

CURRICULAR REVIEW: QUESTIONNAIRE FOR THIRD YEAR STUDENTS.

BIOGRAPHICAL:

1. I am

Male	1	Female	2

2. Year of birth ----------

3. Year of matriculation ----------

4. I was admitted to first year nursing (tick more than one if necessary)

directly from school	1
following some university experience	2
following some college/technikon experience	3
after working for a period	4
after going overseas	5
other	6

5. My home language is English

Yes	1	No	2

6. If you replied no to question 5, please complete this question, otherwise go on to question 7.

I have difficulty with English in the following areas:

	no difficulty 1	some difficulty 2	a great deal of difficulty 3
6.1 understanding lectures			
6.2 talking to others			
6.3 completing written tests/ assignments			

7. I completed the following matric:

Transvaal Education Department	1
Joint Matriculation Board	2
Dept of Education and Training	3
House of Representatives	4
House of Delegates	5
Other Provicial Dodies (Cape, OFS, Tvl., Natal)	6
Other, state which	7

8. My overall symbol in matric was

A	1
B	2
C	3
D	4
E	5

9. List your final symbols for second year in the table below:-

SUBJECT	SYMBOL
Anatomy	1
Physiology	2
Nursing II	3
Community Health Nursing I	4
Microbiology	5

10. Have you failed a year during your nursing curriculum ?

Yes	1	No	2

If so, state which year --------

11. The volume of work in third year is

too little	1	reasonable	2	excessive	3

12. In the table below tick whether you found the volume of work for each subject listed to be:-

	too little 1	reasonable 2	excessive 3
Physics			
Chemistry			
Nursing I			
Psychology I			
Sociology I			
Anatomy			
Physiology			
Nursing II			
Community Health Nursing I			
Microbiology			
Nursing III			
Midwifery			
Psychiatric Nursing I			
Psychology II			
Pharmacology			

13. How relevant was the content (as taught to you), of each of the subjects listed below to the study of nursing?

	extremely relevant 1	somewhat relevant 2	of little relevance 3	of no relevance 4
Physics				
Chemistry				
Nursing I				
Psychology I				
Sociology I				
Anatomy				
Physiology				
Nursing II				
Community Health Nursing I				
Microbiology				
Nursing III				
Midwifery I				
Psychiatric Nursing I				
Psychology II				
Pharmacology				

14. I would have liked more exposure to patients in the first, second and third years of the curriculum

strongly agree	1
agree	2
disagree	3
strongly disagree	4

15. Learning an African language should be a compulsory part of the curriculum

strongly agree	1
agree	2
disagree	3
strongly disagree	4

16. How important do you think communication and interviewing skills are?

very important	1
quite important	2
not very important	3
unimportant	4

17. Irrespective of their importance to you, how much opportunity has there been in the course to learn communication skills?

a lot	1	quite a lot	2	a little	3	hardly any	4

18. How segmented (i.e. into specific subjects) does the course appear to be ?

a lot	1	quite a lot	2	a little	3	not al all	4

19. I have been <u>mainly</u> taught through the following method of instruction (tick one only)

lecture	1
discussion	2
problem solving	3
other	4

Please state which.

20. To what extent are the following methods of assessment used?

	almost all the time 1	most of the time 2	some-times 3	hardly ever 4
20.1 MCQ'S				
20.2 Essays				
20.3 Short answer questions				
20.4 Clinical exams				
20.5 Projects, e.g. case study, research				
20.6 OSCE'S				
20.7 Vivas				

21. Which do you feel are the best methods of assessment? Please state why.

22. Which do you feel are the worst methods of assessment? Please state why.

23.1 Do you think that race influences assessment outcomes?

Yes	1	No	2

23.2 Do you think that gender influences assessment outcomes?

Yes	1	No	2

23.3 Do you think that being a nursing student influences assessment outcomes?

Yes	1	No	2

24. During this year of study I experienced the following problems

Personal problems	1
Poor teaching	2
Poor study methods	3
Financial problems	4
Difficulty with subject matter	5
Sexual harassment	6

25. Please indicate how easy or difficult you found it to cope with the following:-

	very difficult 1	difficult 2	easy 3	very easy 4
25.1 theoretical component of course				
25.2 practical component of course				
25.3 transition from school to first year nursing				
25.4 socially,i.e. making friends, balancing work and recreation				

26. Name the nursing field you intend practising in on completion of your degree

General nursing	1
Midwifery	2
Psychiatric nursing	3
Community nursing	4

27. My home town is in

an urban area	1
a peri-urban area	2
a rural area	3

28. On completion of my degree I intend practising in

an urban area	1
a peri-urban area	2
a rural area	3

Please give reasons.

29. I have found practical nursing experiences (tick two)

useful	1
of no use	2
well supervised	3
need more supervision	4

Any other comments.

30. I have found community health nursing experiences (tick two)

useful	1
of no use	2
well supervised	3
need more supervision	4

Any other comments.

31. I have found midwifery practical experiences (tick two)

useful	1
of no use	2
well supervised	3
need more supervision	4

Any other comments.

32. I have found psychiatric nursing practical experiences

useful	1
of no use	2
well supervised	3
need more supervision	4

Any other comments.

33. What do you regard as the strong points of your current year of study?

34. What do you regard as the weak points of your current year of study ?

35. What were the strong points of your second year of study?

36. What were the weak points of your second year of study?

37. What were the strong points of your first year of study ?

38. What were weak points of your first year of study ?

39. If I could change the B. Nursing curriculum I would

40. I find the staff in the nursing department to be

Thank you for taking time to complete this questionnaire.

ANNEXURE H

Nursing Education

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

• Private Bag 3, WITS 2050 South Africa • Telegrams Univits • Telephone: (011) 488-4272 • Fax: 011-488-4105

Reference: PMcI/dg
Tel No. 488-4270
3 October 1994

Dear Student

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Thank you for participating in this study. We will give feedback when the data has been analysed.

Yours sincerely

P. McInerney

Pat McInerney (Miss)
Senior Lecturer
Department of Nursing Education

The University of the Witwatersrand rejects racism and racial segregation. It is committed to non-discrimination particularly in the constitution of its student body, in the selection and promotion of its staff, and in its administration.

CURRICULUM REVIEW: QUESTIONNAIRE FOR FOURTH YEAR STUDENTS.

BIOGRAPHICAL:

1. I am

Male	1	Female	2

2. Year of birth ----------

3. Year of matriculation ----------

4. I was admitted to first year nursing (tick more than one if necessary)

directly from school	1
following some university experience	2
following some college/technikon experience	3
after working for a period	4
after going overseas	5
other	6

5. My home language is English

Yes	1	No	2

6. If you replied no to question 5, please complete this question, otherwise go on to question 7.

I have difficulty with English in the following areas:

	no difficulty 1	some difficulty 2	a great deal of difficulty 3
6.1 understanding lectures			
6.2 talking to others			
6.3 completing written tests/ assignments			

7. I completed the following matric:

Transvaal Education Department	1
Joint Matriculation Board	2
Dept of Education and Training	3
House of Representatives	4
House of Delegates	5
Other Provicial Bodies	6
(Cape, OFS, Tvl., Natal) Other, state which	7

8. My overall symbol in matric was

A	1
B	2
C	3
D	4
E	5

9. List your final symbols for third year in the table below:-

SUBJECT	SYMBOL	
Nursing III		1
Midwifery I		2
Psychiatric Nursing I		3
Psychology II		4
Pharmacology		5

10. Have you failed a year during your nursing curriculum ?

Yes	1	No	2

If so, state which year ----------

Why do you think you failed?

11. The volume of work in fourth year is

too little	1	reasonable	2	excessive	3

12. in the table below tick whether ou found the volume of work for each subject listed to be:-

	too little 1	reasonable 2	excessive 3
Physics			
Chemistry			
Scciology I			
Psychology I			
Nursing I			
Anatomy			
Physiology			
Nursing II			
Community Health Nursing I			
Microbiology			
Nursing III			
Midwifery I			
Psychiatric Nursing I			
Psychology II			
Pharmacology			
Nursing IV			
Midwifery II			
Psychiatric Nursing II			
Community Health Nursing II			

13. How relevant was the content (as taught to you), of each of the subjects listed below to the study of nursing ?

	extremely relevant 1	somewhat relevant 2	of little relevance 3	of no relevanc 4
Physics				
Chemistry				
Sociology I				
Psychology I				
Nursing I				
Anatomy				
Physiology				
Nursing II				
Community Health Nursing I				
Microbiology				
Nursing III				
Midwifery I				
Psychiatric Nursing I				
Psychology II				
Pharmacology				
Nursing IV				
Midwifery II				
Psychiatric Nursing II				
Community Health Nursing II				

14. I would have liked more exposure to patients during the curriculum

strongly agree	1
agree	2
disagree	3
strongly disagree	4

15. Learning an African language should be a compulsory part of the curriculum

strongly agree	1
agree	2
disagree	3
strongly disagree	4

16. The nursing education at Wits prepares students to work

	extremely well 1	well 2	poorly 3	extremely poorly 4
16.1 at teaching hospitals				
16.2 at non-teaching hospitals				
16.3 at rural hospitals				
16.4 in community settings				
16.5 in a speciality				

Any comments

17. The spectrum of diseases seen in the teaching hospitals reflects that seen in society generally

strongly agree	1
agree	2
disagree	3
strongly disagree	4

18. Throughout the course which of the following aspects could you detect :

	Almost all the time 1	quite often 2	some-times 3	quite rarely 4	very rarely 5
18.1 emphasis on factual details					
18.2 encouragement to learn concepts/ principles					
18.3 intensive pressure of work					
18.4 a scientific orientation					
18.5 opportunity to become involved in research					
18.6 clear guidelines for learning					
18.7 Help with personal problems					

	Almost all the time 1	quite often 2	some-times 3	quite rarely 4	very rarely 5
18.8 Help with academic problems					
18.9 An atmosphere conducive to study					
18.10 Well organised courses					
18.11 Good tutorials					

19. How important do you think communication and interviewing skills are?

very important	1
quite important	2
not very important	3
unimportant	4

20. Irrespective of their importance to you, how much opportunity has there been in the course to learn communication skills ?

a lot	1	quite a lot	2	a little	3	hardly any	4

21. With reference to the curriculum, please indicate

	a lot 1	quite a lot 2	a little 3	hardly any 4
21.1 how segmented the course appears to be				
21.2 does the course lead to learning specialised rather than general nursing knowledge?				
21.3 does this matter to you?				

Any comments.

22. For each of the following topics, indicate how, if at all, you would alter their emphasis :

	increase a lot 1	increase slightly 2	no change 3	decrease slightly 4	decrease a lot 5
22.1 ethics					
22.2 communica-tion skills					
22.3 health care of elderly					
22.4 health promotion					
22.5 preventative nursing					

	increase a lot 1	increase slightly 2	no change 3	desrease slightly 4	decrease a lot 5
22.6 counselling skills					
22.7 social aspects of health					
22.8 family care					
22.9 community-based health care					
22.10 care of dying patient					
22.11 medico-legal aspects					

23. How useful do you find the following methods of learning ? How regularly do you attend ?

	very useful 1	quite useful 2	of little use 3	of no use 4	attendance regular 5	irreg 6
23.1 lecture						
23.2 bedside teaching						
23.3 tutorials/ discussion groups						

	very useful 1	quite useful 2	of little use 3	of no use 4	attendance regular 5	attendance irreg 6
23.4 case studies						
23.5 reading textbooks/ journals						

24.I have been <u>mainly</u> taught through the following method of instruction (tick one only)

lecture	1
discussion	2
problem solving	3
other	4

Please state which.

25. To what extent are the following methods of assessment used?

	almost all the time 1	most of the time 2	some-times 3	hardly ever 4
25.1 MCQ'S				
25.2 Essays				
25.3 Short answer questions				
25.4 Clinical exams				
25.5 Projects, e.g. case study, research				
25.6 OSCE'S				
25.7 Vivas				

26. Which do you feel are the best methods of assessment? Please state why.

27. Which do you feel ate the worst methods of assessment? Please state why.

28.1 Do you think that race influences assessment outcomes?

Yes	1	No	2

28.2 Do you think that gender influences assessment outcomes?

Yes	1	No	2

28.3 Do you think that being a nursing student influences assessment outcomes?

Yes	1	No	2

29. In your experience do clinical assessments test:

	almost all the time 1	most of the time 2	some-times 3	hardly ever 4
29.1 knowledge				
29.2 skills				
29.3 attitudes				

30. What aspects of your competence, if any, are not adequately assessed ?

31. How do you feel about the amount of assessment in the course, is it ?

far too much	too much	about right	too little	far too little
1	2	3	4	5

32.Please indicate how easy or difficult you found it to cope with the following:-

	very difficult 1	difficult 2	easy 3	very easy 4
32.1 theoretical component of course				
32.2 practical component of course				
32.3 transition from school to first year nursing				
32.4 socially,i.e. making friends, balancing work and recreation				

33. How adequate was the range of clinical experience you ained at each of the following places. If you were not allocated put N next to the place name.

	More then adequate 1	Quite adequate 2	Just about adequate 3	Not very adequate 4	Totally in-adeqate 5
J'burg Hospital					
Hillbrow Hospital					
Valley Trust					
Tara					

	More then adequate 1	Quite adequate 2	Just about adequate 3	Not very adequate 4	Totally in-adeqate 5
Sterkfon-tein Hospital					
Koos Beukes Clinic					
Sybrand van Niekerk (Carlton-ville)					
Hospice Local Authori-ties					
Tintswalo					
Community Psych. Services					

34.I have found practical nursing experiences (tick two)

useful	1
of no use	2
well supervised	3
need more supervision	4

Any other comments.

35. I have found community health nursing experiences (tick two)

useful	1
of no use	2
well supervised	3
need more supervision	4

Any other comments.

36. I have found midwifery practical experiences (tick two)

useful	1
of no use	2
well supervised	3
need more supervision	4

Any other comments.

37. I have found psychiatric nursing practical experiences

useful	1
of no use	2
well supervised	3
need more supervision	4

Any other comments.

38.Name the nursing field you intend practising in on completion of your degree

General nursing	1
Midwifery	2
Psychiatric nursing	3
Community nursing	4

39. My home town is in

An urban area	1
A peri-urban area	2
A rural area	3

40. On completion of my degree I intend practising in

An urban area	1
A peri-urban area	2
A rural area	3

Please give reasons.

41.During this year of study I experienced the following problems

Personal problems	1
Poor teaching	2
Poor study methods	3
Financial problems	4
Difficulty with subject matter	5
Sexual harassment	6

42. What do you regard as the strong points of your current year of study?

43. What do you regard as the weak points of your current year of study ?

44. What were the strong points of your third year of study ?

45.What were the weak points of your third year of study ?

46. What were the strong points of your second year of study ?

47. What were the weak points of your second year of study ?

48. What were the strong points of your first year of study?

49. What were the weak points of your first year of study ?

50. I feel that my nursing degree has prepared me for nursing practice

Yes	1	No	2

51. If I could change the B.Nursing curriculum I would

52. I find the staff in the nursing department to be

Thank you for taking time to complete this questionnaire.

ANNEXURE I

Nursing Education

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Medical School, 7 York Road · Telegrams Witsmed · Telephone: (011) 488-4272 · Fax: (011) 488-4195
Parktown, Johannesburg 2193

Reference: P McI/dg
☎ (011) 488 4270
28 October 1997

Dear Fourth Year Students

You have come to the end of your studies and learning experiences for the B Nursing degree. In order to improve the midwifery component of the course I would value your opinions and suggestions. Please answer the questions as honestly and fully as you can. Please do not put your name on the questionnaire.

I take this opportunity to wish you a successful career and good luck in your further studies.

Yours sincerely

Pat McInerney (Ms)
Chairperson - Governing Committee
Department of Nursing Education

The University of the Witwatersrand rejects racism and racial segregation. It is committed to non-discriminatory practices in the constitution of its student body, in the selection and promotion of its staff, and in its [illegible]

QUESTIONNAIRE TO DETERMINE STUDENTS' OPINIONS REGARDING THE MIDWIFERY COMPONENT OF THE B NURSING DEGREE

Please ✓ the appropriate blocks

1.0 Did you enjoy your midwifery course?

□ Yes
Give reason/s:

□ No
Give reason/s

2.0 What part of your midwifery course did you enjoy most?

Why?

3.0 What part of your midwifery course did you least enjoy?

Why?

4.0 Were there any aspects which were taught or included and which you felt were irrelevant to midwifery?

□ Yes

□ No

If 'Yes', please state which.

5 0 Were there any aspects which you felt were inadequately covered or not covered in the course?

□ Yes

□ No

If 'Yes', please state which.

6.0 How would you rate the supervision of the midwifery practica?

□ Adequate

□ Inadequate

6.1 In your opinion, how could the practical supervision be improved?

7.0 With reference to your third and fourth years of study, please state whether there were any aspects which could have been taught or done differently to make your learning experiences more pleasant. (Please confine your answer to the midwifery component of your course.)

Third Year

Fourth Year

8.0 Did you attend Carletonville Hospital?

- ☐ Yes
- ☐ No

If 'Yes', did you use this opportunity to write up:

- ☐ Deliveries
- ☐ Palpations
- ☐ Vaginal Examinations
- ☐ Episiotomy - cutting and suturing.

If not, please say why you did not make use of this opportunity .

9.0 Did you attend the maternity unit at the Alexandra Health Centre?

- ☐ Yes
- ☐ No

If 'Yes', did you use this opportunity to write up:

- ☐ Deliveries
- ☐ Palpations
- ☐ Vaginal examinations
- ☐ Episiotomy - cutting and suturing

If not, please say why you did not make use of this opportunity.

10.0 How would you describe the following as learning environments for midwifery students:

10.1 Johannesburg Hospital

10.2 Carletonville Hospital

10.3 Alexandra Health Centre

11.0 Which would you describe as the most appropriate for learning midwifery clinical skills in the future?
(You need not confine your answer to the above three).

12.0 Do you feel competent as a beginning midwifery practitioner?

- ☐ Yes
- ☐ No

13.0 Would you feel competent to practice in a hospital setting?

- ☐ Yes
- ☐ No

14.0 Would you feel competent to practice in a community or primary health care setting?

- ☐ Yes
- ☐ No

15.0 Is there a specific area you would feel less competent to practice in?

- ☐ Yes
- ☐ No

If 'Yes', please state which.

- ☐ Ante-natal
- ☐ Labour Ward
- ☐ Post-natal

16.0 Factors that relate to culture appear to become issues in midwifery practice. How would you suggest that these can best be managed or overcome?

17.0 How do you perceive the giving of information or education to the patients?

18.0 Any comments you would like to make regarding either the theoretical or practical components of your midwifery course.

Thank you for your cooperation and for taking time to complete this questionnaire.

PMcI/dg
1997:10:27

ANNEXURE J

GRADUANDS INFORMATION SHEET

First of all, I'd like to thank you all for giving up some of your free time this afternoon and for agreeing to participate in this group. The reason that I've invited you to this group is that we are recurriculating in the department and I am carrying out research in the process. We have decided to broaden the field of midwifery to women's health and I am researching an appropriate curriculum for this.

Research has shown that a useful means of evaluating a curriculum is to interview graduands who have or who are working in the relevant practice area. A group discussion is a useful means of collecting information because it allows problems to be identified and possible solutions to be discussed.

I would like to know where you felt that you had gaps or difficulties in your practice when you first graduated. How you think these problems could have been overcome. How did you manage them?

Should you wish to withdraw from the discussion at any time please feel free to do so.

Would anybody mind if I taped the discussion as this will enable me to listen now and to analyse the discussion afterwards? (Verbal consent from the group was obtained at this point.) I assure you that your names will not be used and practice areas will not be informed of any of the content of the discussion.

At the end of the discussion the researcher thanked all participants for expressing their thoughts and for participating in the discussion.

GRADUANDS INFORMATION SHEET

Second focus group

(This group was led by one of the senior graduands who was given this sheet.)
Before the group commenced the researcher met the group and thanked them for agreeing to participate. She explained the purpose of the group (see previous information sheet.) She obtained the group's verbal permission to tape record the discussion. The group was assured that their names would not be used and that practice areas would not be informed of the content of the discussion. The participants were also advised that they were free to withdraw from the discussion at any point.

The researcher left the group at this stage.

The group leader introduced the discussion by reflecting on the previous group discussion and introduced the it as follows:
From the previous group it appeared that the main deficits in our midwifery education related to issues around:

- culture
- alternative practices and how to give health information
- breast-feeding
- information - relating it to patients' level of understanding
- difficulties in applying theory to practice, and
- parenting.

Would you like to comment generally on these issues?
She was instructed to probe each of areas in more detail and led the discussion.

ANNEXURE K

NURSING SUPERVISORS INFORMATION SHEET

I would like to welcome you here this morning and thank you for making time to participate in this group discussion. The purpose of the discussion is discuss the curriculum and the preparation of students in the degree programme for midwifery practice. We in the department, are currently recurriculating and I am particularly interested in researching the preparation of students for women's health care.

Research has shown that a useful means of evaluating one's curriculum is to interview supervisors of new graduands regarding deficits in their knowledge. In this way one would hope to determine areas which are lacking or which need improvement. The reason a group such as this has been chosen is that through discussion problems can be identified and possible solutions identified.

Should anyone wish to withdraw from the discussion at any stage, please feel free to do so. I assure you that in the analysis and written report of this discussion no names will be used. I also ask that you do not refer to any past student by name.
Would anybody object if I tape recorded the discussion, as this will facilitate analysis at a later stage ? (Verbal consent was obtained at this point.)

At the end of the discussion the researcher thanked the participants again for giving up their time and for participating in the group.

NURSING SUPERVISORS INFORMATION SHEET

Second focus group

Thank you for making time this afternoon to join this group. In the previous group I explained the purpose of this group. Once again I ask you permission to tape record the discussion. (Verbal consent was obtained at this point). I also would like to remind you that you are free to withdraw from the group at any stage that you may like to do so. I would also like to remind you that I will not be using any of your names in my findings and also request that you do not refer to any past or present student by name.

In the previous discussion a number of issues were raised which need clarification. Issues that were raised related to:

- the type of training given and that it doesn't provide the beginning practitioner with confidence to practice,
- the exposure as a student is different from what one has to cope with when registered,
- is a suggestion that students do not experience or see holistic care being given,
- an internship and that requirements of the curriculum do not prepare one for practice,
- a suggestion that students need practice in decision making and dealing with crises in management,
- nursing issues and in particular - care and responsibility,
- the fragmentation of learning opportunities and the lack of time for consolidation of practice,
- students being part of the work force, and
- factors which influence the student's clinical opportunities.

Can we discuss these issues in more detail?

At the end of the discussion the researcher again thanked the participants for giving up their time and for joining in the discussion.

ANNEXURE L

PROVINCIAL ADMINISTRATION
PWV

Enquiries: Miss J.M. van Wyk

Reference:

Tel: 201-2895

Fax: 323-4018

Address: Health Services Branch
Private Bag X221
PRETORIA
0001

Miss P. McInerney
Department of Nursing Education
University of the Witwatersrand
Medical School
7 York Road
PARKTOWN

Dear Miss McInerney

QUESTIONNAIRE : DETERMINE THE BELIEFS OF MIDWIVES REGARDING NEEDS OF PREGNANT WOMEN AND THEIR PERCEPTIONS OF THEIR ROLES IN MEETING THESE NEEDS

I have pleasure informing you that approval has been granted to do research at the following hospitals : Johannesburg Hospital and J.G. Strijdom Hospital.

The approval is subjected to the following conditions :

i) The Superintendents of the different Hospitals must be contacted by yourself to obtain permission to do research.

ii) The research may not intervene with the service of the officers concerned.

iii) The Superintendents of the different Hospitals must always be informed concerning the project.

iv) A copy of the completed treatise must be presented to this Administration.

v) Please bear in mind the position of trust as well as the confidentiality of the treatise.

We wish you success with your project.

Yours faithfully

DIRECTOR-GENERAL
94.10.13

JB/BORNZ.LET

ANNEXURE M

PROVINCIAL ADMINISTRATION
PWV

Enquiries: Miss L Acres
Telephone No: 488-3269
Fax No: 488-3050

Johannesburg Hospital
Private Bag X39
JOHANNESBURG
2000

1995-03-10

Miss PA McInerney
Department of Nursing Education
University Of Nursing Education
JOHANNESBURG

Dear Miss McInerney

re-: REQUEST TO UNDERTAKE RESEARCH

I wish to inform you that your request to interview patients and Registered Midwifes in Block 1 has been granted. The relevant persons have perused the questionnaires, and have lodged no objections.

I have taken the liberty of passing on copies of your documentation to Mrs S Schneider who is on the Research Committee of the Johannesburg Hospital.

Yours faithfully,

L Acres

MISS L ACRES
SENIOR NURSING SERVICE MANAGER - OBSTETRICS

ANNEXURE N

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

COMMITTEE FOR RESEARCH ON HUMAN SUBJECTS (MEDICAL)
Ref: R14/49 McInerey

CLEARANCE CERTIFICATE PROTOCOL NUMBER M 950318

PROJECT The development of a community based problem based learning curriculum in the undergrad degree in nursing with.....

INVESTIGATORS Ms P A McInerey

DEPARTMENT Nursing Education, Johannesburg Hospital

DATE CONSIDERED 950331

DECISION OF THE COMMITTEE *

Approved unconditionally

DATE 950413

CHAIRMAN. .....Professor P E Cleaton-Jones)

* Guidelines for written "informed consent" attached where applicable.

c c Supervisor:
Dept of ,

==========

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and ONE COPY returned to the Secretary at Room 10001, 10th Floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.

DATE 95:04:18 SIGNATURE .....

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

ANNEXURE O

JOHANNESBURG HOSPITAL

OBSTETRIC SECTION

LABOUR TRAINING PROGRAMME



LABOUR PREPARATION

This course consists of six talks, which would be more beneficial if attended consecutively.

CLASS I — INTRODUCTION

Feelings about labour, birth and parenthood.
Husband's attitude.
What you expect from the course.
Special requests.
Aims of childbirth preparation course.

CLASS II — Physiology of labour

Body's preparation for labour.
Onset of labour.
Stages of labour.
Coping skills for first stage.

CLASS III — Coping skills for 2nd stage

Active birth.

CLASS IV — Deviation from the normal

1. Induction, augmented, trial labour.
2. Artificial rupture of membranes.
3. Epidural.
4. Pain relief in labour.
5. Foetal monitoring.
6. Episiotomy.
7. Forceps, vacuum.

CLASS V — Caesarean section

CLASS VI — Post partum

1. Hospital.
2. At home.
3. Parenthood.

After each talk there will be a practical period which will cover:

1. Breathing, relaxation and dissociation techniques.
2. Positions.
3. Massage, efflevage.
4. Pushing techniques.

AIMS OF THE COURSE

To prepare you physically and emotionally for a satisfying birth experience be it from : NORMAL DELIVERY (on one end of scale, to CAESAREAN SECTION on other end of scale) - with all the deviations from normal in the middle of the scale. To achieve this you need:

1. Exercise - to become fitter and also to increase your body awareness.
2. Explanation of the birth process and you and your husband's role during this period.
3. Breathing, relaxation and dissociation techniques.
4. Conditioning by daily repetition and practise.

BEFORE LABOUR STARTS

You may experience some of the following 2 - 4 weeks before labour starts:

1. Lightening i.e. when the baby's head goes into the pelvis.
2. Increase in urinary output because of pressure from baby's head or bladder.
3. Increased vaginal discharge.
4. Braxton-Hicks contractions or painless, tightening of uterine muscles.
5. Weight loss or weight plateau.
6. Decreased activity of baby.
7. Energy spurt.

GENERAL ADVICE FOR THIS PERIOD

1. Remember your expected date of delivery is only a guideline.
   You may go into labour 2 weeks before or over 2 weeks later than your date.
2. Patience is a word that is easier said than practised at this time.
3. Stock your grocery cupboard and deep-freeze.
4. Pack your suitcase.
5. Contact Maternity Admissions or Antenatal Clinic if you are ever worried about you or your baby's health in any way, e.g. if baby's movements decrease according to kick chart; if you are uncertain if labour has started, etc.

ADVICE FOR PARTNERS

1. Plan a couple of evenings out together - helps boost morale.
2. Practice breathing and relaxation techniques with her.
3. Make sure you are easily available during the day.
4. Plan route to Hospital, keeping in mind rush hour traffic.
5. Always have petrol in the car.

ONSET OF LABOUR

There are three ways in which labour may start:

1. SHOW: which is a mucousy blood-stained discharge. If this occurs wait for other labour signs before coming into Hospital.

2. CONTRACTIONS: You may experience contractions as period-like pains felt in the front, or as a low backache or as pains radiating down into your thighs. These are normally associated with the hardening of the uterus. True contractions differ from false labour in that they always progress by becoming longer, stronger and closer together. So remember to consider the following three factors about contractions:

2.1 The interval between contractions, which is taken from the beginning of a contraction to the beginning of the next. The contractions should become regular. Once they are between 5 - 10 minutes regularly apart, you should consider coming into Hospital. It will depend on how many babies you have had and how far you stay from Hospital.

2.2 The length of a contraction which is from the beginning of a contraction to when the contraction begins to subside. A ±40 second contraction is a good guideline of when to come in.

2.3 The strength of the contraction is also important. If you are smiling and think-labour is 'a piece of cake', you can still be at home.

3. RUPTURED MEMBRANES: This may occur in two ways - as a gush of fluid or as a slow leak. Either way you should go into Hospital. Do not wait for other signs.

UNUSUAL SIGNS

If any of the following occur you should come into Hospital:

1. Vaginal bleeding: Fresh, red blood of significant amount.
2. Continuous abdominal pain - in that it is not wave-like - it does not stop and start.
3. Greenish, watery vaginal discharge.
4. Baby does not move for an unusual length of time.

ADVICE FOR WHEN LABOUR HAS STARTED

1. Keep yourself occupied, but do not become overtired. Remember, you must now start to conserve as much energy as possible.
2. Take a warm soothing bath or shower if ~~your~~ NOT membranes have ruptured.
3. Eat a light, easily digestible meal, e.g. scrambled egg and toast. Drink at regular intervals and empty your bladder regularly.
4. Practice your breathing and relaxation techniques before labour becomes established.
5. Collect all your 'goodies' together.
6. Travel comfortably to the Hospital. If you have backache-type labour, sit in the back seat and lean forward; if you have front-type labour, use pillows at your back.

ADVICE FOR PARTNERS

1. There is normally no need for alarm.
2. Travel cautiously to the Hospital.
3. Make sure she does not overtire herself but at the same time she must keep occupied.
4. Take some reading matter or something to occupy yourselves with in Hospital, e.g. chess.
5. Remember those 10c pieces for the 'Good News' phone calls.

ADMISSIONS

1. Remember to use Casualty entrance when coming to Maternity Admissions.
2. Once the administrative procedures are complete, you will be taken to a cubicle where you will change into a Hospital Gown.
3. A vaginal examination is done by a Doctor or Midwife to assess if your are in established labour and if so, how many centimetres your cervix has dilated. This is a good chance to see how good your relaxation, breathing and dissociation techniques are.
4. A perineal shave is usually performed.
5. An enema is also given; again, your relaxation is important during this insertion.
6. Observations to assess you and your baby's condition will be done at regular intervals, normal every ½ hour.
7. You will be transferred across to Labour Ward once these procedures are completed.
8. NOTE for husbands: If you have to leave your wife for whatever reason make sure you know where to find her again. The Hospital is very large and can be confusing.

ACTIVE FIRST STAGE OF LABOUR

As labour establishes itself, contractions grow longer, stronger and closer together, dilating the cervix. You will find that your breathing levels change almost automatically according to the strength of the contractions. You will use combinations of 1st, 2nd and 3rd levels.

1. The most important consideration is the maintenance of TOTAL relaxation. Especially watch face, thighs and fingers.
2. Relaxation is easier if you are really comfortable.
3. Do not stay in one position for too long.
4. Maintain an upright position as much as possible.
5. Empty bladder every 1 - 2 hours.
6. Concentrate on each contraction as it rises, forgetting those past and those to come.
7. As each contraction starts, take a fairly deep long breath in. As each contraction ends, sigh deeply with relief and wiggle your toes.

CONTRACTIONS FELT IN FRONT

Positions:

1. Lying on your back, propped up.
2. Lying on your side.
3. Upright kneeling, well-supported against something solid, sitting on a chair, on the loo, in the car, etc., with back WELL-supported.
4. Squatting, tailor style.
5. Standing, shoulder supported by wall.

MASSAGE

Usually over sacral area using fists, knuckles, flat of hand, heel of palm, side of hand. Hard deep massage. Try to relax shoulders, using wrist action as far as possible.

CONTRACTIONS FELT IN THIGH

You will have to experiment to find the position most comfortable for you. Sometimes elevated legs on cushion is helpful; squatting may help.

MASSAGE

Chopping with the sides of hands; upward stroking from knees to groin.

ADVICE TO PARTNER

During this stage you can help by simply being there and passing the time between contractions. This psychological support is invaluable.

Assist with practical aspects of labour; adjusting pillows, closing curtains, giving her water, etc.

Actually keeping your wife in control - checking her relaxation as the contractions get stronger and making her aware of any tensions which creep in. You can do the massage for her, especially if it is a back labour, so that she can concentrate fully on relaxing.

TRANSITIONAL STAGE

This is probably the most difficult part of your labour but remember, it usually does not last for a long period. Once transition is over and you go into 2nd stage, you can actively work with your body and push your baby out. There are some physical and emotional changes which occur during this period which you may experience:

CONTRACTIONS FELT IN FRONT

Positions:

1. Lying on your back, propped up.
2. Lying on your side.
3. Upright kneeling, well-supported against something solid, sitting on a chair, on the loo, in the car, etc., with back WELL-supported.
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TRANSITIONAL STAGE

This is probably the most difficult part of your labour but remember, it usually does not last for a long period. Once transition is over and you go into 2nd stage, you can actively work with your body and push your baby out. There are some physical and emotional changes which occur during this period which you may experience:

Physical changes

1. Shivering and shaking.
2. Nausea and vomiting.
3. Total exhaustion.
4. Your breath may smell like acetone.
5. Pushing urge or involuntary bearing down movement of diaphragm and abdominal muscles or sensation as though your bowels want to work.

Psychological changes

1. Feelings of despair (giving up) or aggression towards husband or staff, are normal.
2. Confusion and amnesia are also normal.
3. You will probably lose control during this period.

Pain

1. You can no longer isolate the pain - it seems to be everywhere.
2. There is also very little time between contractions to recuperate before the next.

ADVICE FOR THIS PERIOD

1. Advise the Midwife that changes have occurred.
2. Once you have been examined and you are not fully dilated do not push or bear down.
3. Use your Hu-Shu level of breathing.
4. Change position to a side lying or go on all fours with bottom up.
5. Hold your uterus with both hands against the urge to push.
6. Keep your eyes open and fixed to a point.
7. Concentrate only on the present and remember, it is nearly over.
8. If you begin to hyperventilate, i.e. feel dizzy and faint, or tingling around mouth, eyes, fingers or feet, breathe into your hands or a paper bag. This collects the carbon dioxide and when inhaled, restores the oxygen balance.

ADVICE FOR PARTNERS

1. This is generally the most difficult stage for your wife and she will need your help and support more so now than before.
2. She will lose control and it will be up to you to help her maintain or regain control by having eye-to-eye contact and breathing with her.
3. Check for tension.
4. Watch for hyperventilation and hold bag or cup your hands over her mouth if it persists.
5. Do not allow her to push without medical permission.
6. Give her constant verbal support and encouragement. Remember the fact that it will not last for long.

SECOND STAGE

This period of your labour takes place in the 2nd stage room which is very similar to a small theatre. Your partner will be required to wear a green gown. Do NOT be alarmed or frightened by the appearance of the room.

Your baby now begins to work his/her way out by twisting and turning. At the same time your uterus, diaphragm and abdominal muscles involuntarily push the baby through the birth canal. At the same time, you will voluntarily assist by 'pushing down' which is hard work. This is in fact one of the reasons your have been conserving your energy.

PUSHING TECHNIQUES

Will vary depending on the position you use. This will be taught and practised in class.

Once the baby's head crowns the Midwife will ask you to stop pushing. Listen carefully to the Midwife at this stage. She will alternate her commands from "Push" to "Part" to allow slow stretching of the perineum and a slow delivery of the baby's head and shoulders. Once the baby is delivered, he/she is usually placed on your tummy or between your legs and the reward you have been waiting for has arrived. CONGRATULATIONS!

ADVICE FOR THIS PERIOD

1. Do not waste your energy. Push with contractions and relax totally between contractions.
2. Think positively, e.g. 'Out, baby out' and work towards that. Remember you will progress with each contraction.
3. Remember your baby - talk to him/her. You are both in it together.
4. Do not withdraw or hold back even if the pushing causes a burning or stretching pain.
5. Listen carefully and obey the commands from the staff.

ADVICE FOR PARTNERS

1. You may be asked to hold her up.
2. Check that she is not pushing into her face and that her legs stay relaxed.
3. Relay the commands from the staff to her; she will probably listen to your voice more so than a stranger's.
4. Encourage her all the time, especially to keep her eyes open and watch the birth, and remember to watch the birth yourself.
5. Wipe her brow and neck with a damp cloth. Give her sips of water (if allowed) or use natural sponge.

THIRD STAGE

The 3rd stage is the delivery of the placenta (or after-birth). Once the baby is delivered the cord is clamped and cut which is a painless procedure. When the anterior shoulder is delivered the Midwife will administer an injection into your thigh. The drug causes your uterus to contract quicker than it would normally do. This prevents excess haemorrhage.

Once the uterus contracts, the Midwife will put slight traction on the cord and deliver the placenta. During this procedure once again listen to the Midwife; she may ask you to push or even cough. Your relaxation and breathing techniques will be useful if any difficulty is encountered at this stage.

The Midwife will check you cervix and vaginal wall for any tears; this can be uncomfortable.

THE BABY

1. The baby will be taken from you at some stage to dry it and maintain its warmth, which is often a problem with newborn babies.
2. Mucous may be sucked from the baby's nose and mouth, if necessary.
3. Identity bands will be attached to baby's arms.
4. Eye drops will be administered to prevent infection.
5. An injection of Vit. K will also be given to prevent haemorrhage.
6. The baby is checked, assessed and given a scoring mark according to his/her condition at birth and 10 minutes later.
7. With all this activity, bonding is still encouraged and the baby will be left with you for as long as possible. The baby may be put to the breast in the Delivery Room.

POST DELIVERY

Stitches: If you have torn or had an episiotomy, the Midwife or Doctor will have to put in stitches (sutures). If local anaesthetic was not administered earlier, it will be given. You will also have to put your feet into stirrups, i.e. lithotomy position. It may be uncomfortable so remember to relax your pelvic floor and use your breathing techniques.

Procedures

1. You will be washed and freshened up.
2. Vaginal bleeding is frequently checked. Remember to find your uterus and keep it well contracted by "rubbing it up"/
3. It may be difficult to pass urine immediately after delivery but this should improve.
4. It is important for your blood pressure to be checked.
5. Once you and your baby's condition is satisfactory, you will be moved to a Postnatal ward, i.e. Ward 186 or 187.

Reactions: This is another emotional period due to the experience and also physical and hormonal changes. You may experience some of the following:

1. Intense joy and excitement.
2. A sense of deflation or "let down" feeling.
3. Exhaustion.
4. Physical shivers and shaking: uncontrollable nausea and vomiting often occur.
5. Weeping for no known reason.

Remember, these are all normal and will pass. The maternal instinct is there, but your love for your baby develops with time as every type of relationship does.

MEDICAL PROCEDURES

PAIN RELIEF

Each individual's pain threshold varies, i.e. it is difficult to say how much pain a woman will experience in labour. The following are some of the methods used to relieve the pain:

Gas (combination of nitrous oxide and oxygen - "laughing gas")

The advantage of gas is that there is no long-lasting effect and that you can control the amount used, yourself.

Analgesic Drugs e.g. Pethidine

1. The advantage of Pethidine is that it sedates, thus relaxing you and often hastens your labour.
2. The disadvantage is if it is given too close to 2nd stage, it may result in too much drowsiness with lack of co-operation or affect the enjoyment of the birth experience.
3. You may experience nausea and vomiting but Stemetil may be given to counteract it.

Epidural Anaesthesia Discussed under Caesarean Section

Episiotomy: An incision made in the perineum to enlarge the vaginal outlet.

Some reasons for Episiotomy:

1. To prevent the perineum tearing badly, e.g. 3rd degree tear which extends through rectal sphincter; also to prevent overstretching.
2. To reduce the length of 2nd Stage because of high blood pressure or the baby becoming distressed.
3. Forceps delivery.

It is very important to remember to co-operate with the Midwife as the head is delivered. If the head is allowed to deliver slowly, and in a controlled manner, an episiotomy or tears may be prevented.

Suture: Discussed under Post Deliver.

After care:

The perineum may be very uncomfortable for the next couple of days. Post-natally you will be offered the hot lamp or ice packs. It is also important to keep the area as clean and dry as possible. The stitches are usually removed on day 5 if they are not dissolving.

Forceps:

Forceps are instruments shaped like two salad spoons. They are placed, one at a time, over the baby's head. Once in place they lock externally so it is impossible for them to squeeze the baby's head. In fact, they protect the baby's head like a crash helmet. It will help if you realise that forceps are designed to save babies' lives.

Some reasons for forceps

Foetal: To protect the soft head of a premature baby.
If the baby becomes distressed and it is necessary to deliver the baby quickly.
If the baby's head does not rotate or gets stuck.
Malpresentation.

Maternal: To shorten the 2nd stage of labour. For example, if the mother has high blood pressure or is a cardiac patient.
For maternal fatigue, i.e. the mother cannot push effectively.

Vacuum extraction

Is used for the same reasons as forceps but it is not frequently used because of the oedema (swelling) of the baby's head that it causes. It may be used, if necessary for only a short period of time - e.g. to rotate the baby's head when stuck.

Induction of labour

Labour is initiated by a drug (Pitocin) i.e. a medical induction, and if the membranes are artificially broken it is a surgical induction as well. If you start labour on your own and the above procedures are used it is not an induction but a method to accelerate your labour.

Method: The drug may be administered as tablets placed under the tongue or as vaginal pessaries or intravenously.

Some reasons for induction

Maternal factors:

If the mother's condition warrants that the pregnancy should come to an end, e.g. cardiac or diabetic patients.

If the mother has pregnancy induction hypertension and her blood pressure is too high.

Foetal factors:

The most common reason for induction is if the pregnancy carries on over due date, i.e. post-dates. We know that the placenta functions for ± 40 weeks, i.e. it is often necessary to initiate labour if the pregnancy carries on for longer than 2 weeks post-date.

Inter-uterine growth retardation because of placental insufficiency.

If the mother is RH Neg. and has antibodies.

If your membranes are unruptured, a vaginal examination is performed and a hook inserted that breaks the membranes. It is a painless procedure.

The contractions caused by pitocin are known to be stronger and longer. This may reduce the length of your labour, but the pain may be more intense, i.e. it is important to start your breathing, relaxation and dissociation techniques early.

It does not mean that you are immobile because of a drip (intravenous therapy). You may still walk about with a mobile drip stand. The drip is usually left in for a while after the baby is born to ensure that the uterus contracts well and prevents postnatal haemorrhage.

Continual Foetal Monitoring

The baby's heart may be continuously monitored by an electrical machine which at the same time records the uterine contractions.

An internal lead may be clamped to the baby's head or an external lead may be placed on the abdomen to record the baby's heart beat. The lead that records the uterine contractions is always placed externally on the abdomen.

Once the cardio tachograph is attached, you are confined to bed, unless the portable machine is used.

The advantages of routine continuous foetal monitoring is outweighed by the disadvantage of being immobile and constricted.

Once confined to bed, it is necessary to use your dissociation techniques more and try not to become too obsessed with the machine.

Continuous foetal monitoring is used when there is any sign of foetal distress or any other complications that may arise, e.g. APH (bleeding), cardiac, diabetic condition.

Manual removal

This is when the placenta does not separate from the uterine wall and has to be manually removed. This is extremely painful and a general anaesthetic will be given if possible. If it is not possible, the patient will be heavily sedated. Antibiotic cover is usually needed. Fortunately this is not a very common complication.

CAESAREAN BIRTH

INTRODUCTION

Until fairly recently the delivery of a baby by Caesarean Section was to be a last resort, usually when all attempts to deliver the baby vaginally, had failed. With the advent of antibiotics and vastly improved procedures, birth by Caesarean Section has become relatively safe and more commonly practised. Any woman contemplating childbirth should give some thought to the possibility of having a Caesarean delivery.

While it is still major surgery with all the inherent risks, one should not forget that it is after all the birth of a baby, and can therefore be a rewarding and fulfilling experience.

At any stage during your pregnancy or labour, the doctor may find it expedient to deliver by Caesarean Section. He will have assessed the situation thoroughly and the decision will be made in the best interest of you and your child.

Should this situation arise, a clear understanding of the procedures and issues of Caesarean birth will not only prepare you for any decisions you might have to make, but will help you to make the birth of your child a rewarding and fulfilling experience.

REASONS FOR CAESAREAN BIRTHS

There are several reasons why Caesarean birth may be necessary. Namely: Maternal (reasons relating to the mother) and foetal (reasons relating to the baby).

MATERNAL

Cephalo-Pelvic Disproportion

This means that the mother's pelvis is not large enough to allow the baby to pass through. Either the pelvis is too small or the baby is too big.

Placenta Praevia

This occurs when the placenta is lying low down in the uterus and is obstructing the passage of the baby through the cervix. The placenta would normally lie in the upper region of the uterus, away from the cervix.

Placenta Abrupto

If the placenta separates from the uterine wall before the baby is born, the baby's life source is cut off, including the oxygen supply. Maternal haemorrhage will occur and it will become necessary to deliver the baby as soon as possible.

Failure to progress, or prolonged labour

This occurs if the cervix does not dilate as it should, or if the mother has been in labour for a reasonable length of time and the contractions are not as effective as necessary.

Previous Caesarean Section

The necessity to repeat Caesarean delivery depends very much on the reason for the first Caesarean. A re-occurrence of the same problem means delivery by Caesarean Section will be necessary. Should there be other reasons trial labour may be allowed. The decision to deliver by Caesarean Section might be taken at the first sign of any problem. Trial labour would also apply if the mother has uterine scar due to some previous operation. Careful watch would have to be kept for signs of the scar rupturing.

Maternal Illness

Should the mother have high blood pressure, toxaemia, diabetes, a heart disorder or any other condition that poses a high risk of the body not being able to cope with the stress of labour and birth, a Caesarian Section may be done.

FOETAL

Foetal Distress

Foetal distress during labour manifests itself in the variations in the baby's heart rate, which might slow down considerably, become very irregular or very fast. Your doctor will determine whether the distress is more than mild, in which case a Caesarean Section is the quickest and safest method of delivery.

Prolapsed Cord

This refers to instances where the umbilical cord drops in front of the baby's head. In this case abdominal delivery would be performed immediately. Should the baby be allowed to deliver in this position its oxygen supply would be cut off on entering the birth canal. In this case abdominal delivery would be performed immediately.

Malpresentation

This means that the baby is lying in an unfavourable position for a natural delivery. For example, presenting a shoulder or face first.

Breech presentation

Caesarean delivery is becoming more common in cases where the baby is lying in a breech position, that is, with the head up and legs and bottom presenting. Abdominal delivery is considered safer for both mother and baby in such a case.

TYPES OF CAESAREAN BIRTHS

A Caesarean birth could be elective or an emergency. It is therefore important that you prepare yourself for both a vaginal delivery and a Caesarean delivery so that you are confident in both situations. If you are to have an elective Caesar, the most obvious means of determining whether the baby is mature enough to be born would be to wait for the first signs of labour. Since this may not always be a convenient and practical procedure, any of the following tests may be performed to determine the baby's maturity:

The Ultrasound Method: By photographing the baby with high frequency sound waves, through the mother's abdomen, an outline of the baby, the placenta and other structures are transmitted onto a video screen, enabling the doctor to measure the size of the baby's head. This is a reliable indication of the gestational age.

Amniocentesis Method: By analysing a sample of the amniotic fluid drawn from the sac in which the baby is contained, it can be determined whether the baby's lungs are mature enough to breathe on their own.

Testing the Estriol Level: Yet another method is by determining the functional level of the placenta. This is done by testing the level of a growth hormone known as Estriol found in the mother's urine and/or blood.

SIGNS OF LABOUR

Contractions

A term referring to the tightening and relaxing of the uterine muscles. Over a period of time contractions become more regular, are longer in duration, stronger and closer together.

Rupture of Membranes

This is the natural rupture of the bag of waters containing the baby. Indication that the membranes have ruptured is a sudden gush or flow of fluid from the vagina.

Show

This refers to a thick mucousy vaginal discharge streaked with blood. If you have an elective Caesar and you start labour before the scheduled date, don't panic. Rather:

CONTACT Maternity Admissions or your doctor immediately and follow their instructions.
DO NOT HAVE ANYTHING TO EAT OR DRINK.

IF your membranes should rupture, do not have a bath, but go immediately to the hospital.

IF you are having contractions, relax and practise your controlled breathing with the contractions.

IF you at any time during the pregnancy - particularly if you have had a Caesar previously - should feel severe abdominal pain, contact the Hospital immediately.

IF you are to have an elective Caesar, you will check into the Hospital the night before. If you have an unplanned Caesar, you will already be there.

ANAESTHETICS INVOLVED IN A CAESAREAN DELIVERY

There are two basic types of anaesthesia used for a Caesarean delivery:
Regional anaesthesia or general anaesthesia.

Regional anaesthesia allows you to be awake during the birth but without any feeling from your waist down. Spinal anaesthesia, not to be confused with epidural anaesthesia, is also a form of regional anaesthesia, but is not commonly used in South Africa. This type of anaesthesia is often accompanied by a drop in blood pressure and a spinal headache post partum. South African doctors choose rather to use the epidural anaesthetic which poses less danger of a headache or drop in blood pressure and is equally safe for the baby. You will generally have more feeling with this type of anaesthetic and can often move your legs and feel pressure during surgery that may be interpreted as pain.

A general anaesthetic is given if you do not wish to be awake during the delivery if - if you are having an emergency Caesar - or if the epidural anaesthetic is not proving effective enough.

EPIDURAL ANAESTHESIA

Advantages

Without a doubt, the greatest advantage of having an epidural anaesthetic for a Caesarean delivery, is that you are awake during the delivery and can witness the birth of your child with minimum pain.

Psychologically, you feel you have participated in the birth of your baby and you will not feel a sense of disappointment and failure as a woman and mother.

There can be immediate bonding between you and the child. This essential "first contact" is delayed in the case of general anaesthetic being administered.

An epidural anaesthetic has little or no effect on the baby.

Recovery from an epidural is much quicker than recovery from a general anaesthetic. There are no side effects of drowsiness or delay in the initiation of the milk supply as is often the case after a general anaesthetic.

The post operative pain is never as bad after an epidural as it takes a good number of hours for the effect of the epidural to wear off. The pain is therefore felt gradually, unlike the intense pain experienced immediately after a general anaesthetic.

One of the most important factors to remember when making the decision as to whether you will have a general or epidural anaesthetic, is that although you are awake and can witness the birth of your baby, you do not see the incision or details of surgery. Firstly, the incision is below your bulge and secondly, you are completely draped in sterile towels and a screen placed between your head and abdomen, preventing you from seeing the actual surgery - the thought of which is what seems to frighten most mothers faced with this decision.

Possible disadvantages of an epidural

The risk of causing neurological damage is 1 : 5000.

Techniques are difficult and should only be carried out by experienced doctors.

There is a possibility of a drop in blood pressure.

Headaches are possible, post anaesthetically.

Epidural delivery is not suitable for every woman. For example, someone who is very anxious or tense, should not contemplate this method.

Some women may be very disturbed by the sensations of tugging and pushing during the surgery.

Occasionally the epidural may fail to anaesthetize sufficiently. Your doctor will not begin the delivery until the full anaesthetic effect is attained. Should this not be achieved through the epidural, a general anaesthetic will be administered.

You will feel nauseous at some time during the procedure.

During this procedure you may experience a referred pain in the shoulder, shortness of breath and burning sensations.

You may panic and experience difficulty in remaining calm.

Shivering and uncontrollable shaking is a common side-effect of epidural anaesthetic.

Epidural anaesthetic cannot always be administered in the case of an emergency which requires immediate Caesarean delivery. A general anaesthetic may then be used.

PROCEDURE FOR AN EPIDURAL ANAESTHETIC

Basically, this involves the injection of a local anaesthetic into the epidural space, located in the lower back where the nerve supply to the uterus is anaesthetized and, depending on the dosage, the surrounding area from the waist down.

To administer the anaesthetic, you will lie on your side with your knees drawn up to your abdomen and head and shoulders flexed. The Anaesthetist will clean the area to be injected with an antiseptic solution and then administer a small amount of the anaesthetic just under

the skin. This can be compared to an injection at the dentist. When this area is sufficiently numb, the Anaesthetist will insert a thin needle through the muscle and with extreme care, locate the tip of the needle in the epidural space. He will then insert a fine polythene tube through the needle until it too is in the epidural space. The needle is then withdrawn, leaving the tube intact. This enables the Anaesthetist to administer as much anaesthetic as is required through the tube and if needs be, keep topping it up should the effects begin to wear off too soon. The syringe will be left attached to the tube which in turn is strapped to your shoulder or a convenient place, to allow for easy access. As the anaesthetic solution is injected into the epidural space you will feel a warm sensation in your legs and gradual anaesthesia from your waist down. The Anaesthetist will check the effect of the anaesthesia by pricking your abdomen lightly with a needle, and when he is satisfied that full anaesthesia has been attained - which may take approximately half an hour - the operation will begin.

POST NATAL AFTER AN EPIDURAL

There is a fair amount of discomfort as the epidural wears off and sensation gradually returns.

You will experience tingling and numbness (pins and needles) in your legs as the anaesthetic wears off.

It takes a good few hours for the effect to wear off completely, depending of course on the dosage administered.

When the anaesthesia wears off, you will feel the pain it was designed to disguise. You will need the help of pain medication to diminish the discomfort and allow you to rest.

A few hours after delivery, when the effects of the epidural have worn off, you will be encouraged to get up and take a few steps. Do not try to get up on your own. It will be uncomfortable and you may even feel dizzy; wait for someone to help you.

Between walks, and even before you get up for the first time, it is very important to do some basic deep breathing and foot circling exercises.

GENERAL ANAESTHESIA

Advantages

In an emergency, where there is no time to waste, a general anaesthetic is preferable as it is the quickest to administer and to take effect.

With a general anaesthetic the baby can be delivered within about 5 - 8 minutes.

Not all women are psychologically suitable for epidural anaesthesia; therefore, general anaesthesia is preferable. Many women don't want to be awake during the procedure and are just too nervous, anxious and therefore not suitable candidates.

Disadvantages

The disadvantages of a general anaesthetic are the advantages of the epidural anaesthetic.

PROCEDURE

With a general anaesthetic you are given a combination of gases to inhale, usually oxygen and nitrous oxide.

You are given a dose of Pentothal or another barbiturate hypnotic to put you to sleep.

The anaesthetic is only administered a few minutes before the delivery of the baby because of its effect going through the placenta to the baby.

Once you are completely "under", the actual delivery takes only 5 minutes. The repair of the incision may consume another half hour or more.

Throughout surgery, you continue to inhale gas, remaining unconscious and feeling nothing.

As soon as the anaesthetic is discontinued, you are wheeled into the Recovery Room where you gradually regain consciousness.

POST NATAL AFTER A GENERAL

The major side effect of general anaesthetic is the grogginess you feel for a good number of hours afterwards.

Another is amnesia. You will remember nothing of the delivery and little of the recovery experience.

The return of sensation is rather sudden after a general anaesthetic and as you regain consciousness you will immediately feel the pain from your abdominal surgery. This will require some pain medication.

STAGES OF THE CAESAREAN DELIVERY

Caesarean deliveries can also be divided into stages as in labour, i.e.

1st stage : Preparatory stage
2nd stage : Delivery stage
3rd stage : Recovery stage

1st or Preparatory Stage

This stage begins with your admission to Hospital. All the preparation necessary will be done at this stage.

You will be shaved from nipples to pubic area.

You may be given an enema.

You should have nil by mouth. Do not accept food from anyone.

A catheter will be inserted into the bladder for urine drainage.

Intravenous therapy will be administered in your arm once you are in theatre.

In an emergency Caesar, the same procedures will be followed. During this preparatory stage you will feel rather anxious. Remember to apply your relaxation and breathing techniques. (Refer to Summary of Breathing Techniques).

Your preparatory stage will be the same regardless of the type of anaesthetic to be given.

2nd or Delivery Stage

If you have had an epidural anaesthesia, you will be fully conscious during this stage.

It is normal to feel a great deal of apprehension in the time preceding the Caesar.

All the techniques for stress control and relaxation can be used throughout this stage.

You will not see any of the procedure, but you will feel movement and pulling and pushing sensations.

You may feel nauseous - this can be controlled by slow second-level breathing and relaxation.

Shivering and shaking may also occur. Try to relax.

Once the baby is delivered you will be rewarded with having been able to participate fully in the birth of your baby and the first few minutes of its life.

Once the baby is born you may request some sedation if necessary.

It usually takes about half-an-hour to complete the whole procedure.

You will then be left in a recovery area for a while until transferred to the Ward.

3rd or Recovery Stage

This is the period after the delivery of the baby until approximately 12 hours later.

Your recovery phase is shorter and easier after an epidural anaesthetic.

Do not hesitate to ask for pain killers if necessary.

Do abdominal breathing and foot circling as soon as possible after the Caesar.

Referred pain is quite common, either above the abdomen or even in the shoulder.

Remember to use "huffing" to help dislodge the mucous in the chest as coughing is very painful during this stage.

GENERAL ADVICE

If you need to cough, laugh, sneeze, etc., hold you hands flat and firmly against the wound as support. Some women find a pillow against the scar gives added support and comfort. When coughing in bed, always bend knees up.

Wind can be very uncomfortable on about the 2nd or 3rd day. Refer to exercise to aid this. (Abdominal breathing with pelvic tilt).

Don't despair if milk is delayed, if breastfeeding. It can take up to 10 days.

After birth contractions as well as post natal bleeding are absolutely normal. This follows as with vaginal delivery.

You may have to graduate your diet from liquids to soft foods - follow your doctor's instructions.

Your incision may be uncomfortable, may itch, feel numb, pull or ooze for a while. The itch may last for up to one year afterwards.

Avoid lifting and driving for the first month after delivery. Ensure adequate domestic help before returning home.

Pamper yourself slightly - try to get as much rest and sleep in the first few weeks post-natally.

Most important of all - enjoy your new baby.

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COPING WITH TRAGEDY AND HANDLING GRIEF

We expect the outcome of a pregnancy to be a health baby. Because of this, there is very little preparation if a tragedy does occur.

Miscarriage or abortion is when a foetus is lost before the 26th week in pregnancy. 14% of pregnancies result in miscarriage.

Stillbirth: When a baby is lost after the 26th week. 1 - 2% of pregnancies result in stillbirth.

Neonatal death: When a child is born alive but dies within seven days. 1 - 2% of pregnancies result in neonatal death.

Prematurity is when a baby is born alive but before 36 weeks.

Malformation or abnormalities of the baby may vary from minor abnormalities e.g. cleft palate to the more serious abnormalities.

The physical management and treatment of all the above is very important but the emotional management is more important. Some emotional reactions which may occur, are:

Denial
Guilt
Anger
Isolation
Depression
Yearning
Bargaining
Disorientation
Loss of self-esteem

ADVICE:

1. Name the child.
2. See the child.
3. Try and find out cause of death or abnormality.
4. Religious support is always helpful.
5. Communal support : meet and talk to other people who have been through the same experience.
6. Mutual support from husband and others who are closely involved. Do not detach yourself from friends and family.
7. Help others to cope with the experience e.g. husband and siblings.
8. Face the reality e.g. packing away clothes etc.
9. Fear may take over with the next and subsequent pregnancy. Do not repress it; use it to build courage and caution.

PUERPERIUM

This is the six weeks after the birth of your baby. Your body takes approximately this length of time to adjust to a normal non-pregnant condition. The following changes will occur during this period.

1. Urinary output is increased. You may notice that you pass large amounts of urine straight after the birth of your baby. This is normal. You may also experience difficulty or unusual sensation when you pass urine. This will improve.

2. Placental Site. The placental area must heal during this period. Your vaginal discharge (bleeding) which is called lochia, will be heavy initially and slowly diminish. You will be swabbed initially and thereafter, using the bidet and bathing, is sufficient.

3. Fundal Height. The uterus must shrink back to its non-pregnant size which is roughly the size of your clenched fist. This is called involution. The Midwife will measure and check that your uterus is going down. Pelvic tilting and tightening and lying on your tummy will aid this process. When the uterine muscles contract to achieve involution you may experience period-like pain which is known as after-birth pains. These may be troublesome, especially with your second or subsequent children. Also, when you breastfeed, this stimulates the uterus to contract.

4. Breast changes. Your milk supply should come in on day three or four. Before this time you have colostrum (thick, yellow substance) which is what your baby needs during the first few days. Remember to wear a well-fitting and supportive bra at all times. You may become engorged before your milk supply becomes well established.

5. Third day "blues". This is normal emotional change due to a hormonal imbalance and it does not last long.

6. Sutures. Your stitches normally are taken out on day five if they are not dissolving sutures. You will be given perineal care which involves cleaning and keeping the sutures as dry as possible. You may also have the hot lamp or ice pack applied to the sutures if you are swollen, bruised or painful. You will be given salt to put into your bath. You should bath twice a day.

7. Constipation and haemorrhoids. Your bowels should work by about the third day. If not, a mild laxative may be taken and thereafter try to rectify constiptation by diet and exercises.

8. Exercises and Relaxation. Is particularly important during this period to aid your body in returning to shape.

9. Sleep. Lack of sleep is a major problem during this period. It is advisable to sleep during the day while baby is asleep.

Post Natal Checkup:

Remember to make your post natal check-up appointment, which will be approximately six weeks after the birth of your baby.

Notification of birth:

Must be done within 14 - 21 days at the Department of the Interior, Harrison Street, Johannesburg.

Before you leave Hospital, you should know where your nearest Baby Clinic is. Also before you leave, you should see the Family Planning Sister. Remember, you CAN fall pregnant while you are breast feeding.

Diet:

A well balanced, nourishing diet is essential during this period.

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LIST OF WHAT TO BRING INTO HOSPITAL

ARTICLES NEEDED IN THE LABOUR WARD

Keep the following items in a plastic sponge bag and make sure this remains with you through the labour:

1. Small piece of natural sponge.
2. Hair brush, elastic bands,, clips, alice band.
3. Face cloth kept in plastic bag and cloth for perineum.
4. Lipstick - Lipice.
5. Deodorant.
6. Tissues.
7. Small size talcum powder.
8. Packet of tablets for heartburn, e.g. Rennie, Phillips.
9. Toothbrush and toothpaste.
10. 10c coins for telephone.
11. Tennis ball.
12. Fruit, Fruit juice, biscuits - to nibble on before and/or after baby is born).

ARTICLES REQUIRED FOR POST NATAL STAY

1. 1 Pair old shorts pyjamas or nightie.
2. 3 - 4 Pairs pyjamas or nighties, front opening for breast feeding.
3. 6 Pairs panties or 12 pairs disposable paper panties.
4. Bras (feeding bras is you have them, otherwise well-supporting bras used during pregnancy).
5. Gown.
6. Slippers.
7. 5 x Sanitary towels.
8. Dried fruit.
9. Fruit juice.
10. Personal toiletries e.g. body lotion, shower cap, soap, etc.
11. Light reading matter.
12. "Thank you" cards and stationery, plus postage stamps.
13. Rollers, hairdryer, shampoo.
14. Nail polish, emery board, etc.
15. Plastic bags.
16. Plenty of 10c coins for telephone.
17. Mirror.
18. Clock.
19. Notepad.

BABY'S REQUIREMENTS

In a separate small suitcase, place baby's clothes to dress him/her when going home. You can also place your home-going outfit in this case and your husband can then bring it to you just before you are due to leave.

1 Vest	1 Pair booties
Cardigan	Dummy (optional)
1 Babygro	2 Disposable nappies
1 Matinee jacket	Shawl, or blanket
Wrapping blanket	Special baby soap/shampoo

ANNEXURE P

Die Suid-Afrikaanse Raad op Verpleging
(Ingestel ingevolge die Wet op Verpleging, 1978)

The South African Nursing Council
(Established under the Nursing Act, 1978)

RIGLYNE VIR DIE KURSUS WAT LEI TOT REGISTRASIE AS 'N VERPLEEGKUNDIGE (ALGEMENE, PSIGIATRIESE EN GEMEENSKAPS-) EN VROEDVROU

1. Filosofie van die Raad
2. Beleid ten opsigte van die opvoedkundige taak van die Suid-Afrikaanse Raad op Verpleging
3. Vakke en vakinhoud
4. Riglyne vir praktykonderrig

GUIDE-LINES FOR THE COURSE LEADING TO REGISTRATION AS A NURSE (GENERAL, PSYCHIATRIC AND COMMUNITY) AND MIDWIFE

1. Philosophy of the Council
2. Policy concerning the educational task of the South African Nursing Council
3. Subjects and subject content
4. Guide-lines for the teaching of practica

Regulasienommer Regulation number	R. 425	22-02-1985
Wysigings Amendments	R. 1312	19-06-1987
	R. 2078	25-09-1987
	R. 753	22-04-1988

1. INTRODUCTION - PHILOSOPHY OF THE SOUTH AFRICAN NURSING COUNCIL

1.1 Objects of the South African Nursing Council

The objects of the South African Nursing Council are determined in section 3 of the Nursing Act, 1978 (Act 50 of 1978).

"3. The objects of the council shall be -

(a) to assist in the promotion of the health standards of the inhabitants of the Republic;

(b) subject to the provisions of the Chiropractors Act, 1971 (Act 76 of 1971)*, the Homeopaths, Naturopaths, Osteopaths and Herbalists Act, 1974 (Act 52 of 1974)*, the Pharmacy Act, 1974 (Act 53 of 1974), and the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974), to control, and to exercise authority in respect of, all matters affecting the education and training of, and the manner of the exercise of the practices pursued by, registered nurses, midwives, enrolled nurses and nursing assistants;

(c) to promote liaison of the education and training, and the manner of the exercise of practices, referred to in paragraph (b), both in the Republic and elsewhere, and to promote the standards of such education and training and the manner of the exercise of such practices in the Republic;

(d) to advise the Minister on any matter falling within the scope of this Act;

(e) to communicate to the Minister information on matters of public importance acquired by the council in the course of the performance of its functions under this Act."

1.2 Definition of nursing science

"Nursing science is a human clinical health science that constitutes the body of knowledge for the practice of persons registered or enrolled under the Nursing Act as nurses or midwives.

Within the parameters of nursing philosophy and ethics, it is concerned with the development of knowledge for the nursing diagnosis, treatment and personalized health care of persons exposed to, suffering or recovering from physical or mental ill-health. It encompasses the study of preventive, promotive, curative and rehabilitative health care for individuals, families, groups and communities and covers man's life-span from before birth."

* Substituted by the Associated Health Service Professions Act, 1982 (Act 63 of 1982).

1.3 Definition of primary health care

"Primary health care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part, both of the country's health systems of which it is the nucleus and of the overall social and economic development of the community." *

1.4 Education in nursing

Council emphasizes that the education and training shall be directed specifically at the development of the nurse on a personal and a professional level and that the principles of learning be observed, namely that learning leads to behaviour change in the cognitive, affective and psycho-motor aspects, through active involvement of the student.

The development of the ability for analytical, critical, evaluative and creative thinking and the stimulation of the exercise of independent judgement of scientific data are of the utmost importance.

2. POLICY CONCERNING THE EDUCATIONAL TASK OF THE SOUTH AFRICAN NURSING COUNCIL

2.1 Council supports the concept of a continuous comprehensive health service, as supported by the Health Act, (Act 63 of 1977)

A comprehensive health service includes preventive, promotive, curative and rehabilitative services which provide for all man's (the patient's)[1] health needs, from before birth until death.

Continuity implies that the various components[2] are not seen as separate entities but as sub-systems[3] of the same comprehensive service linked through the exchange of information and co-ordination.

2.2 Council accepts nursing science as a human clinical health science

It is an area of study in which an objective, systematic approach to problem identification and problem solving should be applied in all health care situations with record keeping as the instrument with which and through which the nurse accounts for her actions as being systematic, scientific and within the framework of the law. The scientific approach in nursing is also referred to as the nursing process.

2.3 Council emphasizes that there is a fundamental need to create an awareness in the registered nurse of the socio-cultural implications in the provision of comprehensive nursing in the South African community

The promotion of the health standards of all the inhabitants of the Republic is entrusted to the Council in terms of the Nursing Act, 1978 (Act 50 of 1978).

* WHO definition of Primary Health Care

2.4 Council considers the stipulation of minimum educational standards for nursing education as the most important requirement to ensure safe, effective nursing for the community

This function is entrusted to Council in terms of the Nursing Act, 1978 (Act 50 of 1978).

Minimum standards are always stipulated in threefold by Council, namely, in the first instance in respect of the training school, secondly in respect of the training programme and thirdly in respect of the individual student.

2.5 Since it is the function of Council to promote standards of nursing education and training and nursing practice, innovation by training authorities and research in these fields are encouraged and supported

2.6 Council institutes new courses or amends existing courses only on the grounds of factual evidence and the identification of the health requirements of the population of the Republic of South Africa

2.7 Council adopts the principle of specialisation to promote standards of nursing education training and nursing practice

It must be possible to differentiate between this knowledge and skill and that required in a basic course.

2.8 With regard to the learning process in nursing science, Council emphasises that the education and training shall be directed specifically at the development of the nurse on a personal and a professional level and that the principles of learning be observed, namely that learning leads to behaviour change in the cognitive, affective and psycho-motor aspects, through active involvement of the student. The development of the ability for analytical, critical and creative thought and independent evaluation of scientific data are of the utmost importance

A student can learn only if an effective variety of learning opportunities is provided in respect of each skill, apart from the clear exposition of the standards which are required. To ensure that the student considers practica an essential learning opportunity[4] and approaches it as such from the beginning, teaching for practice in clinical laboratory[5] situations and proper introduction and orientation of the student with regard to the learning objectives are essential. A learning experience[6] occurs in a learning situation created by the person presenting the learning material and which is utilised by the student to achieve the programme and personal objectives[7]. These[8] include, for example, lectures, projects, clinical teaching[9] and clinical practica, with educational accompaniment.

Since effective practice in nursing depends upon skill in all three of the above-mentioned domains, Council requires that all three fields (cognitive, affective and psycho-motor) shall be evaluated to ensure a safe standard of nursing practice.

In order to ensure that learning opportunities and evaluation at training schools are in accordance with this policy guide, each school shall have a written curriculum for each programme.

2.9 Council's policy in respect of clinical practica stipulates that the student shall function as a member of the health team with certain responsibilities for patient care from the commencement of her training. This level of functioning shall be in accordance with the stage and terminal objectives of the programme

Clinical practica is the learning opportunities which permit the student to practise in the health service under supervision of registered nurses. The clinical practica shall be arranged in consecutive units in order to constitute a meaningful learning opportunity. It need not be continuous.

EXPLANATORY NOTES:

1 A patient is the person, sick or well who needs help to supplement his specific ability to accept optimal responsibility for his own health in the various health service and treatment areas and in all age groups.

2 A component is a structural sub-section of a system: divisions are therefore made merely on the ground of geographical or government boundaries.

3 A sub-system is a functional sub-section of a system: divisions are therefore made on the ground of functional differences.

4 A learning opportunity is the possibility for learning created by the tutor in classroom and clinical teaching situations and used by the student to reach learning objectives.

5 Clinical laboratory refers to such didactic situations as are created for the student in patient, and simulated practica, situations.

6 A learning experience is a learning opportunity used by the student.

7 An objective is a specific description of measurable behaviour required from somebody at a given stage. Stage objectives are objectives which should be achieved at various periods during a programme. The programme may, for instance, be divided into stages of one year each; stage-one objectives would then stipulate what the student should be able to do at the end of the first year. Terminal (or programme) objectives are the general objectives for the entire programme and they are prescribed by the South African Nursing Council in the regulations.

8 Clinical teaching is the practice-orientated teaching given to students in laboratory situations. (Compare 5 above.)

9 Accompaniment encompasses the conscious and purposeful guidance and support for the student based upon her own unique needs, by creating learning opportunities that make it possible for her to grow from passiveness, to involvement, to independent, critical, practice. This process of accompaniment takes place in conjunction with the direct involvement and physical presence of the tutor, supplemented by the availability of guidelines and learning aids.

ANNEXURE Q

No. R. 425	22 February	1985	No. R. 425	22 Februarie	1985
as amended by			soos gewysig deur		
No. R. 1312	19 June	1987	No. R. 1312	19 Junie	1987
No. R. 2078	25 September	1987	No. R. 2078	25 September	1987
No. R. 753	22 April	1988	No. R. 753	22 April	1988

THE SOUTH AFRICAN NURSING COUNCIL

REGULATIONS RELATING TO THE APPROVAL OF AND THE MINIMUM REQUIREMENTS FOR THE EDUCATION AND TRAINING OF A NURSE (GENERAL, PSYCHIATRIC AND COMMUNITY) AND MIDWIFE LEADING TO REGISTRATION

The Minister of Health and Welfare has, on the recommendation of the South African Nursing Council, in terms of section 45(1) of the Nursing Act, 1978 (Act 50 of 1978), made the regulations as set out in the Schedule hereto.

SCHEDULE

Definitions

1. In these regulations "the Act" shall mean the Nursing Act, 1978 (Act 50 of 1978), and any expression to which a meaning has been assigned in the Act shall bear such meaning, and, unless the context otherwise indicates -

(i) "academic year" means a period of at least 44 weeks in any calendar year;

(ii) "course of study" means a programme of education and training approved in terms of section 15(3), leading to the obtaining of a qualification which confers on the holder thereof the right to registration as a nurse (general, psychiatric and community) and a midwife;

(iii) "nursing college" means a post-secondary educational institution which offers professional nursing education at basic and post-basic level where such nursing education has been approved in terms of section 15(2);

(iv) "section" means a section of the Act.

Conditions for registration

2. A nurse (general, psychiatric and community) and midwife shall be registered in terms of section 16 if -

(a) he received education and training at an approved nursing school;

(b) he was registered as a student in terms of the regulations relating to registers for students published under Government Notice R. 3735 of 14 November 1969, as amended by Government Notices R. 171 of 12 February 1971, R. 1204 of 7 July 1972, R. 1647 of 20 September 1974 and R. 2207 of 31 October 1980;

(c) he successfully completed the course of study, has complied with the programme objectives referred to in regulation 6(2), and the other requirements for the award of the qualification concerned.

Conditions for the approval of a nursing school

3. A nursing school shall be approved for the offering of a course of study if -

(a) it is a university with a department or sub-department of nursing or a nursing college which has entered into a co-operation agreement with a university which has a department or sub-department of nursing;

(b) the course of study has been approved in terms of section 15(3);

DIE SUID-AFRIKAANSE RAAD OP VERPLEGING

REGULASIES BETREFFENDE DIE GOEDKEURING VAN EN DIE MINIMUM VEREISTES VIR DIE OPLEIDING EN ONDERRIG VAN 'N VERPLEEGKUNDIGE (ALGEMENE, PSIGIATRIESE EN GEMEENSKAPS-) EN VROEDVROU WAT LEI TOT REGISTRASIE

Die Minister van Gesondheid en Welsyn het, op die aanbeveling van die Suid-Afrikaanse Raad op Verpleging, kragtens artikel 45(1) van die Wet op Verpleging, 1978 (Wet 50 van 1978), die regulasies in die Bylae hiervan, uitgevaardig.

BYLAE

Woordomskrywings

1. In hierdie regulasies beteken "die Wet", die Wet op Verpleging, 1978 (Wet 50 van 1978), en het enige uitdrukking waaraan 'n betekenis in die Wet geheg is, daardie betekenis, en, tensy uit die samehang anders blyk, beteken -

(i) "akademiese jaar" 'n tydperk van minstens 44 weke in enige kalenderjaar;

(ii) "artikel" 'n artikel van die Wet;

(iii) "studiekursus" 'n program van onderrig en opleiding, goedgekeur kragtens artikel 15(3), wat lei tot die verwerwing van 'n kwalifikasie wat die houer daarvan die reg verleen tot registrasie as 'n verpleegkundige (algemene, psigiatriese en gemeenskaps-) en vroedvrou;

(iv) "verplegingskollege" 'n na-sekondêre onderwysinstelling wat professionele verpleegopleiding op basiese en na-basiese vlak aanbied waar sodanige verpleegopleiding kragtens artikel 15(2) goedgekeur is.

Voorwaardes vir registrasie

2. 'n Verpleegkundige (algemene, psigiatriese en gemeenskaps-) en vroedvrou word ingevolge artikel 16 geregistreer indien -

(a) hy onderrig en opleiding aan 'n goedgekeurde verpleegskool ontvang het;

(b) hy as student geregistreer was kragtens die regulasies betreffende registers vir studente afgekondig onder Goewermentskennisgewing R. 3735 van 14 November 1969, soos gewysig by Goewermentskennisgewings R. 171 van 12 Februarie 1971, R. 1204 van 7 Julie 1972, R. 1647 van 20 September 1974 en R. 2207 van 31 Oktober 1980;

(c) hy die studiekursus suksesvol voltooi het, aan die programdoelstellings bedoel in regulasie 6(2) en die ander vereistes vir die toekenning van die betrokke kwalifikasie voldoen het.

Voorwaardes vir die goedkeuring van 'n verpleegskool

3. 'n Verpleegskool word goedgekeur vir die aanbieding van 'n studiekursus indien -

(a) dit 'n universiteit is met 'n departement of subdepartement van verpleegkunde of 'n verplegingskollege is wat 'n samewerkingsooreenkoms aangegaan het met 'n universiteit wat 'n departement of subdepartement van verpleegkunde het;

(b) die studiekursus kragtens artikel 15(3) goedgekeur is;

(c) the head of the department or sub-department of nursing of the university or the head of the nursing college where the education and training is offered, is a registered nurse who holds at least a baccalaureus degree and against whose name an additional qualification in nursing education and an additional qualification in nursing administration are registered.

Admission to the course of study

4. In order to be admitted to a course of study, a person must be the holder of at least a senior certificate or an equivalent certificate which gives admission to formal post secondary education.

Duration of the course of study

5. The duration of the study course is four academic years.

Curriculum

Submission of curriculum to council

6.(1) The curriculum shall be submitted by the university or nursing college concerned to the council for approval in terms of section 15(2).

Programm objectives

(2) Such curriculum shall provide for personal and professional development of the student so that, on completion of the course of study, he -

(a) shows respect for the dignity and uniqueness of man in his social-cultural and religious context and approaches and understands him as a psychological, physical and social being within this context;

(b) is skilled in the diagnosing of individual, family, group and community health problems and in the planning and implementing of therapeutic action and nursing care for the health service consumers at any point along the health/illness continuum in all stages of the life cycle (including care of the dying), and evaluation therof;

(c) is able to direct and control the interaction with health service consumers in such a way that sympathetic and empathic interaction takes place;

(d) is able to maintain the ethical and moral codes of the profession and practise within the prescriptions of the relevant laws;

(e) endorses the principle that a comprehensive health service is essential to raise the standard of health of the total population and in practice contributes to the promotion of such a service, bearing in mind factors from within and outside the borders of the country which are a threat to health;

(f) is able to collaborate harmoniously within the nursing and multidisciplinary team in terms of the principle of interdependence and co-operation in attaining a common goal;

(g) is able to delineate personal practice according to personal knowledge and skill, practise it independently and accept responsibility therefor;

(h) is able to evaluate personal practice continuously and accept responsibility for continuing professional and personal development;

(c) die hoof van die departement of subdepartement van verpleegkunde van die universiteit of die hoof van die verplegingskollege waar die onderrig en opleiding aangebied word, 'n geregistreerde verpleegkundige is wat oor minstens 'n baccalaureus graad beskik en teenoor wie se naam 'n addisionele kwalifikasie in verpleegonderrig en 'n addisionele kwalifikasie in verpleegadministrasie geregistreer is.

Toelating tot die studiekursus

4. Ten einde tot 'n studiekursus toegelaat te word, moet 'n persoon die houer wees van minstens 'n senior of gelykwaardige sertifikaat wat toelating tot formele na-sekondêre onderwys verleen.

Duur van die studiekursus

5. Die duur van die studiekursus is vier akademiese jare.

Kurrikulum

Voorlegging van kurrikulum aan raad

6.(1) Die kurrikulum moet kragtens artikel 15(2) deur die betrokke universiteit of verplegingskollege aan die raad voorgelê word vir goedkeuring.

Programdoelstellings

(2) Sodanige kurrikulum moet voorsiening maak vir persoonlike en professionele ontwikkeling van die student sodat hy by voltooiing van die studiekursus -

(a) respek toon vir die waardigheid en uniekheid van die mens in sy sosiaal-kulturele en religieuse verband en hom as 'n psigiese, fisiese en sosiale wese binne hierdie verband benader en verstaan;

(b) vaardig is in die diagnosering van individuele gesins-, groeps- en gemeenskapsgesondheidsprobleme en in beplanning en implementering van terapeutiese optrede en verpleegsorg vir die gesondheidsdiensverbruiker op enige punt langs die gesondheid/siekte-kontinuum in alle stadia van die lewensiklus (insluitende sterwensbegeleiding), en die evaluering daarvan;

(c) in staat is om die interaksie met gesondheidsdiensverbruikers op so 'n wyse te rig en te beheer dat simpatieke en empatiese interaksie plaasvind;

(d) in staat is om die etiese en morele kodes van die professie te handhaaf en binne die voorskrifte van die tersaaklike wette te praktiseer;

(e) die beginsel onderskryf dat 'n omvattende gesondheidsdiens essensieel is om die gesondheidstandaard van die totale bevolking te verhoog en in die praktyk 'n bydrae tot die bevordering van so 'n diens lewer, inagnemend gesondheidsbedreigende faktore van binne en buite die grense van die land;

(f) in staat is om harmonieus saam te werk binne die verpleegkundige en multidissiplinêre span, volgens die beginsels van interafhanklikheid en medewerking vir die bereiking van 'n gemeenskaplike doel;

(g) in staat is om die praktyk volgens die kennis en vaardigheid at te baken, dit onafhanklik te beoefen en verantwoordelikheid daarvoor te neem;

(h) in staat is om voortdurend die praktyk te evalueer en verantwoordelikheid te neem vir voortgesette professionele en persoonlike ontwikkeling;

(i) evinces an enquiring and scientific approach to the problems of practice and is prepared to initiate and/or to accept change;

(j) is able to manage a health service unit effectively;

(k) is able to provide effective clinical training within the health service unit;

(l) is acquainted with the extent and importance of the environmental health services and knows the professional role and responsibilities in respect of the services and in respect of personal professional actions where the services are not available;

(m) is able to promote community involvement at any point along the health/illness continuum in all stages of the life cycle;

(n) has the cognitive, psychomotor and affective skills te serve as a basis for effective practice and for continuing education;

(i) 'n vraende en wetenskaplike benadering tot praktykprobleme openbaar en bereid is om verandering te inisieer en/of te aanvaar;

(j) in staat is om 'n gesondheidsdienseenheid effektief te bestuur;

(k) in staat is om doeltreffende kliniese onderrig binne die gesondheidsdienseenheid te gee;

(l) kennis dra van die omvang en belangrikheid van die omgewingsgesondheidsdienste en die professionele rol en verantwoordelikhede ken ten opsigte van die dienste, asook ten opsigte van persoonlike professionele optrede waar die dienste nie beskikbaar is nie;

(m) in staat is om gemeenskapsbetrokkenheid op enige punt langs die gesondheid/siekte-kontinuum in alle stadia van die lewensiklus te bevorder;

(n) oor die kognitiewe, psigomotoriese en effektiewe vaardighede beskik om as grondslag te dien vir doeltreffende praktyk en vir voortgesette onderwys.

Subjects

(3) The curriculum shall consist of at least the following subjects and the approach shall be the integration of the various fields of study, particularly in their clinical application:

(a) Fundamental Nursing Science, ethos and professional practice - at least one (1) academic year.

(b) General Nursing Science - at least three (3) academic years.

(c) Psychiatric Nursing Science - at least two (2) academic years.

(d) Midwifery - at least two (2) academic years.

(e) Community Nursing Science - at least to (2) academic years.

(f) Biological and natural sciences - at least two and a half ($2\frac{1}{2}$) academic years.

(g) Pharmacology - at least half ($\frac{1}{2}$) an academic year.

(h) Social Sciences - at least two (2) academic years.

(4)(a)-(b) Deleted by Government Notice No. R. 1312 dated 19 June 1987.

(5) Deleted by Government Notice No. R. 1312 dated 19 June 1987.

Examinations

(6)(a) Subject to the provisions of paragraph (b), examinations shall be conducted in all subjects prescribed in subregulation (3) and an examination mark of at least 50% shall be obtained in each subject.

(b) In the case of nursing science subjects with practical components, the theory and the practica shall be examined and passed separately in terms of the requirements of the nursing school concerned.

Vakke

(3) Die kurrikulum bestaan uit minstens die volgende vakke en die benadering moet wees om die verskeie vakgebiede met mekaar en veral in die kliniese toepassing, te integreer:

(a) Fundamentele Verpleegkunde, etos en professionele praktyk - minstens een (1) akademiese jaar.

(b) Algemene Verpleegkunde - minstens drie (3) akademiese jare.

(c) Psigiatriese Verpleegkunde - minstens twee (2) akademiese jare.

(d) Verloskundige Verpleegkunde - minstens twe (2) akademiese jare.

(e) Gemeenskapsverpleegkunde - minstens twee (2) akademiese jare.

(f) Biologiese en natuurwetenskappe - minstens twee-en-'n-halwe ($2\frac{1}{2}$) akademiese jare.

(g) Farmakologie - minstens 'n halwe ($\frac{1}{2}$) akademiese jaar.

(h) Geesteswetenskappe - minstens twee (2) akademiese jare.

(4)(a)-(b) Geskrap deur Goewermentskennisgewing No. R. 1312 gedateer 19 Junie 1987.

(5) Geskrap deur Goewermentskennisgewing No. R. 1312 gedateer 19 Junie 1987.

Eksamens

(6)(a) Behoudens die bepalings van paragraaf (b), moet eksamen in alle vakke in subregulasie (3) voorgeskryf, afgeneem word, en 'n eksamenpunt van minstens 50% in elke vak behaal word.

(b) In die geval van verpleegkundevakke met praktiese komponente moet die teorie en die praktika afsonderlik geëksamineer en geslaag word volgens die vereistes van die betrokke verpleegskool.

Application of these regulations

7.(1) Subject to the provisions of subregulation (2), examinations in terms of the provisions of the regulations published under Government Notices R. 879 of 2 May 1975, R. 880 of 2 May 1975, R. 881 of 2 May 1975 and R. 882 of 2 May 1975, as amended from time to time, shall be conducted by the council only until 31 December 1990: Provided that the following provisions of the aforementioned regulations shall remain in force and effect until a date to be determined by the Minister in the Government Gazette:

(a) Government Notice R. 879 of 2 May 1975, as amended - regulation 7.

(b) Government Notice R. 880 of 2 May 1975, as amended - regulation 7.

(c) Government Notice R. 881 of 2 May 1975, as amended - Annexure A.

(d) Government Notice R. 882 of 2 May 1975, as amended - Annexure A.

(2) Notwithstanding the provisions of the regulations referred to in subregulation (1) and the regulations relating to registers, published under Government Notice R. 3589 of 24 October 1969, as amended, no person may, after 1 January 1986, be registered as a student for the first time for a course of study leading to registration as a nurse or midwife, unless he registers for the course of study referred to in these regulations, or the course provided for in the regulations published under Government Notice R. 254 of 14 February 1975, as amended by Government Notices R. 479 of 10 March 1978 and R. 2212 of 31 October 1980.

8. The regulations published under Government Notice R. 2118 of 30 September 1983 are hereby repealed.

Toepassing van hierdie regulasies

7.(1) Behoudens die bepalings van subregulasie (2), word eksamens kragtens die bepalings van die regulasies gepubliseer onder Goewermentskennisgewings R. 879 van 2 Mei 1975, R. 880 van 2 Mei 1975, R. 881 van 2 Mei 1975, R. 882 van 2 Mei 1975, soos van tyd tot tyd gewysig, slegs tot 31 Desember 1990 deur die raad afgeneem: Met dien verstande dat die volgende bepalings van voormelde regulasies van krag bly tot 'n datum wat deur die Minister in die Staatskoerant bepaal word:

(a) Goewermentskennisgewing R. 879 van 2 Mei 1975, soos gewysig - regulasie 7.

(b) Goewermentskennisgewing R. 880 van 2 Mei 1975, soos gewysig - regulasie 7.

(c) Goewermentskennisgewing R. 881 van 2 Mei 1975, soos gewysig - Bylae A.

(d) Goewermentskennisgewing R. 882 van 2 Mei 1975, soos gewysig - Bylae A.

(2) Ondanks die bepalings van die regulasies genoem in subregulasie (1) en die regulasies betreffende registers, gepubliseer onder Goewermentskennisgewing R. 3589 van 24 Oktober 1969, soos gewysig, word geen persoon na 1 Januarie 1986 vir die eerste maal as 'n student vir 'n studiekursus wat lei tot registrasie as 'n verpleegkundige of vroedvrou geregistreer nie, tensy hy registreer vir die studiekursus in hierdie regulasies bedoel, of die kursus voorsien in die regulasies gepubliseer onder Gowermentskennisgewing R. 254 van 14 Februarie 1975, soos gewysig deur Goewermentskennisgewings R. 479 van 10 Maart 1978 en R. 2212 van 31 Oktober 1980.

8. Die regulasies gepubliseer onder Gowermentskennisgewing R. 2118 van 30 September 1983 word hierby herroep.

Gereproduseer ingevolge die Staatsdrukker se Outeursregsvergunning 7977 van 1983/06/23

Die Suid-Afrikaanse Raad op Verpleging

(Ingestel ingevolge die Wet op Verpleging, 1978)

The South African Nursing Council

(Established under the Nursing Act, 1978)

MINIMUM REQUIREMENTS FOR THE EDUCATION AND GUIDE CONCERNING THE TEACHING OF STUDENTS IN THE PROGRAMME LEADING TO REGISTRATION AS A NURSE (GENERAL, PSYCHIATRIC AND COMMUNITY) AND MIDWIFE

MINIMUM VEREISTES VIR DIE OPLEIDING EN GIDS BETREFFENDE DIE ONDERRIG VAN STUDENTE IN DIE PROGRAM WAT LEI TOT REGISTRASIE AS 'N VERPLEEGKUNDIGE (ALGEMENE, PSIGIATRIESE EN GEMEENSKAPS-) EN VROEDVROU

Regulations/Regulasies
R. 425

Date/Datum
22/02/1985

1992 Guide/Gids
1994 Amended/Gewysig

1.5 MIDWIFERY

The science and art of midwifery

The teaching must enable to student to extend and integrate the subject content of fundamental nursing science with the other nursing sub-disciplines, the related social, natural and biological sciences and relevant obstetrics to provide a scientific basis for the cognitive, psychomotor and affective skills required for the practice of midwifery in respect of both mother and foetus/neonate/infant, in hospital and community settings.

To achieve this, this the student also needs subject content in respect of

- the health of the mother, the course of normal pregnancy, labour, and puerperium, and the development and health of the foetus, neonate and infant, including
  * anatomical and physiological changes
  * diagnosis
  * management
  * early identification of mother and child (foetus, neonate and infant) at risk
  * psychosocial aspects
- abnormalities/complications in respect of of pregnancy, labour, puerperium, and the foetus, neonate and infant, including the
  * aetiology
  * pathology
  * clinical presentation
  * diagnosis
  * prevention
  * management

  of such abnormalities/complications.

2.2.6 MIDWIFERY

N.B. Before being permitted to personally deliver a patient, the student shall attend at least 5 normal deliveries as an observer.

Clinical allocation in midwifery shall be so planned that the student is enabled not only to master the necessary midwifery skills, but also to be integrated into the midwifery and multi-disciplinary teams functioning in the area.

The student should eventually be assessed not only in respect of clinical midwifery skills but also on the ability to apply management and teaching principles in the implementation of the midwifery regimen and management of the maternity unit, and also to apply self-evaluation in such a setting. This implies *inter alia*, allocation for a meaningful period and the elimination of avoidable fragmentation.

Practising within the legal scope of midwifery practice, the student shall, in the course of such allocation and with suitable accompaniment -

- apply the components fundamental to a scientific approach in -

  * carrying out the comprehensive ante-natal assessment and care of at least 30 pregnant women and recording all relevant information;

  * carrying out pelvic assessments cases of primigravida's or at the onset of labour where pelvic disproportion is suspected, the findings of which shall be checked by a registered midwife or medical practitioner;

  * recognizing the different stages of labour;

  * critically observing, monitoring and interpreting the findings in the course of all stages of labour, and providing appropriate nursing, including the provision of pain relief, in order to ensure the safety of mother and child throughout;

    The findings shall be checked by a registered midwife of a medical practitioner. The use of simulation to practise the skill is permissible, but should not be applied exclusively;

    Opportunities should be created for students to experience continuity of care throughout all stages of labour.

  * delivering at least 15 patients and conducting the 2nd and 3rd stages of labour of at least 5 patients either in the course of carrying out the deliveries indicated above, or conducting deliveries for other students;

  * mastering the skills needed for the the cutting of an episiotomy to prevent a severe tear of the perineum or complication relating to the child, provided the head is distending the perineum;

  * mastering the skills needed for administering local anaesthetic, excluding pudendal block and epidural anaesthesia, and the suturing of first and second degree tears and episiotomies;

* undertaking post-natal care, including guiding the mother in:

  - post-natal exercises
  - care of herself and her child during the puerperium
  - recognizing early signs of ill health in her child
  - breast-feeding and artificial feeding, including oral rehydration therapy for her child
  - understanding the necessity for immunization

  The student shall be responsible for the midwifery regimen in respect of mothers and babies to ensure continuity of nursing during hospitalization and after discharge. Before being implemented, each nursing plan shall be approved by the responsible registered midwife.

* presenting a comprehensive patient study based on a mother and baby nursed;

* carrying out post-natal assessments of mothers and babies during the routine post-natal visits to promote the health of both mothers and their babies. This includes comprehensive assessment of the development of infants.

The student must be enabled to recognize and take appropriate action at all times to handle complications, including obstetrical emergencies. This includes timeous referral to a midwife specialist or medical practitioner. The student must be able to assist in the carrying out of common obstetrical interventions such a induction of labour and vacuum extraction.

2.3. ALLOCATION OF CLINICAL PRACTICE HOURS

The Council requires the student's clinical practice to be appropriately distributed in respect of the nursing sub-disciplines - that is general nursing science, psychiatric nursing science, community nursing science and midwifery; relevant integration is essential.

It is recommended that the following be used as a guide-line for clinical allocation:

A. Nursing Practice (general, psychiatric and community)

Preventive and promotive health	1000 hours
Curative health	1500 hours
Rehabilitation and other, at the discretion of the school	500 hours

B. Midwifery Practice (including preventive and promotive health, curative health and rehabilitation) 1000 hours

Clinical teaching and simulation laboratory hours may constitute part of the above-mentioned hours.

ANNEXURE R

Towards the twenty-first century:

The University's Mission Statement

Wits today -- a vitally important education institution

THE fundamental role of any university is to promote freedom of enquiry and the search for knowledge and truth.
Wits has built a reputation for itself in this role, establishing itself at the industrial and commercial heart of South Africa as a centre for education and research of the highest quality.

Wits's mission is to build on this foundation in a way that takes account of its responsibilities within South Africa today; and to maintain and enhance its position as a leading university in the Republic, in Africa, and in the World by sustaining globally competitive standards of excellence in learning, teaching and research.

We are committed to:

- academic freedom, autonomy, accountability, tolerance of difference of opinion, and transparency
- democracy, justice, equality, and freedom from racism and sexism as enshrined in the Constitution
- playing a leading role in addressing historical disadvantages in the education of the majority of the population of South Africa
- fostering a culturally diverse, intellectually stimulating and harmonious environment within which there is vigorous critical exchange and communication in supporting, developing and unifying its staff and students, through providing opportunities for all to participate in the academic activities of the University, its governance and its cultural and sporting activities
- creating and maintaining accessible, safe, friendly and well-resourced campuses

Our purpose is:

- to communicate with the people and institutions of the community in which we work, so that the community will participate more effectively in fulfilling the goals and priorities of the University
- to continue to support and enhance basic, strategic and applied research, especially research of particular relevance to South Africa
- to ensure that our graduates achieve levels of skill, knowledge and understanding comparable with those of graduates from the best universities world-wide
- to continue to develop our courses to serve the needs of Southern Africa, recognising that this requires a solid foundation in basic, theoretical and comparative studies
- to improve the success rate of students through enhanced teaching and learning, and coherent academic development programmes
- to continue to attract and retain excellent staff, providing ongoing development opportunities at all levels
- to eliminate discrimination based on race, class, gender, sexual orientation and disability, through effective labour relations policies and affirmative action programmes leading to equal opportunity

These are our priorities:

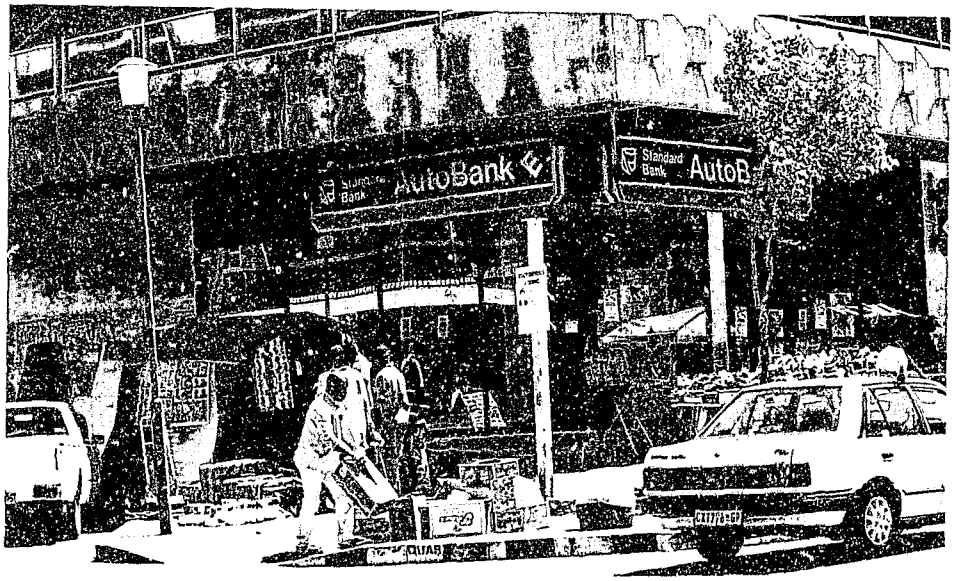
- to foster dialogue and interaction between the different cultural communities within the University, with the goal of rapidly increasing mutual respect and trust
- to ensure that the campuses are safe, well-resourced and clean, so as to build a sense of pride on the part of all stakeholders
- to foster capacity in science and engineering and to increase the number of graduates in these areas, especially from historically disadvantaged groups
- to prepare students for managerial, professional and leadership positions in the public and private sectors and to produce social scientists with the capacity for skilled research on issues of critical importance to the country
- to maintain a commitment to studies in the humanities and social sciences
- to contribute to the production and upgrading of school teachers, particularly in English, Mathematics and the Natural Sciences
- to increase the number of post-graduate students, especially from historically disadvantaged groups
- to develop flexible study programmes that will improve interaction between disciplines, mobility between institutions in post-secondary education and opportunities for part-time study
- to provide executive and certificate courses to sectors of the society it serves, including organised labour, business and the public sector, thereby also increasing income to the University
- to participate with other private and public institutions (nationally and internationally) in developing a rational and effective system of higher education in South Africa.

Wits will seek to use all its assets -- both human and physical -- to serve the intellectual, professional and educational needs of South African society

ANNEXURE S

	NURSING	COMMUNICATION	TEACH/ LEARN	GROWTH DEVELOPMENT	HEALTH ISSUES	PROFESSION	HEALTH CARE SYSTEM	CONTEXT
COMPREHENSIVE NURSING 1	Needs approach Nursing Process Community Nursing Process	• Inter-personal Skills • Written Consent • Self awareness • Group Process • Referral • Interviewing	• Health Education • Client Education • Epidemiology • contracting • Problem solving Decision making	• Elderly person • Life skills • Mental Health • Stress and stress management	• Nutrition • Culture • Lifestyle • Environment • Infection Control • Occupational Safety	• Scope of practice • Nursing Act • Professional Practice & Ethics	• Primary Health Care • W.C.A. • WHO	Bio-psycho social Human rights
COMPREHENSIVE NURSING II	Needs approach • Chronic disease • Infectious disease • Communicable disease • Nursing process • Community nursing process	• Supportive counselling • Crisis intervention	Epidemiology • Application	Coping & Defence Mechanisms	• Violence • Trauma • Culture • Lifestyle • Nutrition • Communicable • Non-Communicable • Chronic Disease	• Associated Legislation • Scope of Practice • WHO • Professional Practice & Ethics	Oncology Communicable Diseases P.H.C P.H.C Formulary E.D.L	Bio-psycho social Human Rights
COMPREHENSIVE NURSING III	Needs approach • Chronic disease • Cancer Care • Child Care Nursing Process • C.N.P	• Therapeutic counselling	• Research methodology	• Gender issues • Infant & child nutrition • Epi programme • Congenital disorders	• Lifestyle • Nutrition • Communicable • Non-communicable • Chronic Diseases • Childhood problems	• Professional Practice & Ethics • Professional • Legislation • Multi disciplinary approach	P.H.C NHP & policies Community Resources	Bio-psycho-social Human rights
COMPREHENSIVE NURSING IV	Specific Nursing Practice • Palliative care • Occupational health • School health Management Process	Professional Communication • Reports • Research • Conflict & negotiation skills	Research Methodology • Teaching • Peers • Clients • Community • Self Evaluation • Self • Patient Care	• Elderly client • School child	• Lifestyle • Trauma • Occupational health • Nutrition	• Professional practice & ethics • Occupational safety act • Nosa • Leadership	• WHO • Associated Legislation • Policies and standards • Occupational Health & Safety • Disaster Planning • Palliative Care • School & health • WCA	Bio-Psycho Social Human rights
PSYCHO-SOCIAL NURSING I	Nursing process Assessment & Diagnosis of Mental health& illness. Psychiatric Nursing skills • Counselling • Group & ind. Skills	Advanced Communication Counselling; Individual & Group skills Psychiatric interview	Self Awareness Assertiveness Stress Management Mental Health Education	Mental Health & illness in : • Child & adolescent • Adult • Elderly	• Lifestyle • Genetics • Biochemical • Psychological • Social factors	Associated Legislation • Mental Health Act • Role & function • Scope of practice • N.H.P • Management • Professional practice & ethics • Multi disciplinary	Mental health facilities: • primary • Secondary • Tertiary • Treatment modalities	Bio-Psycho social Human rights
PSYCHO-SOCIAL NURSING II	Nursing Process Psychiatric Nursing Therapies • Ind & group therapies • Crisis Intervention • Milieu	Individual • Supportive • Cognitive- behavioural • Behavioural Group • Family & Marital • Crisis Therapies • Milieu Mental Health Education	Community Health Care Prevention of relapse Family& marital interventions	Genetics: assessment of mentally retarded child and family. Stimulation Programmes	Abuse • Woman • Child • Domestic • Elderly • Lifestyle • nutrition	• Mental Health Act • S.O.P • N.H.P • Professional Practice & Ethics	Community Psychiatry PHC Alternative practices	Bio-Psycho social Human Rights
WOMEN'S HEALTH I	Needs approach • Women • Neonate	Stress Management Non-verbal Verbal Family relationships	Self Assessment for client Self Care Neonatal Care	• Fertility control • Parenting • Empowerment • Pregnancy • Breast feeding • Menopause • Abortions	• Lifestyle • Mature Woman • S.T.D.'s • Culture • Nutrition • Psycho-social culture	WHO - E.P.L - Safe Motherhood • Scope of practice • N.H.P • Child act • Abortion Act • Professional Practice • Transcultural Care	Primary Health Care Alternative Health practice and ethics	Bio-Psycho social Human Rights
WOMEN'S HEALTH II	Needs approach • Problems • Older women • High risk neonate	Feminist Issues Family Relationships	Health Promotion Older Women	Carcinomas • Cervix • Breast • Impaired Foetal /Neonatal development • Impairments Bearing middle/older women & pathology in child	• Lifestyle • Culture • Nutrition • Women abuse • Single parenthood	• Abortion Act • Professional Practice & ethics	Referral systems Adoption	Bio-Psycho social Human Rights

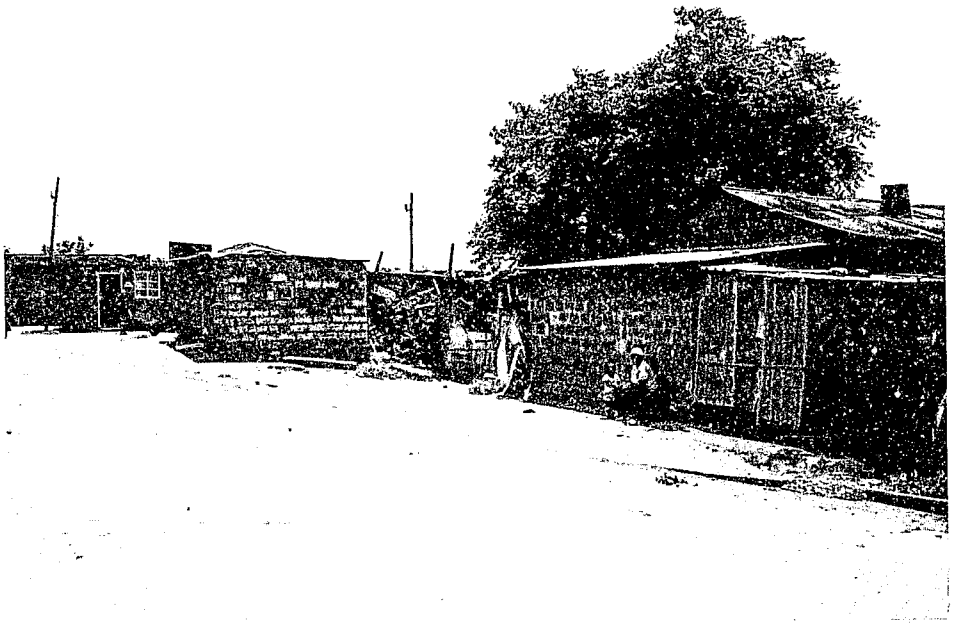
ANNEXURE T



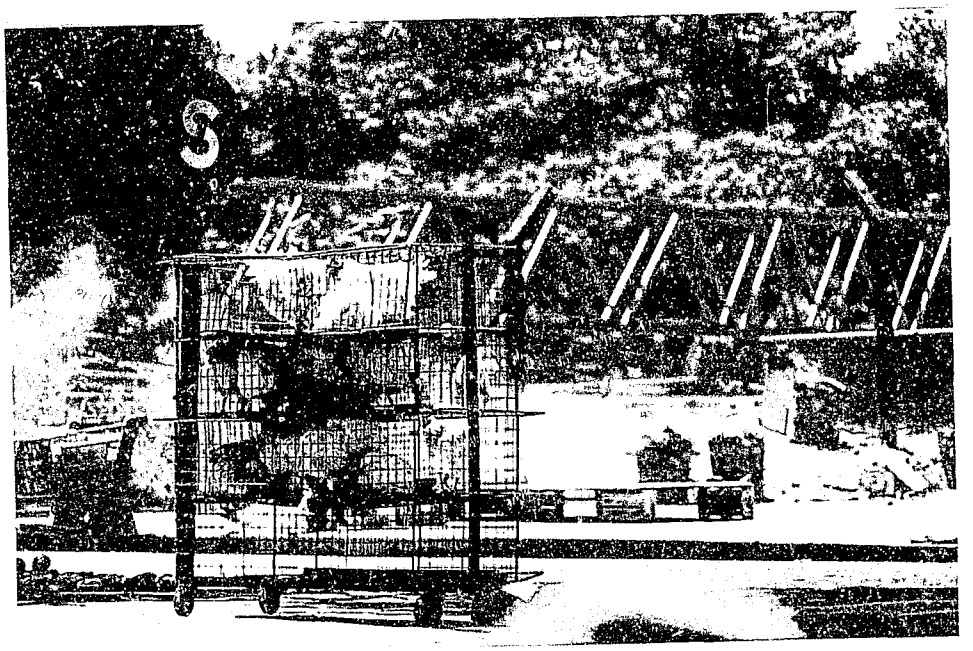
Site A - Street Vendor



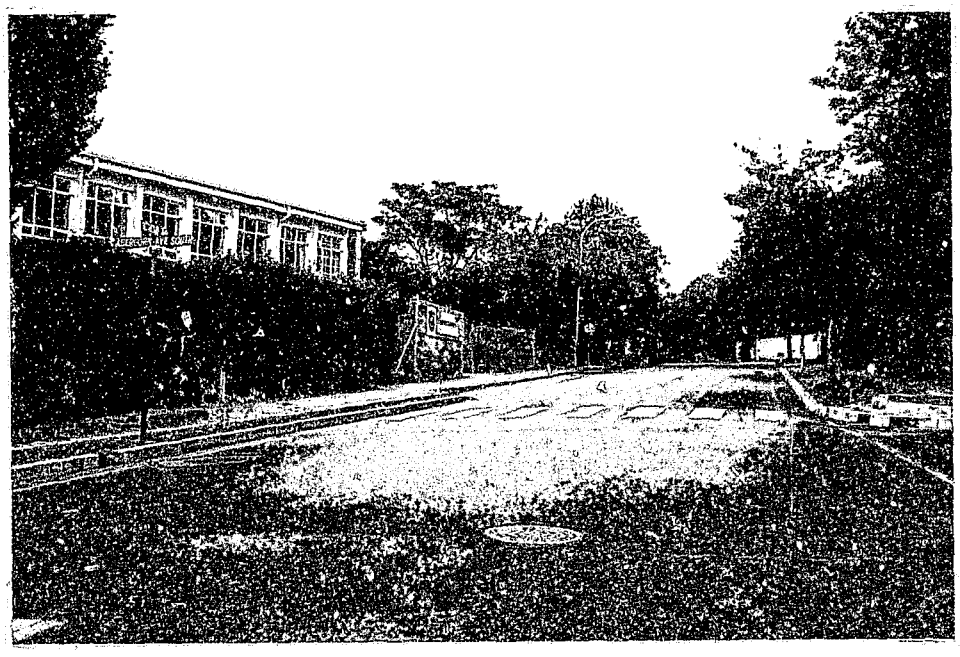
Site A - Street Children



Site B - A "Home" in the street behind the Health Centre



Site C - A Street Vendor



Site D - A school in the suburb and the leafy streets

ANNEXURE U

Recurriculating to a problem-based learning curriculum: The WITS experience

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OPSOMMING

Die rasionaal vir die verandering vanaf 'n tradisionele kurrikulum na 'n probleemgebaseerde kurrikulum word geskets. Die voorbereidings proses vir hierdie verandering word ook beskryf. Gedurende die beplanningsfase was gebruik gemaak van werkwinkels, kernkommittees, internasionale konferensies en besoeke. +Die voorbereiding van mense b:onne en ander hulpbronne in geaffileerde departmente word kortliks beskryf. Die implementeringsfase beskryf sommige van die probleme wat ondervind was, asook die oplossings wat daarvoor gevind was. Ten slotte, 'n informele evaluasie van die eerste ondervindinge van probleem-gebaseerde leer, word aangebied.

The themes that we chose were:
nursing
health determinants
teaching\learning
health care systems
profession
communication

SUMMARY

The reasons for changing from a traditional curriculum to a problem-based learning curriculum are outlined. The process used in preparing for this change is described. The planning phase made use of workshops, core committees and international workshops and visits. Preparation of the necessary resources are enumerated, as are the preparation of the human resources with which the department is affiliated. The early implementation phase describes some of the problems which were encountered and the solutions which were ascribed. Finally an informal evaluation of the first experiences of problem-based learning is presented.

Report

The concept of this gestation was first raised in 1989 when a workshop for the Wits staff and its affiliated colleges was organised. As in nature, the concept was aborted for multi-factoral reasons; possibly the most significant factor being lack of clarity of our understanding of the meaning of the concept and its implementation, or should that read implantation?!

Whatever, in reflection, our understanding of problem based learning was very inadequate. However, in 1993 the need to reconsider the current curriculum and our teaching styles was once again felt.

1995 dawned with the staff of the Wits Department of Nursing Education feeling somewhat apprehensive, but at the same time excited about the new academic year. This, after all was to be the culmination of two years of planning, hard work, heart ache and many sleepless nights for the staff. The time had finally arrived for us to put our decisions and plans into action and introduce a community-based curriculum utilising problem-based learning as the method of teaching and learning.

BACKGROUND AND PLANNING.

In 1993 a curriculum review was begun. It was clear that given the knowledge explosion and the need to educate and adequately prepare practitioners for primary health care that the current curriculum did not meet these needs and that alternative teaching\learning strategies had to be sought. To prepare practitioners for primary health care, a community-based curriculum seemed the obvious solution.

We aim to have a 40:60% community:hospital based curriculum. In order to cope with the knowledge explosion and the need to produce self-directed learners and critical thinkers, but at the same time a health care worker who is able to work in a team, we chose to develop a problem based learning curriculum.

In 1993 we spent a total of 5 days in workshops discussing and debating the existing curriculum and the way forward.Two of these days were spent discussing the concept of community-based education in relation to what we were currently doing and in relation to what we all believed and the department's philosophy. For this workshop we made use of a facilitator, who is a medical practitioner with a keen interest in education and problem based learning in particular.

The fact that this person was not a nurse proved to have many advantages, e.g. he often saw our problems from a different perspective and was therefore able to offer solutions.Following this workshop the staff met on their own for a one day workshop to plan a curriculum based on a philosophy of health to illness and integration of the four nursing disciplines. To do this numerous concepts had to be debated, discussed and defined. The day ended with a broad outline of what we felt could be fitted into each year of study and how this content should be managed.

Later that year we had a two day workshop on problem based learning. We made use of the same facilitator. For most of the staff this was their first exposure to problem based learning - its philosophy and methodology. A lengthy debate followed along the lines of whether we should go this route, and if so, why?

It was agreed that this was the route that the department should follow and commitment and agreement was called for from each staff member because it was obvious that it would require team work. Planning continued in 1994.

In March we spent one day with a visiting lecturer\obstetrician from Mc Master University in Canada. She was briefed on how far we had gone in our planning and gave guidance on the way forward, but essentially it was a question and answer day with many of the staff's fears, anxieties and queries being addressed.

At this stage it was clear that doubt was beginning to creep into the minds of some. This was probably because it was the beginning of the new academic year and like most university nursing departments a number of the staff were persuing their own studies. The thought of all that had to be done in readiness for a new curriculum, now less than a year away, appeared overwhelming.

In March two members of staff attended the community-based education and problem-based learning workshop at the University of Suez in Egypt. This was a valuable experience because it reinforced that our line of thinking and planning was on track. It also provided opportunity for discussion and clarification with people involved with the strategy.

In developing a problem-based learning curriculum, we identified two issues which needed to be given priority. These were: firstly, the need to develop an integrated curriculum, and secondly, to develop themes. As a result of this need two more two day workshops were held. Both were facilitated.

At the first, we developed our themes. We did this by taking the problem of teenage pregnancy and brain storming all the concepts with which it is associated. These were then clustered and appropriate names sought which fitted the philosophy.

The themes that we chose were:

nursing

health determinants

teaching\learning

health care systems

profession

communication

all within the context of values\ beliefs and skills. (Skills include those that refer to basic nursing, communication and emergency care.)

The time had finally arrived for us to put our decisions and plans into action and introduce a community-based curriculum...

Building on the foundation of a community-based curriculum, it was decided to use a health to illness continuum, focusing on the individual, family and the community. Thus the focus for the first year of study became the healthy individual, family and community and that for the second year of study the individual suffering from an illness and the disordered family and community.

At this stage it became obvious that the traditional terminology for the nursing courses was not suitable in an integrated curriculum. General nursing and community health nursing have evolved into Comprehensive Nursing; Midwifery into Women's Health and Psychiatric Nursing into Psycho-social nursing. This approach facilitates integration of the courses at both the theoretical and practical levels of learning.

The next step was to identify the concepts under each theme and which fitted the focus for the first year of study, viz. the healthy individual, family and community.

The second workshop focused on the preparation of facilitators. We used some of the problems that we had written and role-played small group work in a problem-based learning context.

In the planning phase it was also clear

that we had to sell the new curriculum to the faculty and the students. Getting the faculty to agree to the change was not problematic, as there was already a move to change the medical curriculum and there had been several international visitors who came from schools using a problem-based learning approach.

The occupational therapy department was also planning a change in this direction. In order to sell the curriculum to the students, a meeting of all students was called and the philosophy and meaning of problem-based learning was explained to them. As the new curriculum was to be introduced with the 1995 first year students,they were assured that the changes would not affect them.

During the last six months of 1994 a survey regarding the nursing students opinions of the curriculum was undertaken. The demographic data of the survey revealed that the profile of the student entering the programme was more likely to be a female aged 19-25 years. She was most likely to have entered the programme directly from school.

Two national school leaving certificates were identified as being the basis on which the entry requirements would be applied. The successful candidate into the programme was likely to have obtained a C symbol aggregate on her school leaving certificate. In addition, she will very likely come from an urban area and there is an above average chance that her home language will not be English.

During this period meetings were held on a weekly basis and lasted a minimum of three hours. The problems were discussed and refined; books and resource material had to be evaluated and orders placed; resource boxes and methods of control had to be decided upon and opportunities for, and links with, community-based facilities had to be forged.

In preparing for problem-based learning, factors that should be considered at this point are:

1. resource material - cost; orders take months to arrive, therefore, ordering needs to be done at least three months in advance.

2. administrative backup for typing, printing and copying of the problems and accompanying documentation.

3. identification of facilitators and their preparation and identification of resource or expert persons.

4. "sell" the curriculum to hospital and community personnel and to prospective students. With reference to the latter this was done at the interview for the selection of the 1995 intake of students and was reinforced on their arrival in 1995.

Problems encountered in the planning phase.

Reflecting on this now, nearly three years later, I would say that the greatest problems revolved around the need to make the entire staff committed to the concept and the feelings of insecurity which we all felt at some stage or another. It was, and still is not, easy to prepare for such a changed curriculum whilst still teaching the traditional curriculum.

This is because we chose to institute the new curriculum with the 1995 intake of students, rather than to change those already in the programme on to the new curriculum. The fact that we are a small staff did not help the situation. The only solution to the problem was to free one full-time member of staff of her duties and buy in help for a period of five months.

A second member of staff was going on sabattical leave and was keen to be kept involved with the changes. Together, with the head of department, a core committee was formed and weekly meetings were held. During this period one needed to keep focused on the desired changes, and prevent oneself from falling into the trap of "patching" the old curriculum!

In preparing for the community-based aspects of the curriculum, it was necessary to identify, evaluate and gain access to community resources. Whilst there are a number of resources which one could access, transport and violence are major obstacles in determining their use. In addition, we found that many of these resources were not keen to have first year students.The attitude is that students must be useful and at first year level they are perceived as being wide-eyed observers!

Finally, we did not find writing problems for the first year all that easy! There were two reasons for this - firstly, we, the staff, were novices in this aspect and secondly, with the focus on health - how does one create problems!?

Problems encountered in the early implementation phase.

One of the greatest anxieties during this phase was the staff's insecurity in their new role of facilitation. We did make mistakes, e.g. in the first sessions in which the groups formulated their norms, we forgot to tell them that the groups would change mid-year. When we did this after they had set their norms they were angry. Mid-year when we did want to change them, they confronted the staff. The matter was discussed in a combined facilitator and group meeting and was solved to the satisfaction of all. We interpreted this incident as an indication that empowerment was taking place.

Soon after the commencement of the course, it became obvious to the facilitators that the second language students were reluctant to participate in the group discussions. A group was offered to all students who felt that they were struggling with the process. This group was run by a facilitator whose first language is not English.

Offering the support in this way had the desired effect in that although the first sessions were representative of the problem-based groups, they dwindled so that the second language students came to form the core group.

They shared with the facilitator the following difficulties:

- firstly, that because they are mentally translating from English into the vernacular and then back again, they appear slow and stupid;
- secondly, they perceived a lack of patience in the groups with the slow students.

Students were encouraged to share and take risks in this group. The intention being that as they became more self-confident and improved their language skills they would transfer this to their problem-based learning group.

The need was recognised to have a facilitators support group. This group provided opportunity for debriefing and for discussing insecurities about the role, as well as situations which may have caused concern in any problem-based group. This was done without violating group norms.

Other problems which students encountered in this phase related to the depth of study to which they should go; time management and the ability to discriminate what is essential information from the literature. Getting students to access information through the use of subject experts and organizations has also been a slow process.

Another concept with which they have had to come to terms is learning to give their opinions and share ideas.

The matter was discussed in a combined facilitator and group meeting and was solved to the satisfaction of all

Our schooling system is very competitive and does not prepare students for the sharing and group work which is so central to problem-based learning.

AN EVALUATION OF OUR EXPERIENCE

No formal scientific evaluation of our first year's experience has been done. However, we have done a small student evaluation of the problems and have noted a number of subjective incidences. Some of the more subjective incidences, which we the staff have perceived, relate to the following - in planning community experiences the intention was to provide learning opportunities which related to the problem.

Students were encouraged to participate in the process of choosing these opportunities. Entrenched in this, was the moral and ethical responsibility that they had to not only use the community for their purposes, but wherever possible to make a contribution.

One contribution that the students made was to a woman's shelter. They formulated inexpensive, but balanced menus using a food subsidy scheme. The menus were acceptable to the shelter and a link was forged between the shelter and the subsidy scheme.

A year later, this is still operational. The practical preceptors have noticed a different attitude in these students. They have found them to come better prepared to the practical demonstrations and to be more questioning and more willing to make greater use of their practical learning experiences.

Lastly, their written examinations have reflected individual thinking and a break from stereo-typed answers. The second language students appear to have benefitted from the group discussions and having to verbalise their thoughts.

With reference to the students' evaluation of the problems, students were given an evaluation form to complete at the beginning of the second semester. One of the questions asked related to which problem they had most enjoyed and why?

Eleven of 27 had most enjoyed "Rory" - a problem that deals with the adolescent, nutrition and communication.

Some of the reasons given were:

- these are problems in my age group;
- nutrition is interesting - could explore physiology;
- psychological aspects of nutrition;

improved my nutrition.

Nine of 27 had most enjoyed "Mary-Jo" - a problem that relates to the health care system.

It begins with Mary-Jo being examined by the school nurse and scoliosis being detected. The main reason given for choosing this problem was its relatedness to nursing.

Generally students are positive about problem-based learning. During the first six months comments such as "I wouldn't like to go back to traditional methods" have been passed, and a repeat student views problem-based learning as a more exciting and superior methodology.

CONCLUSION

Overall, the staff does not regret having made such a change in the teaching\learning approach. Although not scientifically evaluated, it is fair to say that we have seen evidence of self-directed and critical thinking in the students.

Changing to a problem-based curriculum has not been without all the anxiety that goes with change and we recognise and accept that we still have a long road to travel!

ACKNOWLEDGEMENTS

To Professor Barbara Robertson for her insight and wisdom in guiding us through this change and for giving the staff the courage to do it.

To my colleagues in the Wits Department of Nursing Education for their contributions to the changed curriculum.

To nurse educator colleagues in Canada and Australia who so willingly shared their knowledge and expertise with us.



Author Mc Inerney P A M
Name of thesis The Development Of A Community-Based, Problem-Based Learning Curriculum In The Undergraduate Degree In Nursing With Special Emphasis On The Child-Bearing Women In Women's Health Volume 1

PUBLISHER:
University of the Witwatersrand, Johannesburg
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