

CLINICAL TEACHING PRACTICES IN MATERNAL MENTAL HEALTH IN THE
SELECTED CHRISTIAN HEALTH ASSOCIATION OF MALAWI'S NURSING COLLEGES

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A thesis submitted to the Faculty of Health Sciences in partial fulfillment of the requirements for
the award of the degree of Master of Science in Nursing Education (Clinical Teaching)

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FEBRUARY, 2024

DECLARATION

I, **Chrissie Rashidi Hussein**, do hereby declare that this thesis is my original work and has not been submitted to any other university for any award.

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DEDICATION

I dedicate this work to my parents; Mr. Rashidi Anafi and Mrs. Annie Gertrude Rashid for always encouraging me to pursue further studies. May the Almighty Allah reward them abundantly and make it easy for them. Inshaa Allah.

ACKNOWLEDGEMENT

First of all, I want to thank the Almighty Allah for giving me life, strength and grace to work hard, and wisdom to complete this great achievement in life. I would also like to express my sincere appreciation to:

- My supervisors, Associate Professor Thokozani Bvumbwe and Mr. Masumbuko Baluwa, for their encouragement, advice, and inspiration through this long and interesting journey. Their unconditional support and encouragement kept me going in times when I lost hope.
- I thank the Management of Mzuzu University for funding my studies and St Johns Institute for Health for allowing me to pursue my studies and also for believing in my potential to succeed in life.
- The management of St. Luke's and Ekwendeni College of Health Sciences for allowing me to conduct this study at their institutions. More thanks should go to nurse educators and students at the said institutions for their support during the data collection period.
- My dear husband Daniel and children, Wemma, Waqeela, and Waheeda, for always being there for me. Your unwavering support and love made this achievement possible.

May the Almighty God bless you all!!

ABSTRACT

Clinical teaching practices of nurse educators are very important in building students' competencies and preparing them for practice. However, most nurse midwife technicians trained by the Christian Health Association of Malawi lack competencies in mental health services, as a result, clients are missed and undertreated, which negatively affects care. The study aimed to assess clinical teaching practices in maternal mental health in the selected Christian Health Association of Malawi's nursing colleges. This explanatory sequential mixed methods study was conducted at St. Luke's and Ekwendeni College of Health Sciences, where 183 participants were recruited using convenient and purposive sampling techniques. Data was collected through a survey, in-depth interviews, focus group discussions, and document reviews. Descriptive statistics, Fisher's exact test, thematic analysis, and content analysis were used to analyze the data. The findings show that maternal mental health is a neglected area because nurse educators implement a few MMH competencies in the NMT education program, such as documentation ($M = 4.55 \pm 0.595$), collaboration of care ($M = 4.27 \pm 0.78$), and referral ($M = 4.08 \pm 0.910$). Furthermore, nurse educators use a few teaching practices, like sharing clinical objectives ($M = 4.17 \pm 0.964$), encouraging students to develop individual objectives ($M = 4.51 \pm 0.680$), and orienting students to clinical objectives ($M = 4.39 \pm 0.728$). The Fishers exact test revealed an association between the gender of students and the utilization of clinical teaching strategies in MMH (two-tailed p -value = 0.011). Furthermore, the qualitative findings discovered six themes, which include: the assessment and management of maternal women with mental health problems; clinical teaching and student support; maternal mental health practice has been neglected; difficulty in translating theoretical knowledge into practice; and functional teaching and learning in maternal mental health care. The findings further show that nurse educators face

some challenges when implementing maternal mental health clinical competencies, such as inadequate competencies in the nurse midwife technician's curriculum, a shortage of skilled nurse educators, limited time for student practice, and a lack of teaching and learning resources, which act as barriers to student's achievement of MMH competencies. The study recommends nursing and midwifery curriculum review, continuous professional development, and the mobilization of resources to support student's learning. Nursing colleges should review their curriculum periodically, to maximize student learning opportunities in maternal mental health practice. Effective collaboration between academia, students, and hospital staff is required to enhance student competence development.

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LIST OF ABBREVIATIONS

Bsc	:	Bachelor of Science
CHAM	:	Christian Health Association of Malawi
COPA	:	Competency Outcome Performance Assessment
Dip	:	Diploma
DOF	:	Dean of Faculty
ECHS	:	Ekwendeni College of Health Sciences
FDG	:	Focus Group Discussion
HEE	:	Health Education in England
ICM	:	International Confederation of Midwife
LPE	:	Learning from Patient Experiences
MMH	:	Maternal Mental Health
MMRD	:	Mixed Method Research Design
MOH	:	Ministry of Health
Msc	:	Master of Science
MZUNIREC	:	Mzuzu University Research Ethical Committee
NE	:	Nurse Educator

NMCM	:	Nurses and Midwives Council of Malawi
NMT	:	Nurse Midwife Technician
OSCE	:	Objective Structured Clinical Examination
PMH	:	Perinatal Mental Health
RCOG	:	Royal College of Obstetrics and Gynecology
RNM	:	Registered Nurse Midwife
SLCHS	:	St Luke’s College of Health Sciences
SPSS	:	Statistical Package for Social Sciences
UNFPA	:	United Nations Fund for Population Activities
USA	:	United States of America
WHO	:	World Health Organization

OPERATIONAL DEFINITIONS

Nurse educator: Refers to a nurse-midwife professional, including tutors involved in student teaching theory and practice in midwifery or mental health nursing. The clinical teacher follows students from the classroom experience to clinical practice.

Competence: Refers to the ability of the nurse to integrate and apply the knowledge, skills, attitudes, and personal behavior in the provision of maternal mental health care (Fukada, 2018).

Nurse-Midwife Technician: Refers to a student undergoing a three-year nursing and midwifery diploma program from an accredited institution leading to qualification as a qualified nurse and midwifery technician (Nurses and Midwives Council of Malawi, 2016).

Maternal mental health: Refers to a state of well-being in which a mother realizes her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to her community (UNFPA/WHO, 2009).

Maternal/perinatal mental health problems: These are mental health problems that occur during pregnancy and one year after delivery, and include depression, anxiety, and puerperal psychosis (Nakidde, Kumakech, and Mugisha 2023).

Clinical teaching: Refers to teaching and learning that takes place close to the patient, and forms the basis for competence development in the nursing profession (Atakro and Gross 2016).

Maternal woman: refers to any woman who is pregnant, in labor, and in the postnatal period (Nakidde et al. 2023).

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.0 Introduction

The foundation of competence development in the nursing profession is clinical teaching, which is defined as instruction and learning that occurs near patients (Atakro and Gross 2016). Clinical teaching practices of nurse educators are very important because they strengthen the integration of theory and practice, and help students acquire the competencies required in the nursing profession (Järvinen et al. 2021). Teaching students in the clinical setting builds confidence by exposing students to the realities of professional practice that cannot be conveyed through classroom learning alone. However, for students to develop skills there must be a competent individual who teaches and supervises the integration of theoretical knowledge into practice. This person is called a nurse educator or clinical instructor or faculty member or preceptor or clinical teacher (Oermann et al., 2022).

In Malawi, nurse educators, preceptors, and registered nurses (RNs) are responsible for teaching and supervising students in clinical areas to promote competence development. The majority of the nurse educators are employed by the Christian Health Association of Malawi (CHAM), where their role is to teach in the classroom and supervise students in the clinical area (Mbirimtengerenji 2018). Apart from training paramedics, CHAM, as a network of church-based organizations and a second provider of health care services, also trains nurses midwife technicians (NMT), and RNs. Out of the 11 nursing colleges under the organization, nine offer the NMT program, while the rest train RNs.

It is estimated that over 87% of nurses in Malawi are NMTs, who are the main frontline healthcare providers (Ministry of Health, 2017). NMTs are trained to provide general patient

care, midwifery, and mental health services. Despite these roles, NMTs still lack competence in nursing and midwifery-related procedures, with maternal mental health (MMH) services being the most affected (Chorwe-Sungani and Chipps 2018; Ng'oma et al. 2019; Phuma-Ngaiyaye, Adejumo, and Dartey 2017). However, the way students are supported in the clinical area to attain MMH competencies has not yet been explored, resulting in a dearth of literature on MMH clinical teaching practices of nurse educators in the NMT educational program. It is against this background that this study was conducted to address the knowledge gap.

1.1 Background Information

Student preparation for competence development involves classroom learning, clinical teaching, and practice (Vuso and James 2017). The nurse educator's clinical teaching practices encompass a range of activities aimed at fostering the development of students' competencies in teaching, supervising, and supporting (Gcawu et al. 2021; Järvinen et al. 2021). These practices are crucial in equipping students with essential skills required for their future practice, while also safeguarding patients from potential medical errors and mistakes (Goh et al. 2021). The nursing educational syllabi and curriculum clearly define the knowledge, skills, and attitudes that students are expected to acquire to attain competencies in the nursing profession. Students are expected to spend 75% of the education program in the clinical area to sharpen their skills, under the supervision and support of nurse educators (Gaberson, Shellenbarger, and Marilyn, 2022). This is because clinical teaching is intended to be enriched with skills practice to assist students in acquiring and mastering competencies within a comfortable and secure setting. Following skills practice in a simulated setting, students are required to apply their knowledge on actual patients in the health care setting to integrate theory and clinical practice.

In MMH practice, midwives are expected to have competencies in screening, psychological support, management of common mental health conditions, and use of psychotropic drugs which can be acquired through preservice education and continuous professional training (Davies et al. 2016; WHO 2022). However, there are discrepancies in the training of healthcare professionals worldwide to ensure healthcare providers possess the necessary MMH competencies across countries (Legere et al. 2017). This is evident in the way mental health education is conducted around the world. For instance, in high-income countries such as Australia, England, and Ireland, apart from a course in mental health psychiatric nursing, midwives are also provided with a specific MMH module covering competencies, teaching strategies, and assessment approaches. The MMH module is used for preparing, supervising, and evaluating students' achievement of skills in MMH practice, as a result, students trained using this module were found competent in identifying and supporting clients with MMH-related problems. However, it is reported that students trained had more time for theoretical preparation than clinical practice (Davies et al. 2016; Wang et al. 2022) (Davies et al., 2016; Wang et al., 2022).

In European countries like Finland and France, the MMH course is integrated into child and adult psychiatry, encouraging healthcare providers to practice and develop competencies (Dias et al., 2022). However, it is not clear how students are prepared in the classroom and clinical areas. In Malta, the MMH module is compulsory for healthcare workers, enabling students to learn and practice in the classroom and clinical areas (Sönmez, Dias, and Costa 2017). In Nepal, theoretical and clinical practice are taken as elective courses with few hours of clinical practice; as such, students may decide whether to practice in the clinical area or not (Acharya et al. 2017; Dias et al. 2022). Furthermore, there is limited mental health content in the nursing curriculum and few opportunities for students to practice in the clinical setting, making it difficult for them

to gain MMH competencies. Such variations have resulted in a lack of competence, a practice gap, and inconsistencies in MMH training among healthcare providers across countries since the quality of care they provide depends on the competencies acquired during the preservice education (Bayrampour, Hapsari, and Pavlovic 2018; Dias et al. 2022).

In African countries, MMH competencies have been embedded in adult mental health psychiatric and midwifery courses (Adjorlolo and Aziato 2020; Ambikile, Leshabari, and Ohnishi 2020; Brown, Macnaughton, and Sprague 2020). However, studies done in South Africa and Tanzania observed inadequate content in the curriculum, fewer hours for clinical practice, and a mismatch between skills learned in the classroom and what is expected of the student during practice as challenges to the achievement of MMH clinical competencies (Ambikile et al. 2020; Brown et al. 2020). Furthermore, the limited inclusion of MMH competencies in the curriculum contributes to a lack of understanding regarding these essential skills. Consequently, midwives are prevented from delivering high-quality care to clients.

In Malawi, mental health psychiatric nursing is one of the 16 courses that are taught to NMTs during their preservice education. The main aim of the course is to promote mental health and help students acquire the knowledge, skills, and attitudes required to identify and manage common mental health and psychiatric conditions (Christian Health Association of Malawi 2020). Students are expected to learn various mental health competencies such as knowledge on the management of mental health psychiatric conditions, interviewing, and counselling skills. Some of the mental health competencies are also found in midwifery science courses where the student is supposed to identify and manage maternal women with depression, anxiety, and puerperal psychosis.

Student NMTs spend 240 hours in both theory and clinical practice to enable them to manage clients with various mental health problems (Christian Health Association of Malawi 2020). Out of the 240 hours, 160 hours are for clinical practice, 70 hours for clinical practice, and 10 hours for practice in the skills laboratory. However, despite this preparation, NMTs do not manage MMH problems due to a lack of competence (Kulisewa et al. 2022; Mwale and Mselle 2017). To ensure that midwives are competent, the International Confederation of Midwives (ICM) established mandatory competencies to guide midwifery education curricula, outlining the essential qualities that graduates should possess. Additionally, the Nurse and Midwives Council of Malawi (NMCM) adopted these competencies to inform and direct the training of undergraduate midwives in Malawi. Nonetheless, MMH services in Malawi face numerous challenges, making it uncertain whether midwives achieved the necessary competency during preservice education. How students are prepared to provide MMH services and its teaching strategies have not been studied, making it difficult to determine the extent to which they have been taught these skills. Furthermore, most studies in Malawi have focused on MMH practice and not clinical teaching practices done by nurse educators (Chorwe-Sungani and Chipps 2018; Mutahi et al. 2022; Ng'oma et al. 2019). Considering the crucial role of NMTs in maternal health, it is important for them to possess these skills to enable them to provide quality and holistic care to individuals seeking MMH services. It is against this background that this study was conducted to assess the clinical teaching practices of nurse educators in MMH care in CHAM nursing colleges since it was unknown.

1.2 Problem Statement

Malawi is one of the countries in Africa that is experiencing MMH problems at a rate of 23% (Chorwe-Sungani and Chipps 2018). The prevalence is estimated at 21.1% and 33.3% in

Mangochi and Mzimba districts, respectively (Silungwe 2021; Stewart et al. 2015). There is evidence that screening for MMH problems facilitates early identification and treatment, which further promotes quality care and recovery, hence reducing the burden of MMH problems (Pfoh et al. 2020). Although screening for MMH problems is a core competence of midwives (International Confederation of Midwives 2018), an anecdotal report in Malawi has indicated that most women with MMH problems are not screened and treated for MMH problems because NMTs do not have the necessary MMH competencies. Consequently, women with mental health problems are missed and not treated. It is reported that women with untreated MMH are more likely to experience obstetric problems such as preterm births, stillbirths, low birth weight babies, and maternal deaths (Rondon and Stewart 2017). This is the case in Malawi, where preterm births and low birth weight rates are at 10.7% and 15.1%, respectively, while the maternal mortality rate is at 439 per 100,000 (Balkus et al., 2021; Ministry of Health. Republic of Malawi, 2015).

To improve the competence of midwives, CHAM and the NMCM reviewed the NMT curriculum for all nursing colleges in 2020, where clinical courses were strengthened and nurse educators were encouraged to use participatory teaching methods (Christian Health Association of Malawi 2020). Furthermore, nurse educators in CHAM nursing colleges were also trained in clinical teaching to improve their competencies in supporting students in the clinical area (Mhango, Baluwa, and Chirwa 2021). Despite this preparation, NMTs still lack competencies in nursing-related procedures, with MMH services being the most affected as their focus of care is on physical health only and not mental health problems (Bvumbwe 2016; Mtegha et al. 2022; Ng'oma et al. 2019). Furthermore, observation and experience have shown that NMT students from CHAM colleges are being taught and supported in the clinical setting by both trained and

untrained nurse educators. How nurse educators conduct clinical teaching to help NMT students attain MMH competencies is unknown. Therefore, this study assessed the clinical teaching practices of nurse educators in MMH in selected CHAM's nursing colleges.

1.3 Broad Objective

The study aimed to assess clinical teaching practices in MMH in selected CHAM's nursing colleges.

1.4 Specific Objectives

1. Describe MMH clinical competencies that nurse educators implement during student midwife practice.
2. Assess clinical teaching strategies nurse educators utilize in MMH competencies.
3. Describe the challenges nurse educators face when teaching students MMH competencies.
4. Explore students' experiences in attaining MMH competencies in clinical practice.

1.5 Research Questions

1. What MMH clinical competencies are implemented by nurse educators during student practice?
2. What clinical teaching strategies are nurse educators utilizing in MMH competencies?
3. What challenges are faced by nurse educators when teaching students MMH competencies?
4. What are the experiences of NMT students in attaining MMH competencies in clinical practice?

1.6 Research Hypotheses

1. There is no association between the social demographic variables of nurse educators (age, years of experience, gender, qualifications, specialization) and the MMH competencies, clinical teaching strategies, and challenges.
2. There is no association between the social demographic variables of students (age and gender) and the MMH competencies, clinical teaching strategies, and challenges.

1.7 Significance of the Study

Investigating the clinical teaching practices of nurse educators is very important in promoting and addressing the MMH competence gap among midwives in Malawi. The findings from the study would provide evidence-based information on clinical teaching practices, which would help in determining whether students are adequately prepared for MMH care or not. The gaps identified would help to identify teaching strategies that can be put in place to improve MMH competencies for NMTs. As the standards and quality of clinical teaching improve, this would also improve competence development in students, which would directly influence the quality of MMH care for women. Furthermore, the feedback from the study would be used in developing guidelines for clinical teaching practices in MMH care to be utilized in all CHAM colleges based on the present situation.

Taking into consideration that NMTs are the major healthcare providers in Malawi, they need adequate skills to ensure their ability to provide quality MMH care upon entry into practice and address primary healthcare needs. Additionally, in Malawi, there is limited data regarding clinical teaching practices in MMH for aspiring nurse educators. Assessing clinical teaching practices would help to identify specific competencies in MMH, their teaching strategies, and

challenges faced by nurse educators when teaching students MMH competencies. Additionally, findings from this study can be utilized by stakeholders to improve nursing education in Malawi through curriculum reviews and capacity building for nurse educators to strengthen clinical teaching courses for NMTs. Considering that there is a stigma attached to mental health education, this study intends to motivate nurse educators to develop a positive attitude towards mental health clinical teaching by laying out procedures that will be used in Malawi and other countries. This study will create knowledge gaps and involve other stakeholders who will collaborate with nurse educators to research more in MMH and bring policies that will help to ensure that students are well-equipped with MMH competencies.

1.8 Conclusion

This chapter has presented clinical teaching practices and MMH competencies information at the international, regional, and local levels. The problem statement of the study outlined the need and the reason why the study was carried out. Further, the study has highlighted the aim and significance of the study. Additionally, specific objectives of the study were also outlined, along with research questions and hypotheses.

CHAPTER 2: LITERATURE REVIEW

2.0 Introduction

This chapter presents the available literature on clinical teaching practices in MMH care. The chapter starts by providing literature on the competencies required in nursing practice, MMH clinical competencies, clinical teaching strategies used, challenges faced by nurse educators when teaching students MMH competencies, and experiences of students in attaining MMH competencies. Databases such as PubMed/MEDLINE, Hinari, EBSCO Host, and Google Scholar were used with Boolean operators AND, OR, and NOT to broaden and narrow the search. Keywords used in searching were: clinical teaching, clinical practices, perinatal mental health, maternal mental health education, midwifery education, clinical skills, and clinical education.

2.1 Competencies in Nursing Practice

Competencies are defined as values, knowledge, skills, and attitudes that enable nurses to perform their duties and maintain professional standards (Moghabghab et al. 2018). A competent nurse integrates cognitive, psychomotor, and affective domains in caring for patients in healthcare settings. Competence has been associated with quality work and satisfaction in the nursing profession, but a lack of competence has been linked with medical errors, under-detection, and under-treatment of health-related conditions (Bina et al. 2019; Noonan et al. 2018). However, for students to gain competence there must be a nurse educator or clinical teacher who helps students integrate theoretical knowledge into practice. Nurse educators play an important role in pre-service education, guiding students to become successful nurses. They teach in classroom and clinical settings, offering lectures, mentorship, and supervision (Gcawu et al. 2021). Besides, students develop competencies by observing and reflecting on their clinical

experiences, learning from experienced nurses, and collaborating with peers and mentors (McLeod et al. 2020).

During the preparatory phase of competence development, students are taught in the classroom, while mastery of skills occurs in the simulated skills laboratory and through clinical practice. Thus, clinical teaching fosters a supportive learning environment for students and ultimately prepares them for future practice.

There are three factors that influence the development of competencies in students which include the learning environment, the characteristics of the nurse educator, and the student (Anarado, Agu, and Nwonu 2016; Järvinen et al. 2021). A well-equipped learning environment with appropriate teaching and learning resources plays a crucial role in supporting students' development and their ability to acquire skills through theoretical and clinical preparation. Additionally, the nurse educator's ability to develop and implement the curriculum is essential in fostering students' competencies, which involves identifying effective teaching strategies, assessing competencies, and serving as a role model for the students (Järvinen et al. 2021; Kyerepagr Kobekyaa et al. 2019). On the other hand, both the academic and clinical areas should have enough space for practising, discussing, and providing feedback to students so that skills can be refined (Anarado et al. 2016). This was supported in another study done in Nigeria on factors hindering the clinical training of students by Anarado et al. (2016). In that study, it was found that students failed to attain competencies because the space in the hospital was small and nurse educators were not able to provide feedback. Moreover, other factors such as lack of motivation, language barriers, and the inadequate preparedness of students for higher learning were also identified as barriers to students' skill development. This is because motivated students tend to cultivate interest, leading to a deeper understanding and acquisition of new skills. The

study concluded that nurse educators should create an environment where students are motivated and of good interaction between them.

2.2 Nurse Educator's Core Competencies

The nurse educator's essential competencies are very important for an effective education system. According to the WHO (2016), nurse educators must possess three core competencies such as a deep understanding of adult teaching strategies, curriculum development, and nursing practice to effectively teach students. These competencies make certified nurse educators undergo formal classroom training, a minimum of two years of nursing experience, and accreditation from the nursing regulator (World Health Organization. Regional Office for Africa 2016). This ensures that nurse educators are well-prepared and experienced to fulfill their responsibilities in teaching and supervising students.

Consistent with the core competencies recommended by the WHO, a cross-sectional study of nurse educators' competencies conducted in Japan found that facilitating self-directed learning, supervising, participating in research activities, and acting as one's teacher were considered essential competencies for nurse educators (Satoh, Fujimura, and Sato 2020). These competencies promote students' engagement in learning, which consequently increases their interest and abilities and encourages them to learn evidence-based content. Furthermore, the WHO (2016) recommends training institutions use a competency-based curriculum that ensures that students have the necessary knowledge, skills, and appropriate attitudes before working as qualified nurses. Competence-based education focuses on aligning competencies with the health needs of the public and assessing students to validate

the achievement of learning outcomes and curriculum goals (Hodges et al. 2019). Despite these recommendations, a lack of preparation by nurse educators to understand competencies for student learning has been noted as a challenge in nursing education (Bvumbwe and Mtshali 2018; Muraraneza, Mtshali, and Mukamana 2017).

The lack of competence of nurse educators affects the choice of teaching methods, supervision, mentorship, and achievement of competence in students. The study concluded that competencies to be achieved by students should be known by nurse educators and their learners. Considering that student and nurse educators should be aware of the competencies to be taught, Lenburg (1999) developed eight essential competencies for nursing education, such as assessment, evaluation, intervention, communication, critical thinking, human caring, management, leadership, teaching, and knowledge integration. These essential competencies were designed to guide nurse educators in developing course outcome statements, expectations, content, essential skills, and proficiency assessments that contribute to competent student graduates (Lenburg, Abdur-Rahman, Spencer, Boyer, 2009). It is therefore a requirement that nurse educators and students understand the competencies required for each educational program, teaching strategies, and competence assessment approaches. This knowledge would help them achieve the performance expectations of the nursing educational goals and those needed by the public (Lenburg, Abdur-Rahman, Spencer, Boyer, 2009). If competencies are unknown, the possibility of missing them and not teaching them is high, which may result in students not achieving their educational goals (Gal et al. 2018). Oermann et al., (2022), added that nurse educators should understand the stages of a student's skill development, such as novice, advanced beginner, competency proficient, and expert. This knowledge will help them align the

teaching objectives with the level of students, their needs, and the clinical practice area. However, Gcawu et al. (2021), in a cross-sectional study on the clinical teaching practices of nurse educators, found that aligning teaching objectives to the needs of the student and using teaching and assessment tools were not commonly used by nurse educators. The findings conclude that nurse educators did not use the best teaching practices to help students achieve competencies.

2.3 Maternal Mental Health Status

MMH problems are now becoming a public concern, a burden to many countries, and a great demand for competent and skilled nurse midwives. MMH is defined as the state of well-being in which a mother can fulfill her potential, manage life's usual stressors, work productively and fruitfully, and contribute to the community (Engle 2017). During pregnancy and postnatal period, most women experience mental health problems which include depression, anxiety, and stress which are associated with poverty, intimate partner violence, lack of support, teenage pregnancy, substance abuse, and physical diseases (Baron et al. 2016; Gurvich et al. 2020; Howard and Khalifeh 2020; National Institute for Health and Care Excellence (NICE) 2022). When identified early, MMH problems are frequently very treatable, as well as a significant cause of serious maternal and neonatal complications, and a contributor to 25% of the mortality rate during pregnancy and the postpartum period (World Health Organization 2019).

Globally, there is an increased burden of MMH problems both in high- and low-income countries. For instance; one in every five women experiences mental health problems during pregnancy and one year following birth in high-income countries (Howard and Khalifeh

2020; Royal College of Obstetricians and Gynaecologists 2017). However, the figure is three times more in developed countries due to poverty, limited access to mental health services, and the increased burden of HIV/AIDS (National Institute for Health and Care Excellence (NICE), 2022).

In Sub-Saharan Africa, nearly half of the women suffer from maternal depression (Acheanpong et al. 2022). In Malawi, about 23% of maternal women have depression, however, the overall disease burden might be high as a result of the underreporting of cases (Chorwe-Sungani and Chipps 2018). Although MMH problems are reported to be high in middle and low-income countries, they are not given enough attention they deserve and thus clients seeking mental health services are not routinely screened and treated for mental health problems in primary health care in Africa (Adjorlolo and Aziato 2020; McCauley et al. 2019). Some of the associated factors for not screening and treating MMH problems include lack of competence by midwives.

2.4 MMH Care in Malawi

There are many people with mental disorders in Malawi, however, the majority of them are still seeking mental health services from traditional healers due to limited access to mental health services in health facilities (Udedi 2016). The Ministry of Health has made a tremendous improvement in maternal and child health services where about 95% of pregnant women access antenatal care at various health facilities in Malawi (Ministry of Health 2017). Furthermore, Malawi's National Mental Health Policy integrated mental health and MMH services into primary and general health care respectively to increase the public's access to mental health services (Ministry of Health 2008). However, these

pregnant women despite being at risk of MMH problems, are not assessed for MMH problems because NMTs do not have the necessary competence to screen and manage MMH problems. Elsewhere, a lack of MMH competence by midwives has also been indicated in other countries like South Africa, Tanzania, and Ghana where little content of MMH competencies taught at preservice education was found to be the associated factor (Ambikile et al. 2020; Brown and Sprague 2021; McCauley et al. 2019). Apart from a lack of competence, Malawi faces additional challenges in MMH care due to a shortage of mental health professionals who can administer the interventions. Interventions provided in primary care settings have shown potential indicators to improve maternal health in low-resource income countries (Kulisewa et al. 2022). However, a shortage of specialized mental health nurses has been reported as a barrier to the integration of mental health services into primary care (Bayrampour et al. 2018). Alternatively, to improve staffing levels among health professionals, task shifting has been supported by various studies (Kulisewa et al. 2022; Shahmalak et al. 2019). Task shifting involves using lay healthcare workers such as general nurses to screen and provide mental health interventions since they are accessible and affordable (Kulisewa et al. 2022; Shahmalak et al. 2019). However, a lack of knowledge has been a barrier to the implementation of task shifting. MMH competencies taught in Malawi and the clinical teaching strategies utilized by clinical teachers have not been explored making it difficult to determine the level of competencies for midwives to manage such cases.

2.5 MMH Clinical Competencies

The literature search on competencies needed in MMH care found that the words MMH and perinatal mental health (PMH) were simultaneously used; therefore, these words were also

used interchangeably in this research. There is evidence that supports the importance of having competent educators in mental health psychiatric nursing to help students achieve an appropriate level of competence (Günaydin and Arguvanli Çoban 2021; Yang and Chao 2018). A study on concept mapping carried out in Australia has identified six major skills that nurses should possess. The study reveals that nurses with six fundamental skills are better equipped to provide high-quality care. These skills include risk assessment, recovery principles, person and family-centered care, effective communication, physical health knowledge, and humor (Moyo, Jones, and Gray 2022). These skills help nurses to create a safe environment, support and involve patients in decision-making, build trust, collaborate with other healthcare professionals, and maintain a positive attitude in stressful situations. Enhancing the quality of care and ensuring positive patient outcomes are crucial aspects highlighted in this study. It underscores the significance of essential skills in achieving these goals. The study's findings strongly advocate for mental health nurses to undergo ongoing training and continuous professional development.

Furthermore, the ICM has established essential skills for midwifery training, including competencies in areas like public health, perinatal care, childbirth, and continuous care for mothers and newborns (International Confederation of Midwives 2018). Among the essential skills required for MMH care, which includes, assessing the psychological well and providing support to mothers suffering from anxiety, depression, stillbirth, and infant illness. This highlights the importance of MMH professionals possessing excellent communication, empathy, cultural awareness, and problem-solving abilities to adequately assist mothers coping with mental health challenges. Midwives are encouraged to collaborate with other healthcare providers, offer nonjudgmental support, respect cultural differences, identify and implement

appropriate interventions (Higgins et al. 2018; International Confederation of Midwives 2018). Furthermore, midwives must be empathetic and have strong problem-solving skills to help clients feel heard and validated, and also to address psychological problems for the benefit of maternal mothers and their families. It is therefore the responsibility of educators to assist students in building such competencies so that they can develop confidence and competence following established standards (ICM, 2018). However, educators lack the expertise they need, and as a result, students who are trained also face challenges in managing mental health conditions (Bäck et al. 2017; Downes et al. 2017; Kaddoura et al. 2016; Satoh et al. 2020).

In light of the seriousness of the lack of competence among midwives, Health Education England (HEE) authorized nursing and midwifery education programs to include the PMH module containing topics on screening, counselling, and management of common PMH problems for student midwives (Davies et al. 2016). This initiative was implemented to empower midwives to acquire essential skills in mental health services, enabling them to deliver quality and holistic care. Based on the suggestion, an evaluation study was carried out in Ireland to assess the impact of the PMH module on midwives' competence and confidence in identifying and assisting women with mental health problems. The study revealed that the module was highly effective in enhancing midwives' competencies and confidence in screening and supporting women with mental health problems because there was an increase in knowledge, skills, and attitude on each topic taught, and students were able to identify and report cases (Higgins, Carroll, and Sharek 2016). However, the PMH module is specifically for midwives, providing them with specialized training and support, and it is not intended for healthcare providers in other fields (Davies et al. 2016). This observation resulted in the development of the PMH competency framework for all healthcare professionals working with

maternal mothers to promote the integration of competencies into students' already existing curricula (Health Education England, 2018).

Although the core competency framework was developed, studies have observed that there is little content, poor alignment of PMH competencies and the standards of performance by Nurses Councils, inconsistencies in clinical teaching practices, and lack of seriousness among students (Legere et al. 2017; Morton and Rylance 2019; Sönmez et al. 2017). This was confirmed in a study done in Nepal where the mental health competencies only covered 4% of the whole curriculum making it a challenge for students to acquire competencies and also for nurse educators to teach effectively (Simkhada et al. 2021; Sinaga and Stickley 2020). Therefore, it was suggested that the midwifery curriculum be reviewed to standardize the care of maternal women and improve PMH education across countries. In addition, studies conducted in South Africa, and Uganda on PMH education showed a few competencies being taught to student midwives during preservice education, such as counselling and communication skills, management of postnatal blues, depression, and psychological support (Adjorlolo & Aziato, 2020; Brown & Sprague, 2021; Simkhada et al., 2021). Furthermore, the findings observed that the management of common mental health cases focused more on biomedical care than psychological support, leaving students incompetent in counselling and communication skills (Simkhada et al., 2021). The study concluded that the preservice curriculum should include competencies in psychological support so that students should be adequately prepared for PMH services.

In Malawi, the NMCM identified some specific competencies for training NMTs, which include knowledge, communication and collaboration skills, appropriate behavior and attitudes, responsibility, and accountability (Christian Health Association of Malawi 2020). To

develop these skills, the student must assess, educate, and advocate for the health and safety of the patient while paying attention to their differences and interests. However, studies conducted in Malawi reported that the NMT curriculum is not preparing students adequately for mental health practice (Bvumbwe 2016; Mwale and Mselle 2017). This was confirmed in a qualitative study on the barriers to the utilization of mental health services in Malawi, which found midwives incompetent in the provision of mental health services which affected the care and access to mental health services by clients (Mwale and Mselle 2017). Therefore, the study recommends that student midwives should be adequately prepared for practice so that they can improve mental health services in Malawi.

2.6 Classroom Teaching Strategies in MMH Care

Studies have emphasized the importance of adequately preparing students and equipping them with mental health skills before engaging in clinical practice (Everitt et al. 2022; Higgins et al. 2016). This preparation is crucial as it enables students to effectively integrate theoretical knowledge into practical settings, thereby facilitating the achievement of learning objectives for the education program. Three teaching approaches in MMH education were found in the literature, which include: face-to-face, online, and blended learning (Everitt et al. 2022; Happell et al. 2020; Legere et al. 2017). In the face-to-face teaching approach, nurse educators are encouraged to utilize teaching strategies such as presentations, case studies, role plays, audio recordings, and lived experiences of clients with mental health problems. This is because these strategies promote the development of MMH competencies, screening, managing common mental health problems and actively engaging clients in the teaching and learning process (Everitt et al. 2022; Happell et al. 2020; Legere et al. 2017). However, (Abraham et al., 2018) have highlighted the importance of collaborative efforts between nurse educators and students to

encourage interactions and active participation in the learning process. This collaborative approach can significantly improve communication and counseling skills, while also alleviating any negative emotions that students may experience when working in mental health practice. Nurse educators are also advised to provide students with opportunities to practice their competencies in the skills laboratory setting before entering clinical practice (Sammur et al. 2021). This preparatory phase plays a crucial role in building students' confidence and competence, ensuring they are well-prepared to apply their skills in real-world clinical settings.

A recent study conducted by Sinaga and Stickley (2020) in India emphasizes the importance of utilizing group discussions and group work to enhance student engagement and participation in their learning process. However, the study advised nurse educators to carefully assess class size, students' needs, and the teaching philosophy of the institution before implementing group work. This is because there is a relationship between the number of students and the level of interaction that happens in the group. This knowledge would help educators identify the most effective clinical teaching strategies that can promote student engagement and the acquisition of mental health skills (Sinaga & Stickley, 2020). Furthermore, nurse educators are directed to provide opportunities for clinical practice to allow students to develop confidence and competencies in mental health practice (Albright et al. 2018; Sammur et al. 2021; Tol et al. 2018).

After classroom learning, students should practice skills in the laboratory and then proceed to clinical area. This was confirmed in a randomized study conducted in the USA where simulation and post-simulation of skills improved students' competence in the identification and management of PMH conditions. The study encouraged nursing colleges to have enough resources for simulation so that students practice PMH competencies in a safer simulated environment before exercising the skills on real patients. However, Legere et al. (2017) argue

that many educational programs in MHPN focus primarily on theoretical preparation, leaving students ill-prepared for clinical practice in this field. Furthermore, students also have limited time for clinical practice, ranging from 0 to 15 days, with some cases exceeding 4 weeks, which is considered inadequate for students to fully develop and achieve the required competencies (Acharya et al., 2017; Bayrampour et al., 2018; Bvumbwe et al., 2015; Sammut et al., 2021). Thus, Sammut et al. (2021) underlined the importance of allowing students to have sufficient time for clinical practice of more than 6 weeks to help them develop mental health competencies.

The use of innovative teaching strategies such as online teaching in PMH has been supported by many studies (Albright et al. 2018; Liu et al. 2016). These methods are effective in improving communication and empathetic skills, thereby helping students practice MMH competencies in a more realistic and safer environment before clinical practice. In agreement, a study by (Smith et al., 2018), acknowledged that using online courses and interactive teaching strategies helps students acquire mental health-related competencies and confidence in all eight topics related to screening and management of domestic violence in pregnancy. Nurse educators are strongly advised to incorporate online teaching methods into their curriculum where students can engage in interactive learning experiences through role-playing, group discussions, case studies, and video recordings where demonstrations of mental health procedures can be encouraged.

The utilization of video recordings, role-play, group discussions, and video recordings is also called blended teaching and learning (Happell et al., 2020; Sammut et al., 2021). Blended learning is an online education that improves mental health skills by allowing students to observe screening and psychosocial counselling processes, stimulating their ideas in interviewing techniques, and increasing their knowledge and confidence in managing mental health problems. Recognizing the time constraints midwives face in attending face-to-face classes, Sammut et al.

(2021) propose using online classes, particularly in low-income countries. This approach is not only cost-effective but also addresses the significant challenge of a shortage of human resources. This is because midwives can work and study MMH competencies whenever and wherever they want at their own pace and location.

2.7 Clinical Teaching Practices Utilized in MMH Competencies

There are various clinical teaching practices used in MMH education to assist students in developing essential skills such as planning, addressing safety concerns, use of teaching models, and organizing Objective Structured Clinical Examinations (OSCE) (Fox et al. 2023; Gcawu et al. 2021; Gcawu and van Rooyen 2022; Wenzel et al. 2022). During the planning phase for clinical teaching, nurse educators must consider two key aspects which include; self-preparation and the design of appropriate clinical teaching activities. Self-preparation requires nurse educators to possess a comprehensive understanding of the teaching environment and its strategies to be used (Gcawu et al., 2021). This knowledge enables nurse educators to efficiently utilize resources to help students succeed in their learning goals and ensure a practical learning experience during clinical practice. As noted by Bvumbwe and Mtshali (2018), preservice training and continuous professional development (CPD) activities that focus on teaching methodologies, instructional materials, and student assessment approaches can help nurse educators be fully prepared for student support in achieving competencies.

Furthermore, nurse educators must establish a suitable clinical environment for student teaching and learning through the identification of clinical sites that align with the student's level and the intended clinical objectives (Gcawu et al., 2021). The suitability of a clinical site should encompass factors such as available space, mentors, equipment, and the presence of ample

learning opportunities for students to practice (Gcawu and van Rooyen 2022; Happell et al. 2020). These factors assist students achieve competencies through mentorship, supportive supervision, and getting feedback for mastering skills. However, there might be instances where hospitals do not provide adequate learning opportunities, and alternative arrangements for MMH practice must be made, which should be using the simulated skills laboratory (Everitt et al., 2022).

A qualitative descriptive study on nursing student perceptions of best clinical teaching practices in mental health education conducted in the USA identified three important areas for teaching students such as preclinical meetings, clinical teacher availability, and the sharing of learning objectives (Wenzel et al., 2022). The findings highlighted the need for clinical teachers to hold pre-clinical meetings a week or two weeks before students' clinical practice, where the sharing and orientation of clinical objectives with students and staff members can be done. The sharing of clinical objectives forms part of orientation and guides students on the competencies to be achieved (Gcawu and van Rooyen 2022; Wenzel et al. 2022).

In addition, pre-clinical meetings are also important in aligning students' needs with clinical goals, clarifying expectations, roles, and responsibilities of teachers and students thereby promoting collaborative partnerships. It also allows clinical teachers to identify teaching strategies that alleviate students' negative emotional problems (Gcawu & van Rooyen, 2022; Wenzel et al., 2022). As noted by (Abraham et al., 2018), nurse educators should accompany students during clinical placements to reduce fear and stress and provide a supportive learning environment, as students often have negative attitudes toward mental health. Furthermore, nurse educators' presence in clinical settings assists students in developing mental health skills through mentorship, encouragement, and modelling of behaviors that demonstrate effective communication and empathetic skills. However, a shortage of staff in nursing colleges prevents

students from achieving competencies because there are few opportunities for student accompaniment and supportive supervision (Günaydin & Arguvanli Çoban, 2021).

On the other hand, the use of OSCE is widely supported by studies as an essential tool for teaching and evaluating students' achievement of competencies (Christiansen et al., 2021; Fox et al., 2023; Helminen et al., 2016). An Australian study found that, besides promoting skill development, OSCE provides students with opportunities for achieving PMH competencies in a situation where cases for student practice may not be available in clinical settings (Fox et al., 2023). Although OSCE helps to validate skills achieved by students, not much has been written in the literature on PMH education. Furthermore, a descriptive survey on pre-professional reflective practice by (McLeod et al., 2020) done in Australia highlighted the importance of encouraging students to reflect when teaching mental health competencies because it improves communication skills, self-awareness, and evaluation of the clinical experience. Thus, the findings indicate that students should be encouraged to reflect from year one and should continue throughout their educational training to help them achieve mental health competencies.

Clinical teaching models such as preceptorship, educational units, secondment, and faculty supervision are associated with quality clinical teaching, guiding nurse educators to teach relevant content and align learning goals with students' needs (Leonard et al., 2016; Luhanga, 2018). Although the preceptorship model is recommended because it tailors clinical teaching to the needs of the individual student, the faculty-supervised model, which is preferred because of its efficiency in allowing dual responsibilities and peer learning, limits the student-nurse educator relationship and requires more nurse educators with the necessary formal training in clinical teaching and expertise, which are not readily available in low-income countries (Bvumbwe and Mtshali 2018; Bweupe, Ngoma, and Sianchapa 2018; Luhanga 2018).

2.8 Challenges in MMH Clinical Teaching

Nurse educators face numerous challenges when teaching students MMH competencies, which include limited MMH content, a short duration for skill practice, a lack of resources, large numbers of students, and negative attitudes towards teaching MMH competencies in clinical settings (Asirifi et al. 2017; Kyerepagr Kobekyaa et al. 2019; Yang and Chao 2018). The majority of studies reported that the nursing curriculum is ineffective because it lacks an emphasis on MMH competencies, particularly communication, counselling skills, and management of common mental health conditions, which makes students feel unprepared for MMH practice (Bayrampour et al. 2018; Legere et al. 2017; Shayan et al. 2019; Simkhada et al. 2021). It is critical to recognize that the current nursing and midwifery curricula do not adequately address mental health competencies because their content accounts for only 4% (Simkhada et al. 2021). This insufficient coverage restricts the development of students' MMH competencies and reduces the amount of time available for valuable clinical practice. This was confirmed in a study done in Nepal where students were only allocated to an area of MMH clinical practice for less than 15 days, which was found to be too short for one to develop skills (Acharya et al. 2017). Thus, Davies et al. (2016) encouraged nurse educators to have a prolonged period of student engagement in the clinical setting for more than 6 weeks, which is adequate for acquiring PMH skills.

Studies have also found differences in student preparation, with some countries focusing only on theory and ignoring clinical practice, resulting in a lack of conceptualization of competencies by the students (Shayan et al. 2019; Sönmez et al. 2017; Weber, Delaney, and Snow 2016). In addition, a study by Weber et al. (2016) found that in most clinical settings, MMH services are not readily available to support students' learning.

The inability to provide MMH services in hospitals is attributed to a lack of political will, staff knowledge, and role models, leading to a lack of value placed on MMH competencies (Adjorlolo and Aziato 2020; Bayrampour et al. 2018). Furthermore, large numbers of students in the clinical area also increase the workload on nurse educators and reduce the time spent on student supervision and resources (Asirifi et al., 2017). This is concurred by a study done by Bayrampour (2018) on barriers to addressing PMH issues in midwifery, which reported a lack of learning and teaching resources, especially screening tools for PMH problems, and a shortage of nurse educators. In agreement, other studies done in China and Turkey indicated a shortage of qualified nurse educators, which resulted in task shifting, negative attitudes, using students as a helping hand, and improper teaching practices by non-specialist nursing staff (Günaydin and Arguvanli Çoban 2021; Günay and Kılınç 2018; Yang and Chao 2018). All these factors negatively affect the development of mental health competencies.

2.9 Student's Experiences in the Attainment of MMH Competencies

Studies exploring the experiences of students in the attainment of MMH competencies found both negative and positive experiences (Günaydin and Arguvanli Çoban 2021; McGookin, Furber, and Smith 2017). For instance, McGookin et al. (2017) conducted a study in the United Kingdom on student midwives' awareness, knowledge, and experiences with antenatal anxiety clinical practice. The study reported that students held positive attitudes towards MMH practice because they were interested in caring for women with mental health-related problems. However, the study found a lack of competencies in the management of antenatal anxiety because there was no integration between mental health and midwifery competencies. As such, students in the study requested more theoretical teaching content and clinical practice on antenatal anxiety.

Students' negative experiences with mental health have also been reported in other studies (Günaydin & Arguvanli Çoban, 2021; Kyerepagr Kobekyaa et al., 2019). Fear, stress, and anxiety are common negative emotions experienced by students and are caused by inadequate student preparation for mental health practice, a shortage of clinical teachers, and stigma and discrimination towards people with mental illnesses. Such negative attitudes result in difficulties in translating theory into practice and attaining mental health competencies. It is therefore recommended that adequate student preparation, the availability of clinical staff to support students, and the use of role-play, case studies, visual and multimedia learning materials should be utilized to help students develop confidence and efficacy in mental health skills (Davies et al., 2016; Goh et al., 2021; Günaydin & Arguvanli Çoban, 2021).

2.10 Theoretical Framework: The Competency Outcome Performance (COPA) Model

A theoretical framework is a set of concepts that have been logically developed and linked together so that the relationship between them can be easily understood by the researcher (Dash, 2017; Varpio et al., 2020). The COPA model was applied in the study to understand the competencies required for nursing and midwifery education and the teaching strategies that should be utilized to help students acquire competencies. The model was applied in the investigation to highlight the role of clinical teaching in MMH education.

The COPA model was developed in the early 1990s by Carrie Lenburg (Lenburg, 1999). The model consists of four pillars, such as core practice competencies, end-result competency outcome, practice-oriented interactive learning strategies, and objective competency performance (Lenburg et al., 2009). The theory indicates that nurse educators must identify eight core competencies for student practice such as assessment, intervention, communication, critical thinking, human caring, teaching, management, leadership, and knowledge integration.

These competencies should be applied in all courses of nursing and midwifery education programs to help students develop core competencies (Lenburg et al., 2009). Nurse educators are therefore encouraged to teach these competencies consistent with course content, program level, and patient setting. Additionally, the sharing of learning objectives between students, nurse educators, and others involved in teaching students should be encouraged to help students develop essential competencies for nursing practice. It is the student's responsibility to acquire and attain the necessary competencies, and learning methodologies utilized by nurse educators should be aligned with the defined competencies.

From the COPA model, only two of the four pillars were applied in the study, namely, pillars 1 and 3; core practice competencies, and interactive practice-focused learning respectively. These pillars were applied because they focused on essential competencies needed for nursing education programs, and the identification of effective teaching methods to help students attain competencies and learning outcomes.

Reflecting on the objectives of the study, Table 1 shows how the theory was applied in the study.

Table 1: Application of the COPA Theory

Pillars of the COPA Theory	Research Objectives
Essential competencies	Describe the MMH clinical competencies that nurse educators implement in student practice.
Interactive practice-focused learning	Assess clinical teaching strategies utilized by nurse educators in MMH competencies. Describe the challenges experienced by nurse educators when teaching students MMH competencies.

From **Table 1**, the first pillar was used in the study to identify essential MMH competencies that nurse educators implement during clinical teaching which is in line with the first objective of the study. The second pillar, which indicates practice-driven interactive performance, was used in the study to identify teaching methods used by nurse educators to promote understanding of MMH competencies, which is in line with the study's second objective. The second pillar also covered objective 3, which was to describe challenges that nurse educators face when teaching students MMH competencies.

2.11 The Conceptual Framework

A conceptual framework is a representation of the main variables of a system or topic of interest, showing their interrelationships or linkages (Sharma, 2018a). A conceptual framework helps to identify the variables of the study and their relationship and provides the basis for conducting the study. Figure 1 shows the conceptual framework of the study.

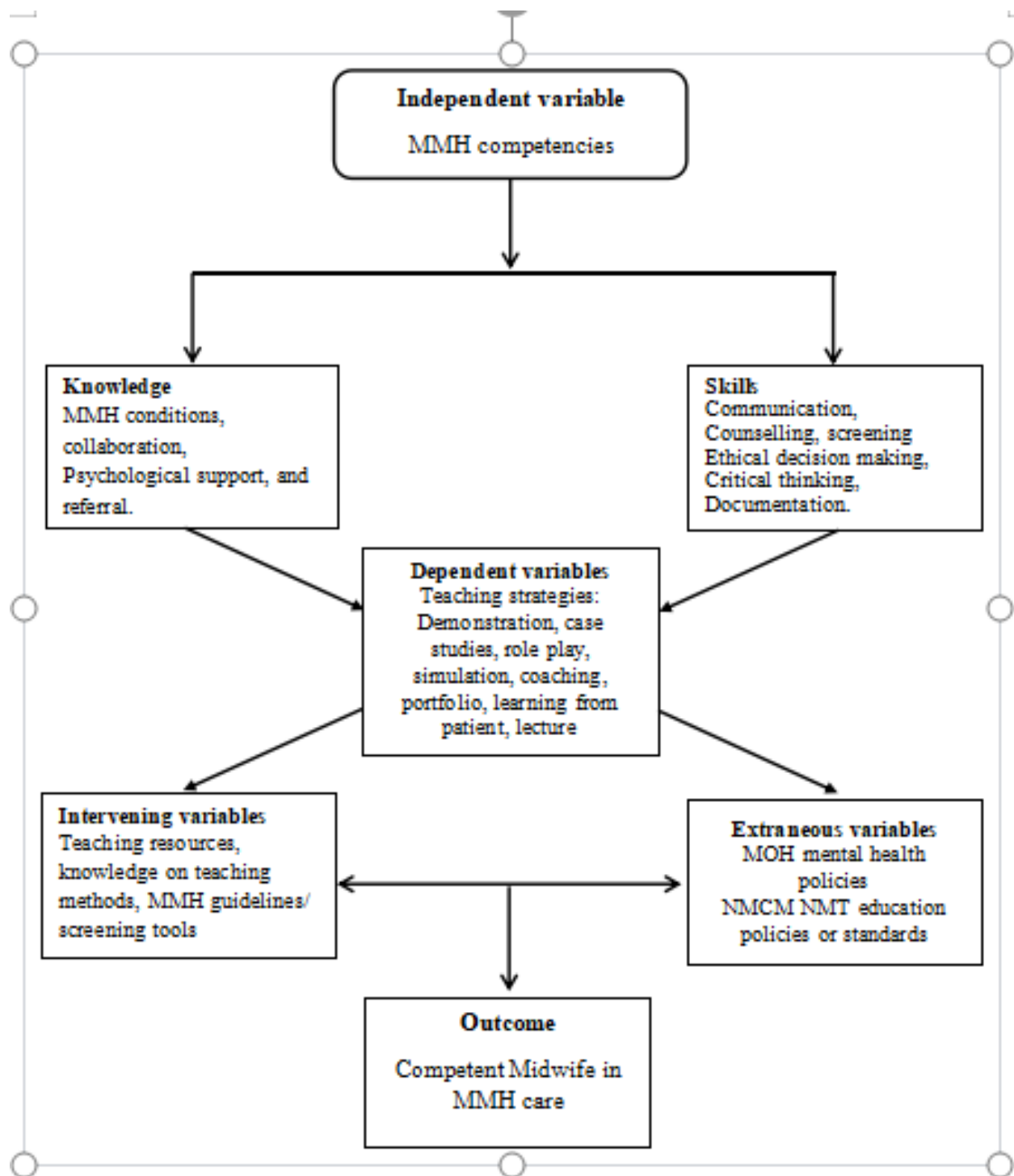


Figure 1: Conceptual framework of the study (Source: Field data, 2022)

Figure 1 shows the conceptual framework of the study. It consists of two variables; MMH competencies (independent variable) and clinical teaching strategies (dependent variable). MMH competencies (knowledge, skills, and attitudes) must be known to the nurse educator and be available in the nursing curriculum. The availability of MMH competencies in the NMT curriculum would influence the identification of teaching strategies to be utilized when teaching students to help them understand and acquire the competencies accordingly. The dependent variables in the study are the teaching strategies that nurse educators use for students to build competencies in MMH care. These strategies include demonstration, role play, simulation, case studies, learning from patient experiences, group discussion or work, coaching, and feedback.

The intervening variables describe the processes by which two variables are related and are used to explain a cause or relationship between other variables important to the study (Polit and Beck 2018). The intervening variables include teaching and learning resources, such as MMH guidelines, screening tools, hospital cases, knowledge of clinical teaching strategies, and MMH competencies. These were considered intervening because their availability would help nurse educators teach MMH competencies effectively, facilitate students' competence development, and help students experience learning. The lack of intervening variables would be considered as challenges to clinical teaching in MMH competencies. Finally, an extraneous variable is anything that could affect the dependent variable and can unintentionally alter the findings or interpretation of the study results (Creswell & Creswell, 2018). These unwanted variables are factors affecting the dependent variable that the researcher did not consider when designing the study. Examples of such variables in this study include educational training policies for the NMT program from regulatory bodies (NMCM) and the Ministry of Health. The relationship between the variables used in the study should help in producing a competent midwife in MMH care.

2.12 Conclusion

This chapter started by reviewing the literature on competencies required for nurse educators and students to achieve MMH competencies, which include knowledge and skills in the identification and management of common mental health problems, psychological support, critical thinking, and ethical legal issues. The literature has also identified the teaching approaches that are to be used when teaching students, and examples are face-to-face, blended, and interactive, or student-centered approaches where nurse educators are encouraged to use role-play, group discussion, simulation, and video recording. Furthermore, clinical teaching strategies like holding preclinical meetings, availability of the teacher, sharing clinical learning objectives organizing OSCE, and providing feedback are considered as best clinical teaching practices in MMH. Moreover, challenges faced by nurse educators when teaching students MMH competencies have been explored, and include lack of resources and knowledge, stigma and discrimination, little MMH content in the curriculum, and lack of guidelines. These challenges prevent students from attaining MMH competencies. A COPA theoretical framework has been used in the study to guide the investigator in understanding the core competencies required in a nursing profession and the teaching strategies to be used for students to acquire MMH competencies. The literature review concludes with a conceptual framework, which outlines the relationships between concepts and variables for the study.

CHAPTER 3: METHODOLOGY

3.0 Introduction

This chapter describes the study paradigm, design and setting; sampling techniques, instrumentation, data collection, and analysis that were carried out in the study to answer research questions. It also describes the ethical principles that were used to protect the participants.

3.1 Research Paradigm

A research paradigm is a theoretical framework that guides a researcher's worldview and research process (Creswell & Creswell, 2018). The pragmatism research philosophy was used to respond to the study objectives. The pragmatist research philosophy emphasizes the practicality and usefulness of a study in people's lives, allowing researchers to combine different approaches to comprehensively understand the problem and find solutions (Kaushik and Walsh 2019). Thus, the pragmatic view was adopted because the focus of the study was to understand the research problem and find solutions to the clinical teaching practices of nurse educators in MMH education.

3.2 Research Design

This study used a mixed-method research design (MMRD), in which both qualitative and quantitative data were collected, analyzed, and integrated into a single study (Creswell and Creswell 2018). The MMRD was appropriate for this study because there is a dearth of literature on MMH education in Malawi, indicating that not much has been studied on the topic, and therefore, a comprehensive approach was required to gain a more in-depth understanding of the study problem. This is consistent with Creswell and Creswell (2018), who recommended using a

mixed-methods approach when the problem is new so that the researcher can gain a more comprehensive understanding of the problem being studied. When used in isolation, the methods have weaknesses, but the integration of both approaches ensured that the weaknesses of one method were covered by the other method, thus providing complete and credible data (Schoonenboom and Johnson 2017). Through triangulation, the mixed methods approach improved data accuracy and reliability, reduced bias, and provided a practical and problem-oriented approach to the research problem (Louis, Lawrence, and Keith 2018). The use of qualitative data helped to explain findings from quantitative data. In this way, the methods complemented each other and provided a richer and deeper understanding of clinical teaching practices in MMH than would have been possible with a single approach. The study used an explanatory sequential design to explain and interpret the quantitative findings. The study gave the highest priority to quantitative data; however, both methods were integrated during data interpretation and reporting. Refer to **Figure 2** which shows how the explanatory sequential design

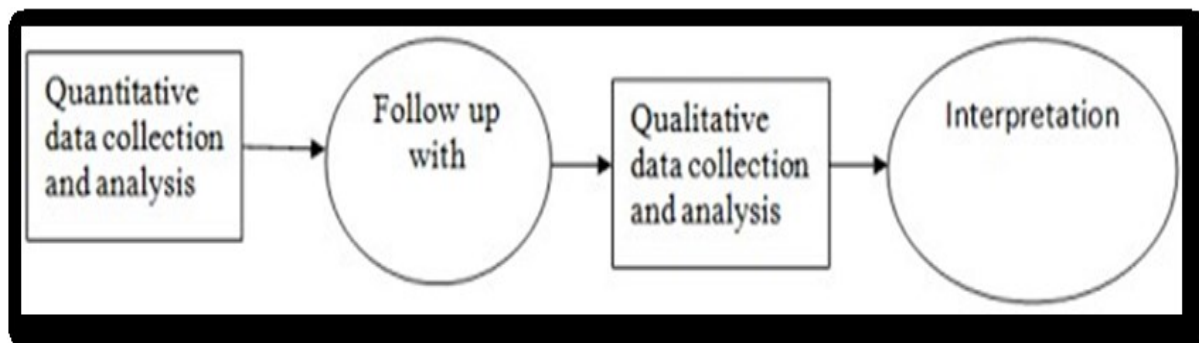


Figure 2: The Explanatory Sequential Design (Source: (Creswell & Creswell, 2018a).

Figure 2 shows the explanatory sequential design where quantitative data collection and analysis were initially done, followed by qualitative data collection and analysis.

For the quantitative research approach, a cross-sectional survey was used because it was convenient and cost-effective, allowing a large number of participants to be recruited at once and providing an understanding of the study problem over time (Creswell & Creswell, 2018; Polit & Beck, 2018). Considering that the study had a time frame, a survey was used to meet the deadline. The qualitative approach used an explanatory descriptive design because it explained participants' experiences and ideas by providing a detailed description of study information in an area that had received little attention (Hunter et al., 2019). Using explanatory study designs helped in explaining reasons why few MMH competencies were taught, the experiences of students in achieving MMH competencies, and why some teaching strategies were favoured over others.

3.3 Study Site

The study was conducted at Ekwendeni College of Health Sciences (ECHS) and Saint Luke's College of Health Sciences (SLCHS). The ECHS is located in Mzimba district in northern Malawi, while the SLCHS is situated in Zomba district in the southern region. Two institutions were selected because they are found in and close to districts with an increased prevalence rate of maternal depression, and no study of this nature was reported to have been done in the districts (Silungwe 2021; Stewart et al. 2015). Furthermore, the sites were selected because they teach MMH competencies and provide clinical teaching services to students in their placements.

3.4 Study Population

The study population comprised nurse educators and third-year students drawn from two nursing colleges.

Students were included in the study to broaden the scope of the problem and promote triangulation. The study population was ideal because nurse educators and students were teaching and learning MMH competencies respectively hence, they provided information for the study. The targeted population was 353 participants, in which there were 51 nurse educators and 302 students. Specifically, for SLCHS, there were 25 nurse educators and 175 third-year students. For ECHS, there were 26 nurse educators and 127 third-year students. The figures were solicited from college registers at SLCHS and ECHS.

3.5 Inclusion and Exclusion Criteria

The study recruited participants with one year of experience in teaching MHPN and midwifery. These participants were recruited because they knew MMH competencies; as such, they were assumed to be experienced in answering the research questions. Third-year students who were recruited in the study were those who were in the second semester of their education program. Their inclusion was on the basis they had learned MMH competencies as such they had information to respond to research questions. All nurse educators with less than one year of experience in teaching and those who were not involved in teaching MMH competencies were excluded from the study. Furthermore, first and second-year students were excluded from the study. Their exclusion was on the basis that they did not teach and had not learned MMH competencies and, therefore could not provide credible information to answer the research questions.

3.6 Quantitative Phase

3.6.1 Sampling and Sample Size

Sampling was done in the study to promote generalizability, and representation, and prevent selection bias and sampling error (Curtis and Keeler 2021). Convenience sampling was used to

recruit participants who met the inclusion criteria and were easily available during the data collection period (Sharma, 2018). Although convenience sampling is associated with sampling bias, it was difficult to use other sampling techniques because some participants were unavailable during the data collection period.

The entire sample was estimated at 217, however, during data collection only 157 participants who met the inclusion criteria were available and this resulted in recruiting the entire population. The sample size of the study was determined by selecting people who accurately represented the population. Since the target population was known, Yamane's Formula by Reid and Boore was used to calculate the sample size as follows (Reid and Boore 1987):

$$n = \frac{N}{[(1+N(e)^2)]}$$

Where n= sample size, N = population, and e= precision level was set at 0.05.

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n

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n = 172 students + 45 nurse educators = **217 participants.**

=

The sample for each college was calculated using a simple proportion where the total number of students at the college was divided by the target population of students and then multiplied by the student sample size.

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The sample size for students at STLCHS was:

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Total sample for STLCHS: (100 students + 22 nurse educators) = **122 participants**.

The sample size for ECHS was:

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Total sample size for ECHS: (72 students + 23 nurse educators) = **95 participants**.

3.6.2. Data Collection Tools

3.6.2.1. Questionnaire

The cross-sectional design collected data using a questionnaire because it helped in gathering data for objectives 1, 2, and 3 of the study. The questionnaire was cost-effective, efficient, and accurate, and it offered privacy to the participants (Kumar 2019). The questionnaire was adopted from a study that was done to assess neonatal competencies in NMTs because it was found effective in assessing competencies and clinical teaching strategies in Malawi (Phuma 2015). The NMT competence assessment tool had 4 areas labeled B1, B2, B3, and B4. However, only 2 parts of the tool i.e. B1 and B2 were relevant to the study objectives, as a result, the tool was modified to suit the study. Modification of the tool was done by removing neonatal competencies and replacing them with MMH competencies as found in the literature (WHO 2022).

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Furthermore, section B4 was also removed and replaced with challenges faced by nurse educators during classroom and clinical teaching.

The tool had 40 items divided into four subsections as follows: social demographic characteristics of participants, MMH competencies, clinical teaching strategies, and challenges faced by nurse educators and students in teaching and learning MMH competencies (**Appendix 6 and Appendix 7**). Items in the tool were similar for nurse educators and students, except for the social demographic data. Students had three social demographic characteristics, such as college, age, and gender, as these variables influenced students' skill acquisition (Rizany, Hariyati, and Handayani 2018). Nurse educators had additional demographic variables, including college, age, gender, years of experience, professional specialization, academic qualifications, and formal training in clinical teaching. These variables were included in the questionnaire because they influenced the clinical teaching practices of nurse educators (Perveen, Gilani, and Muhammad 2018; Rizany et al. 2018).

The questionnaire had a five-point Likert scale ranging from strongly disagree (1), disagree (2), uncertain (3), agree (4), and strongly agree (5) because it allowed participants to rate their level of agreement on the tool's subsections.

Validity and Reliability

According to Phuma (2015), the NMT's competence development tool was valid and was used as a data collection tool for assessing the NMT's competence in neonatology. The internal consistency (Cronbach's test) of the tool scored between 0.8 and 0.9 (Phuma, 2015). This indicated a high level of consistency in the tool, suggesting that it was measuring the concepts exactly as they were supposed to be tested and produced accurate results. A reliable tool should

provide accurate results as indicated by (Polit & Beck, 2018). Furthermore, the tool was repeatedly administered to the sampled participants and yielded consistent responses, and this indicated that the tool was stable (Creswell and Creswell 2018).

However, knowing that modifications were made, the tool was still tested for face, content, and criterion validity. To achieve the face validity of the instrument, a pilot study was done at St Johns Institute for Health which is a nursing college with similar characteristics as those of the study sites. The pilot study was conducted to test the tool for its clarity, appropriateness, and completeness. Furthermore, senior researchers also reviewed the tool for its clarity, appropriateness, completeness, and adequacy. Results from the pilot study and senior researchers helped modify the tool by rephrasing and removing some items; for example, *other teaching methods were removed because of redundancy*.

Content validity was achieved by involving mental health, psychiatric nursing, and clinical teaching experts who reviewed the tool for its appropriateness, clarity, and completeness. Their findings revealed that the instrument was reliable because the internal consistency of items (Cronbach's test) scored 0.8. Cronbach's alpha reliability test is carried out using SPSS. This particular test is widely recognized as the preferred method for evaluating the reliability of questionnaires with multiple-item scales.

The Cronbach alpha reliability coefficient typically ranges from 0.00 to 1.00 (Sharma, 2018). A higher coefficient within the acceptable range of 0.50 to 1.00 indicates a stronger instrument reliability. In this study, Cronbach's coefficient confidence level was Alpha, which was 0.8, which adhered to the recommended standards.

3.6.2.2. Checklist

Data from documents like the NMT syllabus, curriculum, NMCM student competence logbooks, student college logbooks, and course outlines were collected using a checklist to provide information for study objectives 1 and 2. The checklist was valid because it was adopted as a data collection tool to act as a guide so that only appropriate data needed for the study was collected. However, a few modifications were made to the tool by removing *the grading criteria and assessment tools* to fit the study (Phuma, 2015). The checklist had the following variables: the MMH competencies taught (knowledge, skills, and attitudes) and the clinical teaching strategies utilized by nurse educators (**Appendix 5: Document Review Checklist**).

3.6.3. Data Collection Method

3.6.3.1. Survey

Data from quantitative data was collected using a survey, in which questionnaires were handed to participants by hand through face-to-face contact. Through survey was easy to administer, encouraged participants to fill out the questionnaire at their own will, and helped to collect data within a short period (Polit & Beck, 2018).

To recruit participants for the survey, appointments were made in advance through the Dean of Faculty (DOF) of each college. Appointments helped in avoiding disruption of participants' teaching and learning responsibilities. Participants were met at a convenient time in a private room to ensure privacy and confidentiality. The explanation of the study's nature and benefits, their autonomy to participate, and their freedom to withdraw at any time from the study were done to improve their knowledge about the study. By emphasizing anonymity and confidentiality, participants' confidence in providing honest answers was increased. They were asked to sign a consent form to show that they agreed to participate in the study (**Appendix 2**).

To promote anonymity, all questionnaires had code numbers and participants were told not to indicate their names on the questionnaire. They were given 24 hours to complete the questionnaire, and the following day all questionnaires were collected. Some questionnaires were left with the DOF to distribute to all participants who were reported to be busy or unavailable during the data collection period. One hundred fifty-seven (157) questionnaires were distributed to participants, and only 153 questionnaires were collected because others did not return the questionnaires, giving a response rate of 97%. Therefore, the 97% response rate reported for this study formed an acceptable basis for analysis, reporting, and concluding the data.

3.6.3.2. Document Review

A document review was also done to identify available MMH competencies in the NMT program. A document review is a way of collecting data by reviewing existing documents, either hard or soft copies, to gather background information and understand a phenomenon (Kayesa and Shung-King 2021). To ensure that all the data needed for the study was captured, a document review checklist was used (**Appendix 5**). The NMT syllabi, curriculum, NMCM student competence logbooks, and course outlines were all examined to evaluate MMH competencies implemented by nurse educators during student practice and its teaching strategies. To fill in the checklist all topics related to knowledge, skills, attitude, and teaching strategies were documented in their respective columns of the checklist. A review of these documents helped in the identification of MMH content and teaching methods used by nurse educators.

3.6.4. Data Analysis

The study used descriptive statistics to analyze the data as described below.

3.6.4.1. Descriptive Statistics

After data collection, all questionnaires were checked for completeness to evaluate if all items were answered by participants. All questionnaires were fully completed, entered in the Statistical Package for Social Sciences (SPSS) version 25, and were eligible for analysis. To facilitate the analysis procedure, variables were coded with numerical numbers (Albers, 2017; Sharma, K, 2018). For example, code 1 was assigned to indicate ECHS, and code 2 to indicate SLCHS.

The questionnaires had Likert scale scores ranging from 1 to 5, in which; 1 (strongly disagree), 2 (disagree), 3 (uncertain), 4 (agree), and 5 (strongly agree). However, the 5-point Likert scale was transformed into a 3-point Likert scale in which strongly disagree and disagree were combined and labeled 1 (disagree), whilst strongly agree and agree were also combined to be 3 (agree). Using a single mean, the mean of each observation was recorded as: 1.65 to 2.50 = 1 (disagree), 2.51 to 3.50 = 2 (uncertain), and 3.51 to 5.00 = 3 (agree). This formed a 3-point Likert scale: 1 (disagree), 2 (uncertain), and 3 (agree). Data transformation was necessary to ease analysis and interpretation without losing the information from the collected data (Proto and Rustichini 2012).

The first part of the questionnaire generated data on the demographic characteristics of the study participants. The second part of the questionnaire generated data on MMH competencies implemented by nurse educators when teaching students.

The third part of the questionnaire generated data on clinical teaching strategies utilized by nurse educators when teaching clinical competencies in MMH. The fourth part of the questionnaire generated data on challenges faced by participants when teaching MMH competencies (**Appendix 6 and Appendix 7**). Results from these three objectives helped produce answers for

the first three research questions of the study. Findings were presented as frequencies, percentages, mean scores, and standard deviations. All scores were arranged from highest to lowest score, and thereafter, tables containing the scores were used for easy interpretation of the findings.

To decide whether items on the questionnaire agreed or disagreed with participants, a weighted average of each variable was used to simplify the analysis (Ekeh et al. 2020). The weighted average was found by summing up the individual numbers of the means of items divided by the total number of items in the data set. Thus, the mean score for MMH competencies was 3.75, clinical teaching strategies 3.31, challenges in classroom teaching 3.37, and clinical teaching challenges 3.46. Any item that was found above the weighted average was considered to be utilized in MMH clinical teaching practices and those items whose mean score was below the weighted mean were considered to be disagreeable by participants (Ekeh et al. 2020).

Cross-tabulations and Fisher's exact tests were performed on each of the three dependent variables against each of the six (6) demographic characteristics of nurse educators, such as gender, academic qualification, age, professional specialization, years of experience, and formal training in clinical teaching. Cross-tabulation and Fisher's exact test were done to determine if they influenced the teaching practices of nurse educators in MMH practice. Fisher's exact test was chosen because of the small sample size of the nurse educators and also for its accuracy in providing the correct p-value when more than 20% of cells had expected frequencies of < 5 , making the test appropriate for the study (Hae-Young 2017)..

3.7. Qualitative Phase

3.7.1. Sampling and Sample Size

Purposive non-probability sampling was used to recruit participants for this phase. Purposive sampling is a non-probability sampling where participants are recruited to the study because of the various characteristics and perspectives they bring to the study (Creswell & Creswell 2018). Thirty participants (30) were recruited for the study, of which 10 were key informants and 20 were third-year students. From this figure, 4 nurse educators and 10 students were from each college, while 2 preceptors were from teaching hospitals and were employed by colleges. Key informants were nurse educators and preceptors who were involved in teaching MMH competencies and supporting students in the clinical area because they knew MMH competencies and its teaching strategies. The sample size for the study was determined when no new information came from participants, which represented data saturation (Polit & Beck, 2018). The sample size for the study was 30; however, (Sharma, 2018a) recommends a sample size of 10 or less as sufficient for a phenomenological study. In this case, a sample size of 30 was more than sufficient for the study.

3.7.2. Data Collection Tools

3.7.2.1. Interview Guides

The qualitative data was collected using semi-structured interview guides to answer all the objectives of the study. Questions in the interview guides were developed based on quantitative findings to explain and provide a broader understanding of the study problem.

The interview guides had four areas of emphasis, such as MMH competencies taught to NMTs, its clinical teaching strategies, challenges faced by nurse educators when teaching MMH competencies, and the experiences of students in attaining MMH competencies (**Appendices 8**

and 9). The interview guides were flexible, allowing modifications to be made from time to time; hence, they helped in capturing information and also acted as a clue for probing more questions. The use of interview guides helped in controlling the flow of the interview and facilitated the adequacy of information for the study (Smulowitz 2017).

Trustworthiness

Qualitative research must show credibility in its findings so that other researchers and stakeholders can trust the findings (Nowell et al., 2017). It also relates to the degree of confidence that the researchers have in the data collection, analysis, and interpretation (Polit and Beck 2018). The trustworthiness of the interview guide was established by meeting Lincoln and Guba's five criteria, which include credibility, confirmability, transferability, dependability, and authenticity (Lincoln, & Guba, 1985). These five criteria are outlined below:

Credibility

It is the level of trust in the accuracy of the findings from participants that increases the likelihood of believing the findings (Lincoln & Guba, 1985; Polit & Beck, 2018). To ensure the credibility of the results, focus group discussions (FGD) and in-depth interviews were used to promote triangulation. Both interviews were interactive, and this helped to develop a relationship with participants, allowing them to provide truthful information. All interviews were conducted in English, which was understandable to participants, and this enabled them to provide correct information for the study. Additionally, member checking was done, where information collected during data collection was returned to participants to check for the accuracy of their findings. Furthermore, peer debriefing was also done, whereby all transcripts and findings from data analysis were reviewed by supervisors and experts in research to confirm the truthfulness of the findings.

Dependability

Dependability in research ensures a logical, traceable, and documented study process, enabling future researchers to replicate results and evaluate adherence to research practices (Kim, Sefcik, and Bradway 2017; Shenton 2004). This study met dependability through an audit trail that included research designs, implementation, interview notes, and transcriptions. The audit trail in this study is an indication that the study can be traced and replicated if need be.

Confirmability

Confirmability is the degree to which the results of an inquiry can be confirmed or corroborated by other researchers (Kim et al., 2017). This is concerned with steps taken to ensure that the findings of the study and its interpretations reflect the experiences and ideas of informants and are not based on the researcher's ideas or imagination. Confirmability in this study was achieved through continuous bracketing to ensure that the opinions, beliefs, and values of the researcher were not included in the study. In addition, an audit trail regarding the study process, data collection tools and analysis decisions, reflective field notes, and audio recordings have been kept to demonstrate confirmability.

Transferability

Transferability refers to the generalizability of the study, ensuring its findings can be applied to another setting or a similar group of people (Lincoln & Guba, 1985; Nowell et al., 2017). To achieve transferability, the purposive sampling technique and a detailed description of the study were used to increase the applicability of the study results to other contexts. A detailed description includes providing sufficient information about the fieldwork, setting, the study process, limitations, and the study report that has been prepared and presented. This will allow

readers and other researchers to properly understand the study and thus repeat it and reach similar results.

Authenticity

Authenticity is the extent to which researchers fairly and faithfully represent a range of different realities (Polit & Beck, 2018).

Authenticity was achieved through prolonged engagement with participants to capture their experiences in MMH practice. Member checking was also performed in all the processes of the study, i.e., during data collection, analysis, and interpretation. An audio tape recorder and field notes were also used in the investigation to document all information presented by participants, including emotions and experiences. Finally, textual quotations have been presented in the study report to promote the authenticity of the study.

3.7.3. Data Collection Methods

Data collection for the study took place from December 2022 to April 2023, and it was done in two phases. The first phase was for quantitative data collection, in which a survey was utilized, and the second phase was for qualitative data collection, where in-depth interviews, FGD, and document reviews were used to collect data.

3.7.3.1. In-depth Interviews

In-depth interviews were conducted, which involved the collection of data from participants through interviews to learn more about their opinions on various concepts, plans, or circumstances (Creswell & Creswell, 2018). In-depth interviews generated data for all study objectives. To recruit participants, arrangements were made with the DOF, which helped in identifying key informants who were nurse educators and preceptors and were involved in

teaching MMH competencies. Arrangements were made to meet them in a private room at a convenient time as one way of observing privacy and confidentiality. A tape recorder was used during interviews to ensure that the conversation was well captured. In addition, the use of the interview guide controlled the flow of the interview and ensured the collection of appropriate data.

Field notes were also taken to record all elements of the interview, including the setting, participants' emotions, and nonverbal communication. All interviews lasted between 25 and 45 minutes. Ten (10) key informants were interviewed, and data collection was finalized when data saturation occurred and no new issues emerged from participants.

3.7.3.2. Focus Group Discussions

The FGD was also done, which involved gathering 5 to 10 people to discuss a specific topic (Nyumba et al. 2018). The FGD was conducted with students to generate information to meet all study objectives. FGDs were used in the investigation because they were cost-effective and enabled the collection of rich data through group dynamics, allowing participants to build on each other's answers and generate ideas that might not have been thought of in an individual interview.

Similar to the other data collection methods, arrangements were made in advance through the DOFs at the respective colleges to meet third-year students who had learned MMH competencies and were free and willing to provide information for the study. The interview guides containing open-ended questions were used to guide the flow of the interview and elicit more information from participants. Anonymity was maintained by allowing all participants to provide their code numbers when raising a point or answering a question, rather than giving names. To promote

confidentiality, all interviews were conducted after students had knocked off from class in a room away from onlookers and those who might disrupt the discussion. A tape recorder and field notes were used in the investigation to capture emotions as explained by participants.

A total of 20 participants took part in 4 interviews, with each college conducting 2 FGDs with five people per group. The interviews were stopped when data saturation occurred, and no new information came from participants.

All data collection instruments were developed in English, as this was the only formal form of communication in higher education institutions. The FGD and in-depth interviews were conducted in English and lasted between 45 minutes and an hour.

3.7.4. Data Analysis

3.7.4.1. *Thematic Analysis*

Thematic analysis was done to analyze qualitative data, as guided by Braun and Clarke (2006) and Castleberry and Nolen (2018). According to Creswell and Creswell, (2018), thematic analysis involves data reduction through organizing, describing, and explaining the study information to understand the findings. Thematic analysis was done concurrently with the data collection, which helped in identifying areas requiring further probing and also refined the interview guide. Eight stages were followed during thematic analysis, such as data preparation, transcription, familiarization, and memorization; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing a report for the study (Castleberry and Nolen 2018). The eight stages are discussed as follows:

Stage 1: In this stage, all audio recordings from in-depth interviews and focus group discussions were transferred from the tape recorder to the personal computer. A soft copy folder labeled

“Audio Recordings” was created on the computer for easy retrieval. This stage helped in preparing the data for analysis.

Stage 2: this is the stage where transcription is done. In transcription, all audio recordings were converted into a Word document. The transcription involved listening to all audio recordings and writing them down in words as explained by participants (verbatim).

It also involved checking transcripts against the audio recordings for accuracy. This process helped the researcher to become familiar with the data and to record conversations as described by participants.

Stage 3: The transcribed documents were read several times to aid in familiarization with the data set. Transcription also involved taking notes on interesting ideas and identifying the meaning of the data, gaps, and areas for further probing and investigation.

Stage 4: Memoing was done where all reflective notes were recorded on a piece of paper and pasted on the desk. Memoing helped in arranging the flow of ideas, insights, and observations made from the data set. Memoing also helped in having an in-depth understanding of the findings.

Stage 5: Generating initial codes was done, which involved reducing long sentences from the transcribed data into a word or phrase and naming the code. It also involved putting highlighters with different colors to phrases and word extracts that were similar for easy identification of potential codes and themes. This process brought in sixty-seven codes (refer to **Table 2**).

Table 2: Generating Initial Codes

Transcription	Initial Codes
What competencies do you teach in MMH?	
Respondent: <i>Mostly, we teach, I don't know if am missing the question, maybe you can elaborate more on the competencies.</i>	
Investigator: On competencies, we are talking about knowledge, skills, and attitudes that you teach third-year students in maternal mental health.	
Respondent: <i>Mostly, we do teach the students so that they should be able to handle a student with mental health issues. Mostly, we do teach the students I can say aaa mmm on how the student can interact with a person with mental health issues, and also how the student can recognize a client or a patient who is having mental health issues. We can do that through several methods; Firstly, we teach them in class, then we can do maybe role-play so that aaaa the nurse and aaa the patient, methods, they should do role play with issues of mental health, we can engage in discussions, and sometimes we can give them problems to search</i>	Interaction of patient Recognition of mental health patient Classroom teaching Roleplay Discussion Problem searching

Stage 6: Searching for themes was done where codes were grouped according to similarities, differences, and relationships across the data set. It also involved sorting different codes into potential themes and bringing together all the relevant codes from the data set. All codes that were similar or related to each other were combined, and they formed an overarching category, which in turn changed to become a sub-theme. An aggregate of categories helped in the formulation of themes for the study (refer to **Table 3**).

Table 3: Searching for Themes

Code	Subtheme	Theme
1. Puerperal psychosis (maternal depression, schizoaffective, mania)	Topics taught in maternal mental health care	Management and assessment of maternal mental health woman
2. Psychological wellbeing		
3. Legal issues in maternal mental health		
4. Anxiety		
5. Collaboration		
6. Communicational skills	Skills taught in maternal mental health	
7. Counselling skills		
8. History taking		
9. Recognition of maternal mental health patient		
10. Lecturing	Lecture method	Classroom-based learning and teaching
11. Group assignments	Student-centered teaching strategies	
12. Clinical drilling		
13. Roleplaying		
14. Video		
15. Discussion/group discussion		
16. Brainstorming		
17. Problem-based learning		

Stage 7: Defining and naming the themes was done. The name of the theme came from an inclusive of all underlying categories, their relationships, and any related similarities or differences identified in the data. This stage also involved the presentation of themes and their narratives in support of the themes identified in **Table 4**. It also involved making interpretations of the data set.

Table 4: Defining and Naming the Themes

Theme	Subtheme	Codes	Transcripts
Management and assessment of women suffering from maternal mental health	Topics taught in MMH care	Puerperal psychosis	<i>There is only one specific topic and that is puerperal psychosis which has been taught, also known as maternal depression (Participant # 2- F-1-12).</i>
		Postpartum depression	<i>According to the curriculum for NMTs, there is anxiety and there is depression which come in as postpartum depression and postpartum psychosis. We also teach legal issues that we are supposed to follow when we are managing or assessing people with mental health problems (Participant #7-M-25-1).</i>
	Skills taught in MMH care	Communication skills	<i>We teach how the student can interact with a person with mental health issues, and also how the student can recognize a client or a patient who is having mental health issues. (Participant # 1- M-17-12.</i>
		Counselling skills	<i>On skills we have counselling skills so we teach our students how to counsel patients that have or clients that have anxiety, problems depression. You know every condition that the client will come up with has their specific causes so we teach our students to target those specific causes so we counsel them (Participant #7- NE-M).</i>

Stage 8: This stage involved producing a report, where the whole analysis was written, consisting of codes, sub-themes, and participant quotes. It also involved peer debriefing, in which colleagues and supervisors were involved in the discussion of the research findings and their interpretation to validate and confirm the truthfulness of the findings. All this information was included in the study in the form of a report.

3.7.4.2. Content Analysis

Data from checklists was analyzed using content analysis. According to (Shava et al., 2021), content analysis involves grouping the data into smaller units, coding and naming them according to shared concepts, and grouping the coded data according to the concepts needed for studying. In this study content analysis involved organizing information into categories in response to the research question. Thus, data from the NMT syllabi and curriculum, course outlines, and student logbooks were grouped according to MMH competencies taught i.e. knowledge, skills, and attitudes, and MMH teaching methods used as outlined in those documents. Thereafter, data reduction was done, whereby similar items were grouped and recorded. The findings on content analysis brought in 5 topics on knowledge, 6 skills and attitudes, and 9 clinical teaching strategies (refer to **Table 11**).

3.8. Data Management

After data collection, all filled-in questionnaires and document review checklists were filed in the data collection file and stored in a locked drawer that was only accessible to the investigator. All audio recordings from FGD and in-depth interviews were entered into the computer and stored as a soft copy in a password-protected file known only to the investigator.

This was done to protect the participant's identity and personal information, as supplied on the questionnaire and consent forms. All data were kept in the investigator's office until the time when the study was completed, which would not take more than 5 years from the start of the study.

3.9. Ethical Consideration

All ethical principles of research were adhered to during the whole research process. Initially, the research proposal was granted ethical approval by the Mzuzu University Research Committee (MZUNIREC) (**Appendix 2**). This was done to ensure that the rights of the study participants and those of the investigator were protected (Creswell & Creswell, 2018). After approval, permission to conduct the pilot and main studies was obtained from nursing colleges through the college principals before the study was carried out (**Appendix 3**). Both verbal and written consent were sought from the participants as evidence that they understood and accepted to take part in the study (**Appendix 1**). Participants were told the purpose, nature, benefits, potential risks, and time taken to fill out the questionnaire and for interviews, and that their participation in the study was voluntary and they had a right to participate or withdraw if they felt so. The availability of this complete study information allowed participants to make an informed decision about whether to participate in the study or not. Additionally, participants were also encouraged to ask questions related to the study to promote their understanding.

Furthermore, the study carried minimal risk; as a result, no one was harmed because of their involvement in the study. No participant experienced a psychological problem from a negative clinical experience; hence, no one was referred for counselling services. Participants were selected fairly through purposive and convenient sampling, which was guided by the research objectives and inclusion criteria.

All interviews were done in closed rooms, and other participants were not allowed to come close during in-depth interviews to promote privacy and confidentiality. Participants' code numbers were used on the consent forms instead of their names to promote anonymity. All data instruments, like questionnaires, the voice recorder, and the transcripts, were kept in a locked drawer and will be destroyed 5 years after the study findings are shared with relevant stakeholders.

3.10. Study Strengths and Limitations

The recruitment of participants who were teaching and had learned MMH competencies was considered one of the strengths of the study. This is because they had experience with MMH competencies' as a result, they provided enough information for the study. Furthermore, the study was conducted in areas with a high prevalence of maternal depression, reflecting the opinions of participants on MMH competencies and the teaching strategies being used. Besides, the use of multiple data collection tools strengthened the study because it enhanced the credibility of the findings. Additionally, peer review and member checking of the findings were enhanced throughout the study to prevent researchers' effects on the study findings. However, the only limitation is that the study might have been affected by selection bias because it only recruited participants who were available in the study setting during data collection. Although no public or nursing colleges from the central region participated in the study, the results can be generalized because NMT's education program uses the same syllabus and curriculum as all CHAM nursing colleges in Malawi.

CHAPTER 4: PRESENTATION OF RESULTS

4.0 Introduction

This chapter presents the findings of the study on the demographic data of participants, MMH competencies, clinical teaching strategies, challenges faced by nurse educators, and experiences of students in the attainment of MMH competencies. Results are presented in three forms, which include quantitative, qualitative, and document review findings.

4.1 Quantitative Findings

One hundred fifty-three (153) participants were recruited in the first phase, in which over half of the participants (54.2%, $n = 83$) were from ECHS and the rest were from SLCHS. The first section of the questionnaire had information on the demographic characteristics of the participants, such as age and gender. The results of the findings are presented in **Table 5**.

Table 5: Demographic Characteristics of Participants

Characteristic		Frequency	Percentage (%)
Participant	Students	123	80%
	Nurse educators	30	20%
Gender	Female	104	68%
	Male	49	32%
Age in years	< 20	1	0.7%
	20- 30	117	76%
	31-40	23	15%
	41-50	7	5%
	>50	5	3%

N=153

The findings in **Table 5** show that most participants in the study were students (80%; n = 123), with a smaller number being nurse educators (20%; n = 30). Furthermore, the data indicates that the majority of participants were between the ages of 20 and 30 (76%, n = 117), followed by those aged 31 to 40 (15%, n = 23), and only one participant was under 20 years old.

4.1.1 Characteristics of Nurse Educators

Nurse educators had other additional characteristics, such as years of experience, formal training in clinical teaching, academic qualifications, and professional specialization. The findings are presented in Table 4.

Table 4: Showing the Characteristics of Nurse Educators

Characteristics		Frequency (n)	Percentage (%)
Years of Experience	1-5	7	23.3
	6-10	13	43.3
	11- 15	6	20.0
	16-20	3	10.0
	>20	1	0.3
Academic Qualification	Master degree	22	74.0
	Bachelor degree	7	23.3
	Diploma	1	0.3
Professional Specialization	Nurse educators	11	33.0
	Nurse midwives	9	30.0
	Community health nurses	5	17.0
	Mental health nurses	2	6.7
	Other	3	10.0
Formal Training in Clinical Teaching			
Trained		17	57.0
Not trained		13	43.0

N= 30

The study found that most participants (43%, n=13) had 6-10 years of experience, with 23%, n=7, having 1-5 years. Only a few (3%, n=1) had over 20 years. The majority of nurse educators (73%, n=22) had a bachelor's degree, followed by a Master's degree (23.3%, n=7) and only a few

(3.3%, n=1) had a diploma (3.3%). Less than half of nurse educators (57%, n=17) were formally trained in clinical teaching and the rest were not trained.

4.1.2 MMH Competencies Taught to NMTs

Participants were asked to mention MMH competencies implemented by nurse educators when teaching NMT students by rating their level of agreement and disagreement on a Likert scale of 1 to 5. Ten competencies were presented, which include common MMH conditions, psychological support, screening, documentation, critical thinking, communication, counselling, collaboration, referral, and application of ethical legal issues. The findings are presented in **Table 5**.

Table 5: Participants' Responses on MMH Competencies

MMH Competencies	M	SD	Decision
Documentation	4.55	0.595	Agree
Collaboration	4.27	0.728	Agree
Referral	4.08	0.910	Agree
Psychological support	3.94	0.941	Agree
Critical thinking	3.80	0.814	Agree
Critical thinking skills	3.86	0.823	Agree
Counselling skills	3.79	0.910	Agree
Communication skills	3.84	1.046	Agree
Screening skills	2.78	1.367	Disagree
MMH conditions	2.62	0.967	Disagree
Weighted average	3.75		

The findings in **Table 5** show that the majority of participants agreed with teaching students' documentation ($M = 4.55 \pm 0.595$), collaboration ($M = 4.27 \pm 0.728$), and referral ($M = 4.08 \pm 0.910$), followed by psychological support, ethical decision-making, and critical thinking skills,

because their mean scores were above 3.75. However, most participants disagreed with teaching students the management of common MMH conditions ($M = 2.78 \pm 1.367$) and screening skills ($M = 2.62 \pm 0.967$), indicating that these were not taught in the NMT program.

4.1.3 Clinical Teaching Strategies Utilized in MMH Care

Participants were asked to indicate whether they agreed, disagreed, or were uncertain about utilizing 12 MMH clinical teaching strategies when teaching MMH competencies. The results of the clinical teaching practices are presented in **Table 6**.

Table 6: Participant's Responses on Clinical Teaching Strategies

Clinical teaching Method	Mean	SD	Decision
Developing objectives	4.51	0.680	Agree
Orientation to objectives	4.39	0.728	Agree
Sharing objectives	4.17	0.964	Agree
Coaching	3.76	0.958	Agree
Learning from patient experiences	3.75	1.091	Agree
Case studies	3.67	1.276	Agree
Feedback	3.41	1.211	Agree
Discussion	2.88	1.279	Disagree
Return demonstration	2.88	1.314	Disagree
Demonstration of:			
- Communication skills	3.72	1.278	Agree
- Counselling skills	3.18	1.278	Disagree
- Anxiety screening skills	2.52	1.176	Disagree
- Depression screening skills	2.21	0.9964	Disagree
Laboratory skill practice	2.42	0.824	Disagree
Portfolio	2.16	0.919	Disagree
Weighted average	3.31		

Findings from **Table 6** indicate that participants agreed with using 8 out of 13 clinical teaching strategies. However, sharing clinical objectives ($M = 4.17 \pm 0.964$), developing individual clinical objectives ($M = 4.51 \pm 0.680$), and orientation to clinical objectives scored highly ($M =$

4.39±0.728), indicating that these were commonly used in MMH competencies, followed by learning from patient experiences, case studies, coaching, and feedback because their mean scores were above 3.31. Participants disagreed with utilizing these clinical teaching strategies, such as demonstrations of MMH skills such as screening for maternal depression ($M = 2.21 \pm 0.964$), anxiety ($M = 2.52 \pm 1.176$), and counselling skills; and utilizing laboratory skills for MMH practice ($M = 3.18 \pm 1.278$). This entails that these strategies were not commonly used when teaching students MMH competencies.

4.1.4 Challenges Faced by Nurse Educators

The study also wanted to identify classroom and clinical teaching challenges faced by participants when teaching MMH competencies, as follows:

4.1.4.1 Challenges in Classroom Teaching

Participants were asked to indicate a shortage of nurse educators, inadequate MMH skills in the curriculum, a lack of knowledge on MMH competencies and teaching methods, little content on MMH competencies in the curriculum, and a lack of screening tools. The findings are presented in **Table 7**.

Table 7: Participants Responses on Challenges in Classroom MMH Teaching

Challenges	M	SD	Decision
Little content	3.37	1.183	Agree
Shortage of educators	3.95	1.108	Agree
Lack of screening tools	3.91	1.172	Agree
Inadequate knowledge of MMH competencies	3.04	1.208	Disagree
Lack of knowledge of teaching methods	2.58	1.173	Disagree
Weighted average	3.37		

The results in **Table 7** on challenges faced by nurse educators in classroom teaching show that the majority of participants agreed that little MMH content ($M = 3.37 \pm 1.183$), a shortage of nurse educators ($M = 3.95 \pm 1.108$), and a lack of screening tools ($M = 3.91 \pm 1.172$) were common challenges faced by participants when teaching MMH competencies in the classroom. However, participants disagreed with inadequate knowledge of MMH competencies ($M = 3.04 \pm 1.208$) and a lack of knowledge of MMH classroom teaching methods ($M = 2.58 \pm 1.173$), indicating these were not common challenges faced by nurse educators.

4.1.4.2 Challenges in Clinical Teaching

Participants were also asked to indicate challenges they face in the clinical area when teaching or learning MMH competencies. The results of their responses are presented in **Table 8**.

Table 8: Participant's Responses on Challenges in Clinical Teaching

Challenges	M	SD	Decision
Large student numbers	4.12	1.149	Agree
Less time	3.79	1.196	Agree
Inadequate skill	3.88	1.100	Agree
Lack of guidelines	3.65	1.182	Agree
Lack of assessment tools	3.43	1.91	Disagree
Inadequate clinical sites	3.42	1.413	Disagree
Lack of knowledge	3.04	1.143	Disagree
Lack of interest	2.31	1.143	Disagree
Weighted average	3.46		

According to the findings in **Table 8**, on challenges faced by nurse educators in clinical teaching, a large number of students ($M = 4.12 \pm 1.149$), less time ($M = 3.79 \pm 1.196$), inadequate skills for MMH practice ($M = 3.88 \pm 1.100$), and a lack of MMH guidelines or standards ($M = 3.65 \pm 1.182$),

were common challenges faced by nurse educators during clinical teaching, as their mean scores exceeded 3.46. Participants disagreed with the lack of assessment tools ($M = 3.43 \pm 1.91$), interest, ($M = 2.31 \pm 1.143$), and knowledge ($M = 3.04 \pm 1.143$), as their mean scores fell below 3.46. This implies that these were not challenges in MMH clinical teaching.

4.1.4.3 The Association between Social Demographic and Dependent Variables

Cross-tabulations and Fisher's exact test were performed on the three newly derived dependent variables against each of the six (6) demographic characteristics of nurse educators, which are gender, academic qualification, age, professional specialization, years of experience, and being formally trained in clinical teaching, as described in Table 9 below:

Table 9: The Association between Social Demographic and Dependent Variables

Demographic variable	MMH Competencies p-value	Clinical teaching strategies p-value	Challenges in MMH clinical teaching p-value
Gender	0.116	0.568	0.384
Qualifications	0.188	0.860	1.000
Age	0.463	0.885	0.494
Years of Experience	0.069	0.701	0.180
Professional Specialization	0.793	0.652	0.106
Formal Training in Clinical Teaching	0.503	0.430	0.352
Age of students	0.261	0.633	1.000
Gender of students	0.761	0.011	0.860

The Fisher's Exact test revealed no statistically significant relationship between the demographic variables of nurse educators and MMH competencies, clinical teaching strategies, and challenges

faced by nurse educators in clinical teaching. This indicates that the variables are independent and that the study data does not provide enough evidence to reject the null hypothesis. Thus, teaching MMH competencies, use of clinical teaching strategies, and challenges faced by nurse educators are not influenced by the social demographic variables of nurse educators. However, there is an association between students' gender and utilization of clinical teaching strategies in MMH (two-tailed $p\text{-value} = 0.011$) because the $p\text{-value}$ was less than 0.05. Hence, the study data provide enough evidence to reject the null hypothesis and conclude that the two variables are dependent. This means that the gender of students influences the utilization of clinical teaching methods in MMH competencies.

4.2 Qualitative Findings

Findings from qualitative data responded to all research questions and complimented the quantitative data. The results comprise demographic characteristics of participants, themes, and sub-themes.

4.2.1 Themes and Subthemes

The study generated 67 codes, 6 themes, and 14 subthemes, which came from competencies utilized in MMH care, clinical teaching strategies, challenges faced by nurse educators in teaching MMH competencies, and student experiences in the attainment of MMH competencies. The findings are presented in **Table 10: Themes and Subthemes**.

Table 10: Themes and Subthemes

	Themes	Subthemes
1	Assessment and management of women with MMH conditions	MMH topics MMH skills
2	Classroom-based teaching	Lecture method Student-centeredness strategies
3	Clinical teaching and support	Student support Clinical-based teaching
4	Neglected MMH competencies	Inadequate laboratory skill practice General skills Lack of resources
5	Difficulty in translating MMH theoretical knowledge into practice	Lack of opportunity to practice Lack of knowledge Stigma and discrimination
6	Functional teaching and learning in MMH care	Training needs in MMH care

4.2.1.1 Assessment and Management of Women with MMH Conditions

The study revealed that students were taught the assessment and management of women with MMH problems. Two subthemes were identified from this theme, such as the topics and skills taught in MMH care.

MMH Topics

Participants indicated that students were taught how to identify and interact with women with mental health problems, as pointed out by this participant, who said:

“We do teach the students so that they should be able to handle a woman with mental health issues.” Mostly, we do teach the students how to interact with a person with

mental health issues and also how to recognize a client or a patient who is having mental health issues (Participant # 01-NE-M).

According to one participant, students were taught symptoms of puerperal psychosis for them to have knowledge and be able to identify maternal women with such problems.

“Students are taught in terms of knowledge on puerperal psychosis as well as what areas to know that this client has symptoms of puerperal psychosis after delivery” (Participant# 08-NE-M).

Other participants indicated that they teach students anxiety and depression, which is covered as postpartum depression and psychosis, and the application of legal issues, as stated by this participant:

“According to the curriculum for NMTs, there is anxiety and there is depression, which comes in as postpartum depression and postpartum psychosis. We also teach them legal issues that students are supposed to follow when managing or assessing people with mental health problems” (Participant #06-NE-M).

Participants noted that anxiety management is cross-cutting because it is part of health care, and students were taught psychological care as well as puerperal psychosis. However, according to this participant, anxiety is a priority problem for maternal women.

“The topics are wide because mental health touches all aspects of health care. We have a component of psychological care and management of anxiety, which is cross-cutting, but a specific topic for maternal mental health, as regards to midwifery, is found in midwifery sciences 2, which is puerperal psychosis, which is well facilitated. This is the

midwifery diagnosis. I always tell my students that anxiety is a priority. When we are to identify three priorities, anxiety should be number 3” (Participant# 04-NE-F).

This was supported by some participants, who indicated that students were taught the psychology of labour and puerperium, as reported by this participant:

“We have other topics like the psychology of the first stage of labour, the second stage of labour, and the psychology of puerperium, which are taught to students for them to understand mental health problems in maternal women” (Participant # 03-NE-M).

Other participants stated that puerperal psychosis is taught alongside other topics such as schizoaffective disorders and mania.

“In the classroom, we learned about postpartum depression; we also learned about mania; and lastly, we learned about schizoaffective” (FGD# 2-student-college 1).

“All those topics that are postpartum depression and schizoaffective were combined into one topic, which is puerperal psychosis” (FGD#4, college 1).

Even though there were so many topics considered to be topics for MMH care, most participants indicated that only puerperal psychosis came out clearly as an MMH topic in the NMT curriculum, as stated by this participant.

“I think we only have one topic that we teach students about maternal mental health. This one is puerperal psychosis. So mostly, students are taught in terms of knowledge on puerperal psychosis as well as what areas to know that this client has symptoms of puerperal psychosis after delivery” (Participant# 09-NE-F).

However, other participants were not sure about teaching MMH competencies, as claimed by this participant:

"I have never taught depression in pregnancy, but depression in general." In addition, when students learn about puerperal psychosis, it is just general management, and we cannot call it a maternal mental health condition (Participant # 03-NE-F).

MMH Skills

The study discovered that students were taught communication skills to recognize signs and symptoms of mental health conditions, as reported by this participant:

"Mostly, we do teach the students. I can say how the student can interact with a maternal woman with mental health issues and also how the student can recognize a client or a patient who is having mental health issues" (Participant # 01-NE-M).

Other participants supported these sentiments, stating that interviewing and observation skills were used during health assessments to identify MMH problems, as reported by this participant:

"We were taught how to assess a woman when we are examining a pregnant mother during antenatal, labour, and postnatal. We were taught how to ask questions during history taking to identify some problems, and if the woman is facing some anxiety problems. During objective data, we assess head to toe, you assess the general condition to which the woman is having problems and also assess if there are signs of violence, she might be having some bruises or else on the skin as an indication of a maternal mental health problem" (FGD# 09-College 2).

This was supported by this participant who indicated that interviewing and listening skills were also taught to identify MMH problems:

“Clinical practice entails assessing clients and collecting subjective and objective data to determine whether a pregnancy was planned or unplanned. Learners are also taught to recognize mental health problems, particularly when feedback differs from the client's expression, indicating possible MMH problems” (Participant #-10-NE-F).

This study also revealed that NMTs are taught counselling skills to help women identify the underlying causes of MMH conditions as stated by this participant:

“We have counselling skills, so we teach our students how to counsel patients or clients that have anxiety or problems with depression. You know that every condition that the client will come up with has specific causes, so we teach our students to target those specific causes, so we counsel them” (Participant # 06-NE-M).

4.2.1.2 Classroom-Based Teaching

The findings show that participants utilized different teaching strategies to help students develop MMH competencies. Two themes were identified such as lecture and student-centred teaching strategies.

Lecture Method

The majority of the participants indicated that the lecture method was commonly used because it was effective in teaching a new topic like puerperal psychosis as explained by this participant:

“For puerperal psychosis, I teach using the lecture method because it is a new topic to the students, and as such, students mostly depend on the teacher to provide enough information so that they can understand the topic” (Participant # 04-NE-F).

This was supported by another participant who explained that the lecture method involved notes preparation and PowerPoint presentations to help students understand MMH conditions, as reported by this participant:

“We do lecture where we explain using prepared notes, and PowerPoint presentations about the condition, yeah, so that the students can understand MMH conditions”
(Participant# 03-NE-M).

Student-Centered Teaching Strategies

The majority of participants stated that student-centered teaching strategies such as group discussion and assignments were commonly utilized when teaching students MMH competencies to help students gain an in-depth understanding of MMH problems as explained by this participant:

“We use discussion, lecturing, and a small part of student-centered methods like group assignments. Using a variety of methods helps students to understand and critique more on the condition, its cause, and how they can manage the client” (Participant # 08- NE-M).

Other participants indicated that group discussion and question and answer were also used to help students recall previous knowledge gained from MMH conditions as explained by this participant:

“We use discussion because these students know about psychosis because they know psychiatric nursing, so they know about psychosis, anxiety, and depression, so we hope that they might have information. In some instances, after group discussion, we sum it all

up with other teaching methods like lectures, where we present what we have prepared on that topic so that they can understand better. We feel lecturing, discussion, questions, and answers are important because, as I have already said, this group in the NMTs program also did mental health psychiatric nursing on the general nursing part of it, so we feel these students still have some knowledge and can apply it. Not only that, their clinical practice for Midwifery Science Part I, which we also take as normal midwifery, exposes the student to what they might have encountered, so there is sharing of experiences. So we feel asking questions is good, allowing students to discuss is good, giving views of what they have experienced before is good, so it cannot be lecturing throughout” (Participant # 10-NE-F).

The findings indicate that students did not get adequate MMH content and although group assignment was done by nurse educators debriefing was not done to help students understand MMH competencies.

During learning, we did not get much information on MMH competencies, since it was given to us as an assignment, so we never had the chance to discuss as a group to know if what we were writing was correct or wrong and get the right answers through, discussion with the group and after that and get the right content from our teachers, so it was very challenging to understand, we were just given marks (FGD#1-F- college 2).

Other participants supported this, stating that students were guided by learning objectives to work on the group assignment, but feedback was not provided to students, as described by this participant.

“We were given the objectives for the group assignment, so when we were writing the assignment, we were following those objectives, so partly, we can say that we were helped by the lecturer because we had objectives that guided us, but in content form, we were not helped, since we did not receive feedback from the lecture, so we don’t even know to say how much information that was needed for that puerperal psychosis, so in that part we say that it we were not sure” (FGD#5-F-college 2).

The study also established that nurse educators use group discussion, brainstorming, role play, and problem-based learning to help students find information and understand MMH topics as stated by this participant:

“I usually involve students in group discussion, class discussion, and brainstorming because I build the lessons on their previous knowledge. Sometimes we also use role-play, for example, a mother walking into the labour ward and nurses shouting at them so that they can understand the sources of MMH problems. I also use problem-based learning just to give them a scenario and then let the students find information; this helps students to be active players in their learning” (Participant # 04-NE-F).

This was supported by another participant who explained how group discussion was done to help students understand MMH competencies as said by this participant:

“Ok, we give a scenario related to MMH conditions, and from the scenario, we discuss with the students how to manage that client because most of the mental health conditions are not practical; they require interpersonal skills or communication skills, so, through discussion, students can learn and understand interpersonal skills” (Participant # 05-NE-F).

Other participants stated that video recordings were also used to help students gain interviewing skills as stated by this participant:

“We also use a video recording in the classroom teaching that we beam for them to see and appreciate exactly what to do when interviewing clients. They should be able to marry what we have demonstrated with what they can see in those videos” (Participant # 06-NE-M).

4.2.1.3 Clinical Teaching and Support

Participants had different views on student clinical teaching and support in MMH care. Two subthemes were identified such as student support and clinical-based teaching as described below:

Student Support

The findings show that students were provided with clinical objectives and encouraged to formulate their objectives from a list of clinical objectives provided as verbalized by this participant:

“Student objectives are provided each time they are going for an allocation so that they should know what is expected of them during that allocation. Normally this is done 2 days before students are sent for practice. In the clinical area, we also encourage students to formulate their objectives from a list of objectives provided. It’s like one way of checking on themselves that they have gained the skills and competencies required for that allocation” (Participant # 02-NE-F).

Participants indicated that students were supported by visiting them in the clinical area where a demonstration of MMH competencies was done as reported by this participant:

“You support them, like when you visit them, you look at their objectives and assist them to accomplish them if they are not accomplished through demonstration of other competencies, or you can encourage them to do so because some students would prefer not to have individual objectives” (Participant # 02-NE-F).

Clinical-Based Teaching

The findings indicate that participants use various clinical teaching strategies to support students in the clinical setting, such as demonstrations, case studies, and clinical conferences. Participants explained how demonstrations were done in the clinical area to help students develop MMH competencies as reported by this participant:

“We do demonstrations in the sense that I will take a woman who is having mental health problems, and then I assist the woman while students are just watching. When we have done that, we do a reflection afterward on how we have handled the woman. This is done just for me to evaluate if indeed students have gained skills needed in mental health practice” (Participant #01-NE-M).

This was supported by this participant who indicated that nurse educators accompanied students and demonstrated MMH competencies however, students disagreed on being supported in MMH competencies.

"Our lecturers supported us; they escorted us on the day of clinical placement, and they demonstrated the objectives that we were supposed to achieve in mental health competencies, and this helped us to understand what was expected of us during that allocation. However, they never demonstrated how we should screen women with mental health problems, I don't know why” (FGD # 06- F-College 1).

Other participants indicated that case studies were used to help students gain MMH competencies, as claimed by this participant:

“We also do case studies where we can give them scenarios about the woman who came into the labour ward and was presenting with mental health symptoms, and we tell students, let’s discuss and make a proper diagnosis. So, case studies are also used to teach students to identify MMH conditions” (Participant # 03-NE-M).

Findings also revealed that clinical teaching conferences are also utilized to help students acquire MMH competencies which promote peer learning and mentorship as narrated by this participant:

“Usually, we use teaching conferences where students from different colleges present their cases in a conference. After presentations, we employ discussion so that they can give us their experiences with clients. These discussions help students learn from each other and also from us about how we manage maternal women with mental health problems” (Participant # 07- Preceptor-M).

4.2.1.4 Neglected MMH Competencies in Midwifery Practice

The findings show that MMH competencies are neglected in midwifery practice. The study found three sub-themes to support this allegation such as; unspecific MMH competencies in the curriculum, limited opportunities for MMH skill practice, and lack of resources.

Inadequate Skills Laboratory Practice

The majority of participants indicated that there were limited opportunities for students to practice MMH competencies in the skills laboratory because such competencies were missing even in the students' class schedules, as reported by this participant:

"I have never taken students to the skills laboratory because our clinical schedules do not provide for such. They have not provided periods for practice in the skills laboratory. I have never seen any provision for MMH skills practice in the skills laboratory" (Participant # 02-NE-F).

This was supported by another participant who pointed out that during skills laboratory practice, only midwifery competencies were emphasized more unlike MMH competencies because not much was written in the curriculum.

"This is an area that is neglected; we only focus on midwifery skills in cases of mental health practice in midwifery; there is no such time when we go to the skills laboratory to practice with students because, in the curriculum, not much has been written about MMH competencies" (Participant # 04-NE-F).

This was also agreed upon by another participant who indicated that students were not taken to the skills laboratory because they believed that MMH competencies were building on previous knowledge gained from a psychiatric nursing course:

"When it comes to teaching this course on puerperal psychosis, we rarely take the students to a skills laboratory specifically to do the skills practice on the assessment of patients presenting with psychosis because we build on the previous knowledge of mental health and psychiatric nursing, so it is seen as a duplication of competencies. We only take the students into the skills laboratory to learn Midwifery Science 2 competencies but not specifically assessing for puerperal psychosis" (Participant# 10-NE-F).

However, most students were concerned that despite learning about mental health-related topics, they had forgotten the content as stated by this participant:

“Another challenge is that we did mental health in the second year, and it took us at least a year to relearn mental health-related topics in midwifery. So, the prolonged period we had without learning mental health topics made us forget, and it was hard for us to recall and grasp the classroom mental health content that we studied in that semester” (FGD #09-M-College 1).

The findings also revealed that nurse educators explained that their roles in teaching students MMH competencies were just theory because MMH competencies were not specified in the curriculum, as stated by this participant.

“It’s just theory; we have never taken students to skills laboratories because in the curriculum it’s not specific that we should demonstrate mental health competencies” (Participant #09-NE-F).

This was also supported by other participants who indicated that the lack of skills practice makes them feel that MMH competencies are useless and thus not taken seriously by nurse educators, as stated by these participants.

“As much as we learned about mental health psychiatric nursing, and also puerperal psychosis, when we went to the practical site, especially in the skills lab, we have never met any station where we found any scenario concerning psychosis, especially when we looked at puerperal psychosis. Since we don’t practice it, we just feel that puerperal

psychosis is a useless topic. These mental health issues are neglected; the lecturer might not be serious. They think the topic is useless” (FGD #02-M- College 2).

General skills

Most participants stated that MMH competencies are not specific and that there is little content in the NMT curriculum, so nurse educators only teach general mental health management, as indicated by this participant:

“I would say that maternal mental health problems may not be very specific, but they still come into the general context. Just like a woman who has come, assessing something like that, not specifically to say you want to pick some mental health disorders for an antenatal woman, no. It is just a general assessment. So, it just comes in as a bullet, it does not have a prescribed number of student assessments. Basically, the content is little for a student to achieve competencies” (Participant #10-NE-F).

This was supported by this participant indicated that since MMH are not specific, students are taught according to what is presented in their objectives:

“Most of the time we can support them at the psychiatric unit, for example, Zomba mental hospital, we look at objectives and again. Mmmm in their objectives, we don’t have specific objectives for maternal. Thus, the challenge so we cannot teach students something that is out of their objectives we focus on their objectives again when they are practising here they too focus on their objectives. I think we need to incorporate those mental health objectives into the general objectives (Participant#6-NE-F).

The findings also revealed that students were not aware of the nursing curriculum that was being used by nurse educators for them to gain competencies in MMH as said by this participant:

"Maybe, as for me, we don't know the curriculum that our lecturers are using because we are not dealing with specific issues about maternal mental health or the psychosis of women" (FGD # 04-M-college 2).

Some participants were not sure whether they indeed teach students MMH competencies because the component of it does not come out clearly in the NMT curriculum.

"Maternal mental health, I can say we do, and I can say we don't, because it doesn't come out clearly as maternal mental health. It comes as a component in a certain comprehensive assessment whereby the student should note the physical and psychological well-being of the client. But it's not clear" (Participant #05-Preceptor-F).

Lack of Resources

The findings show that MMH competencies are not adequate to support student's teaching and learning. These resources include a lack of learning guides, screening tools, books containing MMH content, limited time to teach students and also for students to practice, and space to teach students. Most participants indicated that there were no MMH learning guides to be used when teaching students. As a result, the few MMH competencies that were known were incorporated in midwifery learning guides as said by this participant:

"We don't have specific guidelines in MMH to be used as learning guides for teaching students but we just incorporate them into antenatal guidelines. When I say they are incorporated into midwifery competencies, it's when the student is supposed to assess the

psychological well-being and social well-being for example whether the pregnancy was planned or not and also if the husband has accepted the pregnancy. Even if the assessment is for midwifery, the student can still pick out psychological issues. This is where am saying we don't have specific guidelines but we just incorporate them into antenatal competencies” (Participant # 09-NE-F).

Other participants expressed dissatisfaction with the impact of the lack of learning guidelines, which resulted in nursing educators teaching students MMH content that was different from each other as this participant said:

“The lack of guidelines, especially when it comes to clinical practice, means it's like we teach them what I know and others will also teach students different things. As a result, there are inconsistencies in teaching students because we don't have guidelines in MMH care” (Participant # 08-NE-M).

These sentiments were supported by other participants who reported the lack of screening tools for MMH competencies alternatively, general checklists were used to make a diagnosis for puerperal psychosis and also each college has its own checklist:

“We don't have screening tools as of now for these maternal mental health conditions, but in the case of psychosis, we have several general checklists that students can use to make a diagnosis of psychosis, but each college has its own” (Participant# 6-NE-M).

This was supported by this participant who indicated that there are no screening tools to evaluate the achievement of students' competence as reported by this participant.

“We do not have specialized tools to assess the competency of a student in maternal mental health apart from maybe employing the general depression tool, which in itself is just introductory as it does not exhaust all levels of competency. The absence of an assessment tool means that the student’s achievement of MMH competencies is not evaluated (Participant #07-Preceptor-M).

Most participants indicated that there is a shortage of nurse educators and other clinical teachers to support students in MMH care, as stated by this participant:

“We also have a few mental health nurses and educators to teach and support students in the clinical area. If there are no nurses who are knowledgeable about mental health issues, the unspecialized nurses are asked to teach students, as such, they cannot provide adequate knowledge to our students, so what they get in class is like that” (Participant #03-NE-M).

Other participants indicated that space for clinical teaching is not adequate at the antenatal clinic for nurse educators to teach students MMH competencies, as said by this participant, said:

We have challenges in finding a space to demonstrate proper care in antenatal care. We are allocated at a place where, to me, it’s like close to the toilet, is not conducive to be teaching students, and honestly, verbal privacy is not observed”(Participant # 04-NE-F).

Other participants explained that there are few teaching resources, especially books with inadequate MMH content to teach students, as reported by this participant:

“We struggle to gather teaching materials, and usually we scout on the internet for such materials. Furthermore, in most midwifery books, MMH information is not adequate. So

even the NMT curriculum does not tackle the issues of MMH or those of breastfeeding mothers. So, if I teach one condition in mental health, then your search for information is also inadequate; as such, the information to prepare for student teaching is also limited.”

(Participant #08-NE-M)

The findings show that time is limited for student teaching and also an increased workload for nurse educators and as a result, students are not supported adequately.

“Time is inadequate; to manage to work here and also to attend to your supervision duties is a challenge. This is exacerbated by the increase in the intake of nursing and midwifery students over the years, while staffing numbers have stagnated. In most cases, students are only allocated for 4 weeks which is not adequate for us to teach them properly” (Participant # 07, Preceptor-M).

These sentiments were supported by other participants who indicated that students were only supervised in the morning hours which was felt inadequate for achievement of MMH competencies:

“We have limited time to support students in the clinical area. Mostly we just go there in the morning if students are within Mzuzu and in the afternoon we are not there, we have limited time to interact with students in the clinical area. This is because we have a lot of work to do here” (Participant#01-NE-M).

Most participants indicated that there is little content of MMH in the NMT curriculum to ably support students in MMH, as said by this participant:

“At the colleges, there is not enough knowledge being given to the students, especially on maternal mental health. As such, here at the hospital, we have to go back to the basics to explain the issues, which are a waste of time” (Participant #07-preceptor-M).

Participants explained that there is a single MMH condition that does not prepare students accordingly as said by this participant:

“In the curriculum for NMT, if we look at maternal mental health, basically it comes as a single topic because it comes as puerperal psychosis so as it comes as puerperal psychosis it provides a general management because this is specific in maternal that is midwifery otherwise if it was a stand-alone as mental health, then we would have been talking of many courses so it comes as one topic” (Participants#10-NE-F).

However, students supported that they were not adequately supervised in the clinical area because nurse educators only supervised them twice in the whole allocation.

We were not supported adequately, the lecturer would come at the time we arrived at the hospital, and also the lecturer would come during the time of assessment, I just wish he was around to support us (FGD#7-M- College 2).

4.2.1.5 *Difficulty in Translating MMH Theoretical Knowledge into Practice*

The study has revealed that students fail to attain MMH competencies because MMH clinical objectives are not specific, lack of knowledge, and limited opportunities for students to practice in the clinical area.

Lack of Opportunity to Practice

Most participants reported that clients with MMH conditions are rarely found in clinical settings, and as such students lack the opportunity to practice in a clinical setting, as said by this participant:

“The big challenge is that we teach and orient students to MMH skills, but such cases are very rare at Zomba Mental Hospital, and for the past 3 years, we haven’t seen any patient or client with MMH problems. As a result, students fail to attain MMH competencies because cases are rarely found” (Participant #06-NE-M).

This was supported by another participant, who indicated that most clients with MMH conditions` are rarely found at the antenatal clinic but can be found in the labour ward and postnatal ward.

“Most MMH cases requiring counselling services happen in the labour ward and postnatal ward. At the antenatal clinic, it might happen but I have never seen qualified midwives counselling pregnant women on psychological issues” (FGD#9- F-college 2).

Other participants indicated that qualified nurses were not screening or managing women with MMH conditions, as a result, students also felt mental health competencies are not important, as stated by this participant, who said:

“Another challenge is that when we go to the clinical areas, the qualified nurses do not concentrate much on mental health conditions, and when a client has been found, they just refer; as a result, we don’t know how to diagnose those conditions” (FGD#02-F-college 1).

Other participants felt MMH competencies are not practised because teaching hospitals do not prioritize MMH competencies, and as a result, students have minimal exposure to practising MMH conditions.

“I think hospitals in Malawi are not prioritizing mental health services because if they see qualified nurses not screening clients, they take it as if it is a normal practice. Had it been that they were prioritizing mental health services; definitely, these students would have been encouraged to go back to their notes and study, practice, and counsel such women because students learn by observing the qualified nurses (Participant# 06. NE-M).

“I think there is minimal exposure of students to these kinds of cases; maybe we might be having situations where we manage or we might not manage these kinds of patients if we don’t meet them at the hospital” (Participant #09-NE-F).

This was supported by this participant, who explained that students fail to attain MMH competencies because they were allocated to male wards where there were no clients with MMH conditions:

“At first, we thought that we would have that chance to manage women with MMH problems as we were allocated to St. John of God and Zomba Mental Hospital. But reaching there, we were allocated to the male maximum ward, where there were only males, so I didn’t have the chance to see patients with postpartum depression or puerperal psychosis” (FGD#03-F-college 2).

The findings also observed that students fail to attain competencies in MMH because the maternal client was violent, as indicated by this participant:

“At Zomba Mental Hospital, I had a chance to see a woman who had just delivered, and she had puerperal psychosis just 48 hours after delivery. I had a chance to see one. However, there was no demonstration on how to manage that woman because she was violent; she was beating everyone who wanted to touch her. I was afraid, I would have been beaten” (FGD #01-F-college 1).

Lack of Knowledge

The findings show that nurse educators reportedly had insufficient knowledge of MMH competencies due to their limited teaching methods, resulting in students lacking the necessary as stated by this participant, who said:

“In our curriculum, they don’t concentrate much on this topic, so we should have many skills or more content for us to know them better. So that we can come up with a diagnosis so that we can diagnose a person with these conditions” (FDG #9-M-college 1).

This was supported by another participant who reported that most nurse educators have inadequate knowledge of MMH care, and as a result, cannot support students accordingly:

“I think our lecturers don’t have enough knowledge in MMH. If they had then why did they leave mental health-related topics without teaching us? You can’t teach someone issues that you don’t know. I think those that are exposed to MMH may teach better than

someone who is doing a master's degree in midwifery or Pediatric nursing" (FGD# 02-M-college 2).

Stigma and Discrimination in MMH Care

This was supported by another participant who indicated that there is a stigma in MMH that prevents students from acquiring competencies and also from failing during examinations, as said by this participant:

"The first challenge as I have already said about is attitude. You know when someone has negative attitudes; they act as a barrier on their own. They don't want to get information from you because they don't like the course so we can say this also affects their understanding and performance" (Participant#06-NE-M).

This was supported by another participant who said:

"Mental health issues are stigmatized and discriminated. So even the students themselves when they are learning mental health issues, we observe that their motivation is not like these other courses that's why even their performance is also not satisfactory." (Participant #03-NE-M).

Another participant indicated that some nurse educators are also not interested in teaching students MMH care as said by this participant:

"There are few lecturers who are interested in participating in the teaching process of mental health-related topics. So, it's a big challenge because if there are few lecturers, you cannot afford to support the students in the classroom and clinical areas." (Participant #05-NE-F).

4.2.1.6 Functional Teaching and Learning in MMH Care

This study has revealed that nurse educators and students are expecting functional teaching and learning in MMH practice.

MMH Training Needs

The findings indicate that NMTs need to learn more MMH competencies to ensure that they are prepared to respond adequately to the needs of the public. They further wished that screening tools for common mental health problems could be incorporated into their syllabus and that there should be more mentors in MMH who could support students in the clinical area to enable them to achieve competencies related to MMH, as narrated by this participant, who said:

“I think our curriculum should emphasize certain topics that need to be taught so that we can be competent in the provision of care” (Participant # 02-NE-F).

These thoughts were supported by this participant who reported:

“I just want to emphasize that we need to do more in our curriculum. I feel like, apart from puerperal psychosis, women also face issues like stress, anxiety, and depression. So, management of these conditions should come out clearly in the curriculum, even in their own professional assessment guides or diagnostic guides” (Participant 03-NE-M).

Students also supported the above opinion that they need to learn more topics in MMH care, as narrated by this participant, who said:

“Topics for maternal mental health should be put in the curriculum so that we should learn as many as we can to have adequate knowledge to diagnose and manage the

conditions and offer counselling services if clients may need them to improve maternal outcomes” (FDG#1-F-college 1).

Furthermore, other participants mentioned that students should learn mental health, psychiatric nursing, and midwifery concurrently so that they can apply MMH competencies. One participant expressed that:

“If such students could have begun with maternal health classes, I would have loved it. If not, they could have taken maternal and mental health courses simultaneously, enabling them to marry these two” (Participant 07-NE-M).

Students also suggested that mental health nurses should be available in hospitals so that they can provide comprehensive management to maternal women for early identification, as explained by this participant:

“I believe that mental health nurses ought to be available to assess every woman, even if they are the only ones who come to work if there is a psychiatric condition. Otherwise, we may overlook cases where a woman has a mental health condition, for which there may be no assessment or examination” (FGD# 09- F-college 2).

4.3. Findings from the Document Review

A document analysis was done at the study sites to investigate competencies implemented by nurse educators and their clinical teaching strategies for students’ attainment of MMH competencies in the NMT program. The document analysis was done to respond to study objectives 1 and 2. The documents reviewed included the NMT syllabus, curriculum, course outlines, student competence books, and NMCM assessment forms. It was noted that in all the

two selected nursing colleges, participants used the same syllabus, curriculum, course outlines, and NMCM student assessment forms. However, mental health-related competencies were found in mental health psychiatric nursing and midwifery courses.

4.3.1 Mental Health Psychiatric Nursing Course

The findings show that NMT students learn mental health and psychiatric nursing in the fourth semester of their second year of the program. Students are supposed to take the course for 240 hours for both theory and clinical practice. Students are supposed to cover 70 hours for theory, 10 hours for skill practice, and 160 hours for clinical practice. Furthermore, the NMT student is expected to acquire knowledge, skills, and attitudes for the identification of common mental health problems and psychiatric conditions. The study found that the competencies gained by students in mental health psychiatric nursing are general and not specific to maternal women, as indicated by the aim of the course quoted in the NMT syllabus:

“The aim of the course is to equip learners with the knowledge, skills, and attitude required to identify mental health problems and common psychiatric conditions to promote mental health and manage the common psychiatric conditions.”

4.3.2. Midwifery Courses

The findings show that NMT students are taught midwifery courses in semesters 5 and 6 of the nursing program, where they are expected to cover 180 hours in the classroom and 480 hours in the clinical area. The study found three topics in midwifery part one where students are taught mental health-related topics, which include the psychology of pregnancy, labour, and puerperium. These findings were consistent with those found in the survey and interviews. In the second part of midwifery, which is called Midwifery Science 2, students are expected to acquire

knowledge and skills and have an appropriate attitude for managing maternal mothers with medical, surgical, and obstetric conditions and complications during pregnancy, labour, delivery, and the postpartum period. The study found that students are expected to cover 180 hours in the classroom and 600 hours during clinical practice.

4.3.2.1. MMH Competencies Taught to NMT Students

The study findings indicate that MMH competencies are not specific in the documents as quoted in the documents:

“The student should demonstrate the knowledge, skills, and attitudes necessary to provide comprehensive care to women throughout pregnancy, labour, and puerperium, including neonates, using the midwifery process.”

“To enable a student to acquire knowledge, skills, and an appropriate attitude in managing mothers with medical, surgical, and obstetric conditions and complications during pregnancy, labour, delivery, and the postpartum period.”

“The student should demonstrate the knowledge and skills required to provide high-quality and culturally sensitive immediate and long-term postpartum care to women with pregnancy complications within the midwife’s scope of practice.”

Under each statement, there were several competencies that students were supposed to be taught by nurse educators. However, for topics related to MMH conditions, only two topics were found, namely, postpartum depression and puerperal psychosis or postpartum psychosis. The student was also expected to learn counselling, communication, and documentation skills. On the part of attitude, the student was expected to show respect and empathy, uphold human and patient

rights, and be non-judgmental in the course of providing care. The findings were consistent with those found during the survey, in-depth interviews, and focus group discussions. However, none of the findings of the survey, in-depth interviews, or focus group discussion investigated attitudes.

4.3.2.2. Clinical Teaching Strategies

The findings indicate that nurse educators used various forms of teaching strategies, such as demonstration, lecture, discussion, case study, role-play, problem-based learning, and debate. The findings were consistent with those found in in-depth interviews, surveys, and focus group discussions. However, it was noted that debate was not commonly utilized by nurse educators in teaching students, as evidenced by findings from the survey and interviews.

4.3.3 Student's Attainment of MMH Competencies

The findings show that both colleges had Skill Laboratories for student practice in preparation for clinical practice. The document analysis of class schedules found only midwifery competencies such as examination of antenatal and postnatal women, management of the first stage, and many more.

The findings showed that four tools were used in the clinical area to help students achieve their learning objectives, namely: clinical learning objectives, learning guides, student college log books, competence log books from NCMM, and the NMCM assessment forms.

Clinical Learning Objectives

The document review findings revealed that clinical learning objectives and learning guides were shared with all students before their clinical placement. However, it was discovered that the

clinical learning objectives for MMH were not specific but incorporated into other learning outcomes, as quoted from the learning guide and clinical objectives:

“Conduct assessments of clients with medical, surgical, and obstetrical conditions and complications in pregnancy, labour, and puerperium.”

Learning Guides, Clinical Log Books, and NMCM Assessments

Both colleges provide students with learning guides to help them achieve clinical competencies. However, MMH competencies were not specifically documented but were incorporated into other competencies. The skill that came close to identifying MMH problems was when students were asked to conduct a health assessment such as interviewing and observation as described below:

“To ask maternal women about their history of mental illness and if the pregnancy was planned or not.”

“To observe the facial expression of the maternal woman to note whether the woman was stressed, anxious, or depressed to facilitate the collection of objective data”.

“To assess signs and symptoms of domestic violence by asking the woman or by observing bruises on the skin.”

These findings are consistent with those found during in-depth interviews and FGDs. The study found that communication and counselling skills were directly related to MMH care, as quoted in these sentences:

“Support parents and significant others during the grieving process.”

“Support and counsel parents with babies with abnormalities.”

Besides, it was discovered that there were other general competencies taught to students that could be applied to any midwifery-related practice, for instance, documentation, ethical and legal issues, collaboration, and referring maternal women for further management, as quoted:

“Collaborate with other health care workers in the provision of care.”

“Document care during the provision of midwifery care.”

“Apply ethical legal principles in the management of mothers and neonates during the perinatal period.”

There were no specific tools identified in the investigation used for screening MMH conditions. These findings are consistent with those found in the survey, in-depth interviews, and FGD, as shown in **Table 11**.

Table 11: Findings from Document Review

Knowledge	Skills	Attitudes	Teaching methods
Postpartum depression,	Psychological support,	Respect, Empathy	Lecture, Question and
Postpartum psychosis,	Counselling	Upholds human	answer,
Psychology of labour, and	Communication	and patient rights	demonstration,
puerperium	Collaboration	Non-judgmental	clinical conferences
Collaboration,	Documentation,	Maintains	Case study,
Legal issues	Comprehensive history taking;	professionalism	role play
	History of mental illness, if		Debate,
	pregnancy was planned or not,		Problem-based
	general survey if stressed,		Reflection
	depressed, or anxious		

4.4 Summary of Findings

The quantitative findings revealed that nurse educators implement the following MMH competencies: documentation ($M = 4.55 \pm 0.595$), collaboration of care ($M = 4.27 \pm 0.78$), referral ($M = 4.08 \pm 0.910$), followed by psychological support, ethical decision-making, critical thinking, communication, and counselling skills because their mean scores were above 3.75. However, participants disagreed about teaching students the management of common MMH conditions ($M = 2.78 \pm 1.367$) and screening skills ($M = 2.62 \pm 0.967$). The findings further showed that participants agreed with 8 out of 13 teaching practices, such as sharing clinical objectives ($M = 4.17 \pm 0.964$), developing individual clinical objectives ($M = 4.51 \pm 0.680$), and orientation of students to clinical objectives ($M = 4.39 \pm 0.728$). Other teaching methods used include learning from patient experiences, case studies, coaching, and feedback.

Participants disagreed with utilizing case study presentation and demonstration of MMH skills such as screening for maternal depression ($M = 2.21 \pm 0.964$), anxiety ($M = 2.52 \pm 1.176$), and laboratory skills for MMH practice ($M = 3.18 \pm 1.278$). In addition, a shortage of nurse educators, inadequate skills in the curriculum, large numbers of students, and a lack of screening tools or guidelines were common challenges faced by nurse educators. The study found no association between socio-demographic characteristics of nurse educators and teaching MMH competencies, utilization of clinical teaching strategies, or challenges faced by nurse educators in MMH clinical teaching. However, there was an association between the gender of students and the utilization of clinical teaching strategies in MMH (two-tailed p -value = 0.011).

The qualitative findings revealed six themes, such as assessment and management of women with MMH conditions, classroom-based teaching, clinical teaching and support, neglected MMH competencies, difficulty in translating MMH theoretical knowledge into practice, and functional

teaching and learning in MMH care. Findings from the document review indicated that puerperal psychosis, postpartum depression, psychological support, collaboration, ethical legal issues, counselling, documentation, and communication skills were clinical competencies implemented by nurse educators. In addition, respect, empathy, non-judgment, and upholding patients' rights were attitudes taught to NMT students. The findings on teaching strategies were similar to those found in the survey and document review, except for the debate. However, students are only assessed on a few MMH competencies, which do not prepare them adequately for practice.

CHAPTER 5: DISCUSSION, RECOMMENDATIONS AND CONCLUSION

5.0 Introduction

This chapter discusses and interprets the major findings of the study as presented in Chapter 4. The findings are discussed and interpreted with reference to the relevant literature. The discussion is also based on the objectives of the study, which were to describe the MMH clinical competencies that nurse educators implement during student practice in CHAM nursing colleges, to assess clinical teaching strategies utilized by nurse educators in MMH clinical competencies, to describe challenges faced by nurse educators when teaching students MMH competencies, and to explore student midwives' experiences in the attainment of MMH competencies in clinical practice.

5.1 Demographic Characteristics of Participants

The majority of participants (80%, n = 123) were students, and only a few were nurse educators (20%, n = 30). This increase in student numbers in nursing colleges is one way of increasing skilled and competent healthcare providers in Malawi and overcoming the chronic shortage of nurses and midwives in Malawi (Bvumbwe and Mtshali 2018; Mbakaya et al. 2020). The results

are consistent with other studies conducted in Malawi, which found an increased number of students than nurse educators (Mwale and Kalawa 2016). Although there were many students, the results showed that the student-to-nurse educator ratio was 1:4, which met the NMCM standards for nursing and midwifery education of 1:5 in classroom learning (Nurses and Midwives Council of Malawi, 2021). However, large student numbers could be felt in clinical settings because of the shortage of specialized hospitals in Malawi that offer mental health services. The large student numbers increase workload and reduce time spent on clinical supervision by nurse educators (Mhango et al., 2021).

The majority of nurse educators (73%, n = 22) had a bachelor's degree, with a few of them being men (63%, n = 19), while the rest were women. However, both men and women were involved in teaching MMH competencies. The findings indicate that nurse educators with bachelor's degrees agreed to teach students MMH competencies, used clinical teaching strategies, and faced more challenges in clinical MMH teaching than those with other qualifications. This stems from the fact that there were more bachelor's degree holders in the sample than those with other qualifications. The other factor could be consistent with the NMCM, which recommends nurses with bachelor's degrees teach students regardless of whether they are trained in clinical teaching or not (Nurses and Midwives Council of Malawi, 2016). These findings are consistent with findings from other studies done in Malawi, which showed that registered nurses with bachelor's degrees were involved in the clinical teaching of students.

Furthermore, over half of the nurse educators (57%, n = 17) were formally trained in clinical teaching whilst the rest were not trained. Nevertheless, all nurse educators in this study were involved in clinical teaching. However, of those without formal training, nearly half of them (20%, n = 9) agreed with using MMH clinical teaching methods, while the rest were uncertain.

This inconsistency could be due to a lack of knowledge of clinical teaching strategies used in MMH, as they were not formally trained. The lack of formal clinical training could be attributed to the poor preparation of nurse educators for the role of teachers in MMH services. This discrepancy may have impacted the teaching and support rendered to students to develop MMH competencies. The study's results support previous findings that clinical teaching in Malawi is conducted by nurse educators without formal training (Bvumbwe & Mtshali, 2018; Phuma-Ngaiyaye et al., 2017). As reported by Gcawu & van Rooyen, (2022), nurse educators should be formally trained in clinical teaching so that they can effectively help students acquire appropriate competencies.

Although the quantitative results did not indicate any association between formal training in clinical teaching and the use of clinical teaching strategies in MMH competencies, the qualitative results supported the need for nurse educators to know about MMH competencies and their clinical teaching strategies. Considering that clinical teaching is the backbone of competence development, it is therefore important that all nurse educators be trained in MMH practice and its clinical teaching so that they can support students accordingly.

The study also found an association between the gender of students and the utilization of clinical teaching methods by nurse educators in MMH practice ($p = 0.001$) indicating that clinical teaching strategies used by nurse educators in MMH competencies are dependent on the gender of students. This might be attributed to the utilization of clinical teaching methods by nurse educators to relieve negative attitudes. The findings from this study indicated that female students experienced more negative emotions (fear) in managing clients with MMH problems than male students. This fear might be due to a lack of knowledge and role models to support their learning and the risk of exposure to violent behaviour, as they did not completely cover

theoretical topics before entering the clinical area. These results are in support of findings by Günaydin and Arguvanli Çoban (2021), who found student's negative emotions before clinical practice. Similar to the results of the current study, Wenzel et al. (2022) proposed engaging students in interaction with clients. The more students interact with clients in a more supportive environment, the more their negative emotions can improve. Furthermore, it has been reported that tailoring student needs with interactive teaching methods helps to reduce negative emotions (Everitt et al., 2022).

Therefore, a comprehensive theoretical preparation and a longer duration of clinical practice would help students acquire knowledge and develop positive attitudes towards mental health practice. Considering that students experience negative attitudes even before being allocated to the mental health clinical area, nurse educators must utilize student-centered teaching strategies to help relieve negative emotions experienced by students during clinical practice (Abraham et al., 2018).

The study reveals a significant shortage of skilled nurse educators, with the majority of the sample (90%, $n = 27$) being nurse educators with different specializations and only a few (10%, $n = 3$) being psychiatric mental health nurse educators. The shortage of skilled mental health personnel is caused by a lack of knowledge and inadequate mental health training in Malawi (Mwale & Mselle, 2017). These results are consistent with other studies conducted in Turkey, Japan, and Malawi where the shortage of skilled nurse educators increased the workload in teaching, but, also resulted in poor student clinical support, which affected students' attainment of mental health competencies (Günaydin & Arguvanli Çoban, 2021; Mchenga et al., 2022; Yang & Chao, 2018). As reported by Moyo et al. (2022) and Yang & Chao (2018), students need competent mental health educators to teach and support them in classroom learning and clinical

practice to help them acquire mental health competencies. Therefore, the way students are prepared for MMH practice may have been impacted by the shortage of qualified nurse educators. Thus, to overcome the shortage of skilled mental health experts, task shifting is recommended, allowing non-specialized staff to provide mental health services as long as they have the necessary training (Kulisewa et al., 2022). In this case, NMT students and non-specialized nurse educators should be trained in mental health competencies so that they can fit well with task shifting.

5.2 MMH Competencies Implemented by Nurse Educators

The findings indicate that the majority of participants agreed that student NMTs were taught MMH competencies, which are documentation, collaboration, psychological care, communication, counselling, and referral, with puerperal psychosis being the most common condition being taught. However, more than half of the participants disagreed with teaching students the management of other common MMH conditions and their screening skills. The findings can be attributed to a lack of knowledge about other MMH competencies, which are also important in preservice education. A lack of knowledge on the management of common MMH problems may suggest that midwives in Malawi are not adequately prepared for MMH practice. Consistent with the findings, Carroll et al. (2018) asserted that midwives have a knowledge deficit on the management of other MMH conditions such as maternal anxiety, depression, and suicide. However, the lack of knowledge on the management of common MMH problems and screening skills is contrary to the recommendations made by ICM, where the core competencies for midwives include screening, emotional support, and referral of such cases for further management (International Confederation of Midwives 2018).

The current MMH practice in Malawi is also contrary to the World Health Organization recommendations, where non-specialized healthcare providers are encouraged to be familiar with the management of common mental health conditions, screening, psychological support, and the use of psychotropic medication (WHO, 2022). The findings suggest that, although the NMT curriculum was reviewed by NMCM, not many MMH competencies were added to the curriculum.

This entails that MMH competencies in the curriculum are not adequate to build student's competencies, which is not in line with Malawi's National Mental Health Policy, which expects midwives to provide care to all vulnerable groups, like women, for any mental health services in any healthcare setting (Ministry of Health, 2008). This therefore necessitates the need to review the NMT curriculum so that MMH competencies such as common PMH conditions and their screening skills can be added, thereby helping students to be adequately prepared for practice. Adequate preservice preparation will also help them to provide care as indicated in the National Mental Health Policy.

The qualitative findings established that puerperal psychosis is the only MMH condition taught to NMTs. This meant that other MMH conditions like anxiety, suicide, and depression, which are also equally important in providing holistic care to maternal women were not taught. Little MMH content in the nursing curriculum was also identified in other studies conducted in Uganda, Nepal, and Ethiopia (Acharya et al., 2017; Adjorlolo & Aziato, 2020; Legere et al., 2017). However, such studies were not specific enough to outline the specific competencies taught to midwives. The current study has specified that it is only puerperal psychosis, psychological support, communication, documentation, and counselling skills that are taught to the NMTs. This implies that, despite the integration of MMH services in primary care, NMTs

still face challenges in the management of MMH cases. As explained by participants, these conditions were not taught because they believed that students already acquired the competencies in their second year of training. Despite being taught mental health and psychiatric conditions, NMT students expressed dissatisfaction with their memory as it took them a year to acquire knowledge in midwifery after completing their studies in mental health conditions. (Carroll et al., 2018) indicated that midwives still need to have competencies in MMH conditions so that they can ably support maternal women. As students were taught these conditions in mental health nursing, similar conditions are supposed to be taught in midwifery because the management of maternal cases differs from general management (Higgins et al., 2018). This entails that if NMTs are to be adequately prepared for practice, adequate MMH competencies should be taught to equip students with enough knowledge so that they can screen and manage MMH problems accordingly.

Furthermore, most participants disagreed with teaching screening skills for common mental health problems in pregnant women. The probable factors might be a lack of resources (screening tools) and knowledge on teaching screening skills for MMH conditions. The findings of this study agree with the role of preservice and in-service education in improving midwives' capacity to provide MMH services, as corroborated by previous studies (Davies et al., 2016; Noonan et al., 2018; Sammut et al., 2021). The recently developed WHO PMH guidelines for training healthcare providers and integrating PMH services into primary care should facilitate the incorporation of MMH competencies into Malawi's existing pre-service nursing curricula. The WHO (2022) in the *Guide for Integration of Perinatal Mental Health and Child Health Services* recommends that non-specialized healthcare providers have basic knowledge of the management of common MMH conditions. Taking into consideration that NMTs work in remote and poor-

resourced settings, adequate preparation in MMH care would also enable them to provide safe and effective care, thereby helping in achieving SDG number 3, which emphasizes good health and well-being for all maternal women in Malawi and beyond (Daher-Nashif & Bawadi, 2020).

The qualitative findings revealed that students were taught a few MMH skills, such as interviewing and observation skills. Interviewing skills were used during history-taking, where the student was expected to ask the maternal woman about her *history of mental illness and whether the pregnancy was planned or not*.

Furthermore, the student was also *expected to observe if the client is depressed, anxious, stressed, or experiencing intimate partner violence by observing the facial expression and scars or bruises on the skin of the client*. Despite students learning about these skills, they indicated a lack of knowledge about the management of such conditions because the focus of their practice was on midwifery rather than mental health competencies. These findings are consistent with the findings of the document review of the current study and also a study done in Tanzania where nurses had insufficient knowledge to provide competent intimate partner violence care (Ambikile et al., 2020). As noted by (Nakidde et al., 2023), in Africa, antenatal assessment only focuses on the physical health of the mother because screening questions for MMH problems have not been fully incorporated into antenatal care and there are no structures in place to manage such cases. This may explain the lack of knowledge and a few competencies in the curriculum. The current study suggests that students are equipped with fewer competencies, which do not adequately prepare them for MMH management. Taking into consideration that students are taught MMH skills, they should also be taught management of such cases so that they can provide comprehensive care to women throughout pregnancy, labour, delivery, and the postpartum period.

5.3 Clinical Teaching Strategies Utilized by Nurse Educators

The preparation for student clinical practice starts with classroom teaching, where students gain knowledge, skills, and the appropriate attitudes required for the profession (Gaberson et al., 2022). The study findings revealed that in both classroom and clinical settings, nurse educators were using various teaching methods such as lectures, student-centered teaching strategies demonstration, and clinical support which included sharing and orienting students to clinical objectives.

5.3.1. Classroom-based Teaching

The qualitative findings indicated that participants utilized the lecture method when teaching MMH competencies in the classroom because it was effective in teaching a new topic such as puerperal psychosis. In the lecture method, the nurse educator is the only source of knowledge, and the student's involvement in the provision of knowledge is minimal because they rely on the teacher to provide enough information (Lateef & Mhlono, 2019). The use of the lecture method is consistent with other studies done in Africa, where it was found effective and efficient in teaching students because of limited time, large groups of students, and a lack of knowledge of other teaching strategies (Lateef & Mhlono, 2019; Mbirimtengerenji & Adejumo, 2015). However, in MMH competencies, the lecture method was supposed to be combined with other methods like video recordings, learning from patient experiences and role play to promote the development of MMH competencies (Everitt et al., 2022). Although the method is efficient, the lecture method makes students passive, bored, and frustrated, which further prevents them from being active players in their learning (Gaberson et al., 2022). Considering that each student is unique with different learning needs, the facilitation of the lecture method has been associated with a poor understanding of the course and a reduced concentration span (Lateef & Mhlono,

2019). If nurse educators use the lecture method, the possibility that students will not understand MMH care cannot be underestimated. It can therefore be concluded that the use of the lecture method alone for teaching MMH competencies has been a source of student ill-preparedness for MMH clinical practice.

The findings have also established that learner-centered teaching methods such as role-play, group discussion, and group presentations were used when teaching students MMH competencies to help them develop communication, interpersonal, problem-solving, critical thinking, and empathetic skills. These teaching methods were used in MMH competencies because students were considered to have previous knowledge that was gained from mental health psychiatric nursing in the second year of their training. The use of group discussion has been recommended in mental health nursing education because it encourages interaction and sharing of ideas and promotes critical thinking skills (Everitt et al., 2022). However, it does not promote learning if guidelines for discussion are not followed (Everitt et al., 2022; Gaberson et al., 2022). Participants from this study lamented that as much as discussion was used in their learning, debriefing and supportive supervision were not done by nurse educators, making it difficult for students to grasp the content. These findings are inconsistent with the study findings done by (Rahman et al., 2019), where group discussion improved student's competencies in MMH care. However, Rahman et al. (2019) suggested that for an effective group discussion, nurse educators should use video recordings, feedback, and supportive supervision to ensure that students understand the content and gain the required competencies.

The use of role-play as a teaching strategy for MMH care is consistent with other studies (Everitt et al., 2022; Goh et al., 2021; Smith et al., 2018). In this study, role-play was done to help students gain communication and counselling skills for interacting with, assessing, and

counselling clients on their mental health needs. Smith et al. (2018) asserted that mental health competencies are best understood by students when nurse educators combine video recordings and role-play to help students see how questions are phrased for practice. The current study has established that role-play was utilized in the absence of video recordings, which might have prevented students from developing MMH competencies and skills for practice. Considering that NMTs are primary health care providers, they need to be well prepared for practice to provide holistic care to maternal women.

The qualitative findings revealed that nurse educators were also using demonstration as a clinical teaching strategy to help students gain MMH competencies. Demonstration involves teaching students through the process of explaining step by step using a visual aid or a PowerPoint presentation (Gaberson et al., 2022). The current study findings indicate that nurse educators used demonstrations when teaching counselling and communication skills to help students understand how they can interact with and counsel patients with mental health problems. The demonstration teaching strategy is one of the most commonly used methods in the NMT training program because of its effectiveness in the retention of memory and skill development (Mbirimtengerenji & Adejumo, 2015; Phuma, 2015). Although the demonstration was found to be commonly used, this study discovered that nurse educators only demonstrated a few competencies, such as communication and counselling skills, which were not enough to build students' MMH competencies. As noted by Fox et al. (2023), apart from counselling skills, psychosocial assessment, screening, and clinical evaluation are some of the skills undergraduate students need for the identification and management of MMH problems. Similar findings were found in Nigeria, where demonstration leads to minimal student involvement in their learning, thus leading to low assimilation of the nursing practice (Lateef & Mhlongo, 2019). Thus, it was

suggested that to be effective, demonstration as a method should be combined with other teaching methods and visual aids like video recordings and role-play. It is therefore important that nurse educators should be trained on how best they can use demonstration in teaching to ensure its effectiveness. Moreover, although demonstrations were used in teaching students, this study has established that there were limited opportunities for students to do return demonstrations. In nursing, a return demonstration is used to evaluate if students have acquired the necessary MMH competencies in a less-threatening environment (Gaberson et al., 2022).

Participants explained that there were limited opportunities for student practice in the skills laboratory because MMH competencies were too general in the curriculum and missing from the classroom schedules. The findings support the observations made in another study conducted in Australia by Fox et al. (2023), where students had limited opportunities to practice PMH competencies in the clinical setting. Practising in the skills laboratory is considered best practice because it provides an opportunity for students to practice and refine skills in a less threatening environment, thereby allowing nurse educators to teach, coach, demonstrate, and evaluate student competence development (Gcawu & van Rooyen, 2022; Jamshidi et al., 2016). The findings in this study suggest that students were allocated to clinical practice with insufficiently developed skills, which might have affected their internalization of MMH competencies.

The results also showed that case studies and coaching in the NMT education program were used by nurse educators to help students develop MMH competencies. A case study was used to help students make a proper diagnosis and identify MMH conditions. These results are consistent with results from other studies done in Australia and Japan (Everitt et al., 2022; Yang & Chao, 2018). In case studies, students analyze patients' information to identify patient problems and needs, and manage the patient's problems, thereby promoting integration of the theoretical knowledge into

practice (Gaberson et al., 2022). Case studies have been reported to be effective in teaching midwives because they promote interaction, critical thinking, and problem-solving skills (Everitt et al., 2022; Knapp et al., 2018). As indicated by Everitt et al. (2022) and Oermann et al. (2022), adequate training on the utilization of clinical teaching methods is required for nurses to use case studies as teaching methods.

5.3.2. Clinical Teaching and Support

The study has established that students were provided with clinical objectives and were encouraged to develop personal objectives from the list of objectives provided. However, there was an inconsistency in how students were oriented to the clinical objectives of colleges. Participants reported that orientation was conducted during the first week of clinical allocation, while others claimed it was conducted two days before clinical practice. These inconsistencies meant that the procedure for orienting students and clinical staff on the learning objectives was not followed. Gaberson et al. (2022) stated that the orientation process for staff members and students should be done a week before students' clinical placements. Through preclinical meetings, students, nurse educators, and clinical staff design collaborative teaching and learning by clarifying roles, and responsibilities and explaining strategies to help students achieve their learning objectives. This study has established that there were limited opportunities for such meetings, which can be attributed to a lack of skills in collaborative teaching by nurse educators and clinical teachers.

In addition, the findings also showed that students were encouraged to develop their objectives from the main list of objectives given. This was done to ensure that students were organized, had control of their learning, and improved communication between the nurse educators and clinical teachers. Consistent with other studies, encouraging students to develop learning objectives was

regarded as a learning contract that motivates students in their learning process (Gcawu & van Rooyen, 2022; Wenzel et al., 2022). Although students were encouraged to develop their learning objectives, this study has discovered that nurse educators only encouraged students to develop midwifery competencies and not those related to MMH care. This made students concentrate more on midwifery competencies and not MMH care competencies.

The lack of emphasis on MMH care competencies might be attributed to the preconceived thoughts by the nurse educators that students had gained competencies in Mental Health Psychiatric Nursing; as such, MMH competencies were considered a duplication of courses. To prepare students with competencies and confidence in MMH care, there is a need to ensure that the learning experience is strategically designed, and all personnel involved in teaching students should be aware of specific MMH competencies, resources to be used for students to achieve the competencies, and also the criteria for evaluating them (Robinson & Persky, 2020).

5.4 Challenges in MMH Clinical Teaching

The findings show that there are many challenges faced by nurse educators when teaching students MMH competencies, which include neglected MMH competencies, inadequate resources, and difficulty translating theory into practice.

5.4.1 Neglected MMH Competencies

The majority of participants in the study indicated that MMH care has been neglected. This is because students were taught a few competencies, clinical objectives were too general, and their competencies were not evaluated to validate whether they were attained or not. This made participants perceive MMH competencies as less important in the NMT training. These findings are similar to those of other studies done in Nepal, Uganda, and South Africa (Ambikile et al.,

2020; Brown & Sprague, 2021; Carroll et al., 2018; Simkhada, 2021). The lack of emphasis in MMH clinical teaching affects students' achievement of competencies. Being the frontline healthcare providers in Malawi, NMTs needed to be adequately prepared for service so that they could improve MMH services. Furthermore, the findings also indicate that hospital staff are not prioritizing MMH services, and as such, it was difficult for students to learn and acquire the skills.

As noted by Chorwe-Sungani & Chipps (2018), in most African countries, the focus of care is on physical care at the expense of MMH care. Thus, Gcawu et al. (2021) asserted the need for nurse educators to tailor their teaching to the needs of students and those of the public. This entails that during preparation for clinical practice, nurse educators were supposed to identify clinical sites that were providing MMH services to provide an opportunity for students' practice. Even though hospitals cannot provide such opportunities, it is the responsibility of nurse educators to arrange such learning opportunities in the skills laboratory to help students achieve MMH competencies (Fox et al., 2023).

Inadequate Resources

The findings expose the lack of adequate resources for MMH care. These include a limited number of skilled nurse educators against large numbers of students, a lack of MMH screening stools, and guidelines to support student teaching and learning both in class and in the clinical area. The lack of guidelines in MMH entails that there are no standards for teaching MMH. This might explain the reasons why participants in this study lamented that *“each nurse educator teaches what he or she knows concerning MMH competencies.”* These inconsistencies in teaching might affect how students are supervised and evaluated in the clinical area. The findings are similar to those of other studies (Adjorlolo & Aziato, 2020; Bayrampour et al., 2018; Brown

& Sprague, 2021), which reported a lack of resources to support students teaching. The current study has exposed that there are few skilled mental educators in the colleges, which has increased workload, task shifting, and poor student supervision in the clinical area. It can therefore be concluded that, apart from increasing human resources, having MMH screening tools and guidelines would help standardize MMH clinical teaching practices and help students gain MMH competencies.

5.4.2 Difficulty Translating MMH Knowledge into Practice

The study found that implementing MMH theoretical knowledge in practice is challenging due to a lack of knowledge, stigma, and discrimination and that MMH is not part of routine care. The findings showed that despite students learning MMH competencies and being allocated to clinical practice, they never had a chance to practice mental health competencies in midwifery because MMH services are not part of routine care. This made educators also concentrate more on midwifery at the expense of MMH competencies. Furthermore, there are no structures in place to support maternal women experiencing MMH because once those women are identified, they receive general management.

The findings also showed that the time allocated for student clinical practice was only 4 weeks, which participants felt was not enough for students to build MMH competencies. These findings are in support of other previous studies done in Ethiopia, South Africa, and Uganda, which identified a lack of knowledge of PMH competencies in preservice education and inadequate time for practice (Adjorlolo & Aziato, 2020; Legere et al., 2017; McCauley et al., 2019). Adequate student theoretical preparation and a longer period of practice would help students to have positive attitudes toward the attainment of MMH competencies. Thus, (Hussein et al., 2023) recommend allocating NMT students to areas of practice for a period longer than 6 weeks.

As noted by (Muraraneza et al., 2017), for students to adequately acquire competencies, whatever has been learned in the classroom should be integrated into practice so that the gap between theory and practice can be minimized. Considering that the scope of practice of NMTs goes beyond the provision of general patient care, qualified NMTs need to be well prepared for practice so that they have adequate skills to enable them to respond adequately to the needs of the public.

5.5 Experiences of Students in the Attainment of MMH Competencies

Previous studies on students' attainment of MMH competencies found both positive and negative experiences with the attainment of MMH competencies (Alghamdi & Jarrett, 2016; Günaydin & Arguvanli Çoban, 2021; McGookin et al., 2017). In this study, students reported that they experienced negative attitudes toward the attainment of MMH competencies because they were allocated to clinical areas that did not offer MMH services, and there was a discrepancy between theoretical knowledge and clinical practice. They also reported that they experienced fear because some maternal women with MMH were aggressive. These findings correspond with previous studies done in Malawi that found that students lack confidence in managing clients with mental health problems because of fear and poor allocation (Bvumbwe, 2016). As noted by Günaydin and Arguvanli Çoban (2021), students' negative attitudes may arise even before being allocated to a mental health unit and such feelings may prevent them from acquiring mental health competencies or even choosing mental health as a career in the future. Thus, Wenzel et al. (2022) recommend that nurse educators be competent so that they can help students attain desired competencies and relieve any negative emotions that might prevent them from achieving MMH competencies. Students also reported that they found it difficult to attain MMH competencies because there were some inconsistencies in teaching by nurse educators between

theory and practice, with students missing MMH competencies in the clinical objectives, NMCM logbooks, and limited time for practice. Similar findings were reported in other studies in Ethiopia and Australia (Adjorlolo & Aziato, 2020; Legere et al., 2017). Thus, it is important to ensure that nurse educators teach students all competencies in line with the skills that are required after preservice education. Furthermore, findings from the current study indicate that hospital staff and nurse educators were not supporting them in achieving competencies because they had inadequate knowledge.

The findings are similar to those made in other studies where a lack of knowledge was discovered to have increased negative attitudes of both students and nurse educators towards mental health clinical practice (Günay & Kılınç, 2018; Günaydin & Arguvanli Çoban, 2021; Kyerepagr Kobekyaa et al., 2019). The current study suggests the need for students to be well prepared for practice so that they can have enough knowledge and skills in MMH care. On the other hand, students expressed the need to learn MMH competencies to improve their knowledge of managing maternal women.

5.6 Contributions of the Study

The study has added evidence-based knowledge on MMH in nursing education. This study has revealed that students learn a few MMH competencies, and there are inadequate resources to support students' teaching and learning during preservice education. This knowledge is important to all stakeholders involved in nursing education to consider incorporating more MMH competencies into the nursing curriculum and mobilizing resources so that NMTs are well prepared for comprehensive management of maternal women. The study has also revealed that there are few teaching strategies used by nurse educators when preparing students for mental health practice. This evidence-based knowledge will help colleges, CHAM, and NMCM

reinforce ongoing CPD sessions on clinical teaching methods to improve nurse educators' competence in supporting and supervising students in the clinical area. Furthermore, the study discovered that nurse educators with teaching experience of 6 to 10 years were using more teaching methods than those over 10 years. This information can be used by the management of nursing colleges to consider this new knowledge when recruiting nurse educators who can be confident in supporting students in mental health clinical education.

5.7 Recommendations

The study has revealed several issues that need to be addressed by all major stakeholders in the nursing and midwifery education sectors. The recommendations have been grouped into policy, education, practice, and research as follows:

5.7.1 Policy

The study findings have implications for local policies in the Ministry of Health and nursing education. Considering the increased burden of mental health problems in Malawi of 22%, there is a need for a policy in the country on routine screening of mental health conditions for all maternal women. This study is advocating for the Ministry of Health to develop a MMH policy which if implemented, will help in prioritization of MMH care in Malawi and allow adequate resources to be allocated to support MMH care services. The availability of the policy will encourage healthcare providers to screen and identify common mental health-related problems in pregnant women for early management. It will also provide a learning environment for students to practice MMH competencies. The policy should be shared with all healthcare settings and nursing colleges for easy implementation. It is also important that NMCM, in conjunction with college management, develop policies and clinical teaching strategies to be used in mental health practice. This will help to provide guidance and standardize the teaching practices of all nurse

educators in mental health practice, which will improve the competence of students in the country.

5.7.2 Nursing Education

This study has identified that student NMTs learn a few MMH competencies which is not adequate for them to support maternal women with mental health problems. Therefore, this study demonstrated the training needs for student midwives and nurse educators in MMH and innovative clinical teaching strategies.

Perhaps more importantly, the inclusion of MMH competencies in the curriculum and the involvement of nurse educators in supporting students to achieve MMH would strengthen MMH care provided to clients' competencies. It was believed this is more effective in the response to mental health issues during the perinatal period. The study is therefore recommending that the NMCM, as a regulator of nursing education, should, in conjunction with nursing colleges, review the NMT curriculum so that they can add a module on common mental health disorders that occur during pregnancy and up to one year after delivery into the medical, nursing and midwifery curriculum. This will help nurse educators teach and help students acquire more MMH competencies in preparation for practice. More importantly, it is to include MMH skills such as communication, counselling, screening, and psychological support. The first step to the inclusion of MMH should be the one suggested by one of the participants (*Section 4.6.1.6*), to merge midwifery and mental health psychiatric courses so that these courses can be taught concurrently. The study revealed that students tend to forget mental health competencies after learning about Mental Health Psychiatric Nursing courses.

This study therefore recommends that nursing colleges should merge Mental Health Psychiatric Nursing and midwifery courses so that students can integrate both competencies during practice. Considering that all competencies are important in practice, NMCM and nursing colleges should add MMH competencies in antenatal, labour and delivery, and postnatal in students' log books and assessment forms. This will help to evaluate and monitor students' competence achievements in MMH practice. Nursing colleges should also specify in the student's clinical objectives for MMH competencies to be practised in skills laboratories and those to be documented in the student's competence achievement clinical log books. This will act as a guide for both educators and students to help them achieve the competencies.

Furthermore, this study revealed that nurse educators have inadequate knowledge of MMH competencies and their teaching strategies. This study recommends that NMCM, CHAM, and colleges reinforce CPD sessions for all nurse educators on MMH competencies and clinical teaching to improve their competencies so that they can support students accordingly. The study is recommending that the NMCM as a regulator of nursing and midwifery services should prioritize MMH competencies as necessary for a renewal of NMCM licenses for nurses and midwives. This will promote competence acquisition in midwives.

The study found a shortage of nurse educators in mental health education. This study recommends that CHAM review the college's staff establishment so that more skilled personnel can be employed to support students' teaching and clinical practice. The MOH and CHAM should also offer scholarships to training institutions so that more mental health nurses can be trained.

5.7.3 Research

According to the outcome of this study, to improve NMT competencies in MMH care practice and education, this study recommends nursing colleges prioritize the implementation of research in MMH care so that evidence-based information and interventions on MMH education can be identified. Through the implementation of research, it will increase advocacy of resources to promote the provision of MMH services its research activities and MMH competencies to be achieved by students will be known to the public and other key stakeholders. This study also identified the need for further studies in the following areas:

1. The effectiveness of clinical teaching methods used in mental health in supporting student competence development. This is because the method used may differ depending on the college, student, and nurse educator's characteristics.
2. The impact of psychological support provided by students in relieving common mental health problems during the perinatal period. This will help to strengthen the topic and its competence in counseling.
3. A study should be done involving all nurse educators on the clinical teaching strategies in MMH in public nursing colleges. This will help to have a wider knowledge of how students are prepared in public nursing universities.
4. A study is to be done to assess factors influencing students' negative emotions in MMH practice and education in all nursing colleges. This will help to identify MMH teaching strategies suitable for a specific gender of students and their negative emotions.

5.7.4 Clinical Practice

The findings from this study recommend that there is a need for nursing colleges to properly allocate skilled mental health psychiatric nurses in MMH practice, so they should support, teach, and supervise students in mental health practice. Nursing colleges also need to promote a collaborative partnership between nurse educators and students in the clinical supervision of students. This will help maintain uniformity and standardize the clinical teaching practice of all those involved in supporting students in achieving MMH competencies. Nurse educators and hospital staff can use the findings from this study to strengthen their teaching approach to clinical teaching in mental health and address the challenges that they face when teaching students. Collectively, this will have an impact on the provision of high-quality care to pregnant women with mental health problems. Furthermore, hospitals should mobilize more resources, like MMH standards, protocols, and screening tools, for MMH practice and student teaching.

5.8 Conclusion

In Malawi, MMH problems are very common, and there is some evidence that they have a major negative influence on the outcomes of mothers, newborns, and children as well as long-term growth and cognitive developmental consequences. Strong clinical teaching practices of nurse educators that promote the integration of theoretical knowledge into practice would help students achieve MMH competencies and improve quality maternal and neonatal outcomes in Malawi.

The study was carried out to assess clinical teaching practices in MMH in selected nursing colleges under the Christian Health Association of Malawi. Four specific objectives were formulated, namely; to describe the MMH clinical competencies that nurse educators implement during student practice in CHAM nursing colleges; to assess clinical teaching strategies utilized by nurse educators on clinical competencies in MMH care; to describe challenges faced by nurse

educators when teaching students MMH competencies; and to explore student midwives' experiences in the attainment of MMH competencies in clinical practice.

This study has established that NMTs learn a few competencies in MMH care, such as puerperal psychosis, collaboration, referral, and documentation of care, among others. This study has identified gaps in the nursing and midwifery curriculum, indicating that the training colleges are not adequately preparing students for MMH. The lack of competence entails that maternal mothers do not holistically receive adequate care during the perinatal period. Perhaps more importantly, the inclusion of other MMH competencies in the curriculum and the training of nurse educators on how to teach the competencies would improve the care provided to all maternal women within the first year before and after delivery. It was believed that this would be effective in reducing maternal mortality rates which the country is experiencing.

The study further established that nurse educators utilize a few teaching strategies when supporting students in MMH care, which include orientation and sharing clinical objectives, encouraging students to develop individual objectives, demonstration, case studies, role play, and lecture methods. It was interesting to see that nurse educators utilize these clinical teaching practices as recommended in mental health clinical teaching. However, it will be effective if nurse educators include objectives for MMH competencies as indicated by some participants in the study.

In Malawi, efforts have been made to reduce maternal and neonatal mortality rates to the expected level as described by the WHO (WHO, 2022b). However, the study has demonstrated that MMH education is a neglected area even though students and nurse educators were eager to learn. Therefore, this study has shown that if nurse educators have the necessary resources for

teaching MMH competencies, students can be equipped adequately to manage MMH conditions which will then reduce the morbidity rate. Furthermore, the study identified areas for further investigation, including having MMH policy and guidelines that will support student learning both in the classroom and on clinical sites. Finally, the study recommends that mental health psychiatric nurses be allocated to the maternal and child health departments so that they can support students' learning, and be able to provide care to all maternal mothers who may need mental health services.

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APPENDICES

Appendix 1: Informed Consent Form



Introduction: I am *Chrissie Rashid Hussein* a Master of Science in Nursing Education in Clinical Teaching student from Mzuzu University. We are researching teaching practices in maternal mental health in the Christian Health Association in selected nursing colleges in Malawi. This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take the time to explain. If you have questions later, you can ask me about this research.

Purpose of the Research: This research aims to assess clinical teaching practices in maternal mental health in the Christian Health Association in selected colleges in Malawi.

Type of Research Intervention: This research will involve your participation in answering a questionnaire and/or individual interview. Additionally, there will be a document review of the NMT curriculum, syllabi, clinical log books, and course outlines.

Participant Selection: You are invited to take part in this research because you are a clinical teacher and a student of the selected CHAM nursing colleges in Malawi.

Voluntary Participation: Your participation in this research is entirely voluntary. It is your choice whether to participate or not. If you choose not to participate nothing will change. You may skip any question and move on to the next question.

Duration: The research will take place for a period of four months from December 2022 to April 2024.

Risks: You do not have to answer any question or take part in the discussion/interview/survey if you feel the question(s) are too personal or if talking about them makes you uncomfortable.)

Reimbursements: You will not be provided with any incentive to take part in the research.

Sharing the Results: The knowledge that we get from this research will be shared with you and your community before it is made widely available to the public. Following this, we will publish the results so other interested people may learn from the research.

Who to Contact: If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact: Ms Chrissie Rashid Hussein. +256884671884/ +265994558359

This proposal has been reviewed and approved by the Mzuzu University Research Ethics Committee (MZUNIREC) which is a committee whose task it is to make sure that research participants are protected from harm. If you wish to find out more about the Committee, contact Mr Gift Mbwele, Mzuzu University Research Ethics (MZUNIREC) Administrator, Mzuzu University, P/Bag 201, Luwingu, Mzuzu 2, Phone: 0999404008/0888641486

Do you have any questions?

Part II: Certificate of Consent: I have been invited to participate in research about Clinical teaching practices in maternal mental health in the Christian Health Association of Malawi selected nursing colleges, Malawi. I have read the foregoing information, or it has been read to

me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

Name of Participant _____ Signature of participant _____

Date _____ Day/month/year _____

If illiterate ¹

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.



Print name of witness _____

Thumbprint of participant

Signature of witness _____ Date _____

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands the research project. I confirm the participant was allowed to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Signature of the Researcher /person taking the consent

Date _____ Day/month/year _____

¹ A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.

Appendix 2: Ethical Approval Certificate



MZUZU UNIVERSITY

DIRECTORATE OF RESEARCH

Mzuzu University
Private Bag 201
Luwinga
Mzuzu 2
MALAWI
TEL: 01 320 722
FAX: 01 320 648

MZUZU UNIVERSITY RESEARCH ETHICS COMMITTEE (MZUNIREC)

Ref No: MZUNIREC/DOR/22/96

24/11/2022.

Chrissie Hussein,
Mzuzu University,
P/Bag 201,
Luwinga,
Mzuzu 2.

chrissiehusein@yahoo.com

Dear Ms. Hussein,
**RESEARCH ETHICS AND REGULATORY APPROVAL AND PERMIT FOR
PROTOCOL REF NO: MZUNIREC/DOR/22/96: CLINICAL TEACHING PRACTICES IN
MATERNAL MENTAL HEALTH IN CHRISTIAN HEALTH ASSOCIATION OF MALAWI SELECTED
NURSING COLLEGES IN MALAWI**

Having satisfied all the relevant ethical and regulatory requirements, I am pleased to inform you that the above referred research protocol has officially been approved. You are now permitted to proceed with its implementation. Should there be any amendments to the approved protocol in the course of implementing it, you shall be required to seek approval of such amendments before implementation of the same.

This approval is valid for one year from the date of issuance of this approval. If the study goes beyond one year, an annual approval for continuation shall be required to be sought from the Mzuzu University Research Ethics Committee (MZUNIREC) in a format that is available at the Secretariat. Once the study is finalised, you are required to furnish the Committee with a final report of the study. The Committee reserves the right to carry out compliance inspection of this approved protocol at any time as may be deemed by it. As such, you are expected to properly maintain all study documents including consent forms.

Wishing you a successful implementation of your study.

Committee Address:

Secretariat, Mzuzu University Research Ethics Committee, P/Bag 201, Luwinga, Mzuzu 2; E-mail address: mzunirec@mzuni.ac.mw

Yours Sincerely,



Gift Mbwele

SENIOR RESEARCH ETHICS ADMINISTRATOR

For: CHAIRMAN OF MZUNIREC



Committee Address:

Secretariat, Mzuzu University Research Ethics Committee, P/Bag 201, Luwinda, Mzuzu 2; E-mail address: mzunirec@mzuni.ac.mw

Appendix 3: approval Letters from Study Sites

	ST. LUKE'S COLLEGE OF NURSING & MIDWIFERY, P.O. BOX 21, CHILEMA TEL: +265882900320, +265982049187 E-mail admin@stlukesnursingcollege.mw	
7th December 2022		
Mzuzu University Faculty of Health sciences Private Bag, 201 Luwinga.		
Dear Chrissie Hussien		
<u>Re: Permission to Conduct Academic Research on 'Clinical Teaching Practices in Maternal Mental Health in CHAM-selected nursing Colleges in Malawi</u>		
Thank you for your application for permission to conduct the above research at our institution. I am glad to inform you that permission has been granted.		
Please remember to share the results with us if possible		
 Maxwell Pangani Principal	THE COLLEGE PRINCIPAL ST. LUKE'S COLLEGE OF NURSING AND MIDWIFERY 2022-12-07 P.O. BOX 21, CHILEMA	

CHURCH OF CENTRAL AFRICA PRESBYTERIAN



SYNOD OF LIVINGSTONIA
Ekwendeni College of Health Sciences
P.O Box 49, Ekwendeni, Malawi
Tel/Fax: +265(0) 1339 339
Email: principalecoh@unilia.ac.mw



9th January 2023

TO : Ms Chrissie Hussein,
Mzuzu University,
Private Bag 201,
Luwinga.

Dear Ms Hussein,

**RE: PERMISSION TO CONDUCT A RESEARCH STUDY AT EKWENDENI
COLLEGE OF HEALTH SCIENCES.**

New Year's greetings from Ekwendeni College of Health Sciences in the name of our Lord Jesus Christ.

Reference is made to your letter dated 1st December 2022 in which you requested permission to use Ekwendeni College of Health Sciences as a site for your study on '*Clinical Teaching Practices in Maternal Mental Health in CHAM-selected nursing Colleges in Malawi*'. I am pleased to inform you that permission has been granted and you can visit the college at your convenient time for implementation of the study.

Wishing you all the best as you carry out your research activity.

Yours faithfully,

Esau. A. Kasonda

COLLEGE PRINCIPAL

Appendix 4: Permission to use the Questionnaire

Dear Dr Phuma and Prof. Brain Van Wyk,

I am Chrissie Hussein writing from Mzuzu- Malawi. I am currently pursuing a MScNECT degree with the Mzuzu University of Malawi. As a requirement for the said degree, I have to conduct a study towards the attainment of the same. I have come across your thesis titled ' Development of Neonatal Nursing Care Clinical Competency-based Assessment Tool for Nurse-Midwives Technicians'. In this study, you used a document analysis checklist and a clinical teachers' questionnaire. I am in the process of developing a research study entitled Assessing Clinical Teaching Practices in Maternal Mental Health in CHAM Nursing Colleges. I feel I can use the document analysis checklist and the teacher's questionnaire based on the study variables I am focusing on. For the questionnaire, I am more interested in competencies taught to NMT because it is in line with one of the study objectives. I am requesting permission to utilize the document analysis checklist and clinical teacher's questionnaire or adapt them to my study. If possible, I am further requesting that you send me a copy of the tools so that I can critically have a look at them. Waiting to hear from you soon.

Thank you.

Chrissie Hussein

On Thursday, July 28, 2022, at 01:43:49 PM GMT+2, Ellemes Phuma
<phumaellemes@gmail.com> wrote:

This is noted. You can go ahead to use the tool only for the intended purpose. You will need to indicate where modifications will be applicable if you are using the tool in its entirety. Hoping to see your work once done.

Kind regards

Ellemes Phuma-Ngaiyaye, Ph.D, RN, RM

Senior Lecturer, Department of Nursing & Midwifery,

Mzuzu University, P/Bag 201, Luwingu, Mzuzu 2. MALAWI. email: phumaellemes@gmail.com

Appendix 5: Document Review Checklist

Name of the College: Date:

<u>Type of document</u>	<u>Competencies</u>			<u>Teaching</u>	<u>Assessment</u>
				<u>method</u>	<u>approach</u>
	<u>Knowledge</u>	<u>Skill</u>	<u>Attitude</u>		
NMT syllabus					
NMT Curriculum					
Course outline					
NMCM assessment tools					
College Log books					
NMCM Green books					

Appendix 6: Questionnaire for Nurse Educators

Please tick the correct answer in the corresponding box

Participant Code..... College..... Date.....

Section A: Demographic Data

Gender: Male ☐ Female ☐

Professional qualifications: PhD ☐ MSc ☐ BSc. ☐ Diploma ☐

Age: 20 – 30 ☐ 31-40 ☐ 41- 50 ☐ over 50 ☐

Professional specialization: CMHPN ☐ MHPN ☐ AHN ☐ Midwifery ☐ CHN ☐

Nursing education ☐ Nursing & mid ☐ others.....

Years of experience in clinical teaching: 1- 5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐

> 20yrs ☐

Formally trained in clinical teaching: Yes ☐ No ☐

Section B; Competencies, teaching strategies and challenges faced when teaching MMH

Tick in the appropriate box: 1= strongly disagree; 2= Disagree; 3= Uncertain; 4 = agree; 5= strongly agree.

Competencies taught to students in maternal mental health	1	2	3	4	5
	SD	D	UN	A	SA
Students were taught the following competencies:					
1. Management of common mental health problems					
2. Screening skills of maternal women suffering from common mental health problems.					
3. Psychological support to maternal mothers with mental health problems					

4. Counselling skills in the management of maternal mothers with mental health-related problems.					
5. Communication skills in the management of maternal women with mental health problems					
6. Application of ethical decision-making when managing maternal mothers with mental health problems.					
7. Application of critical thinking in the management of maternal mothers with mental health problems					
8. Referring maternal mothers with mental health problems for specialized care					
9. Collaboration with other healthcare providers in the management of maternal mothers with mental health problems					
10. Documentation of patient care in the case files					
Clinical teaching strategies utilized in maternal mental health care	1	2	3	4	5
	SD	D	UN	A	SA
11. Learning objectives were shared with students before clinical practice					
12. The student was oriented to clinical objectives before placement					
13. The student was encouraged to develop daily objectives from the course objectives.					
14. I demonstrated the following maternal mental health conditions to the student before clinical practice:					
15. Anxiety screening skills					
16. Depression screening skills					
17. Counselling skills					
18. Communication skills					
19. The student was given a chance to do a return demonstration					
20. I encouraged skill discussion after demonstrating a skill.					
21. The student was given a patient to take care of as a case study					
22. The student was encouraged to make a case study presentation on mental health problems in midwifery.					
23. I encourage skills practice of maternal mental health-related conditions in the skills laboratory.					
24. Students were encouraged to learn from patient experiences on mental health problems in midwifery					

25. I coached the student when he was not sure					
26. I provide timely feedback immediately after a skill has been done					
27. I Encourage students to submit portfolios after clinical practice					
Challenges in classroom teaching on maternal mental health practice	1	2	3	4	5
	SD	D	UN	A	SA
28. Inadequate knowledge of teaching student's maternal mental health-related conditions.					
29. Lack of knowledge of student-centeredness teaching methodologies					
30. Little content in the nursing curriculum on maternal mental health care					
31. Lack of screening tools to demonstrate to students on detection of maternal mental health-related problems in women.					
32. Shortage of nurse educators to teach maternal mental health-related topics					
Challenges in clinical teaching on maternal mental health practice					
33. Inadequate skills in the curriculum for students to practice maternal mental health competencies in the skills laboratory.					
34. Less time allocated for clinical supervision to support students.					
35. Large numbers of students in the clinical area					
36. I don't like teaching student's maternal mental health topics.					
37. Lack of assessment tools to evaluate student competencies.					
38. Lack of maternal mental health guidelines and standards for teaching students.					
39. Inadequate clinical sites for student placements					
40. Lack of knowledge in teaching student's maternal mental health care in the clinical setting					

Appendix 7: Questionnaire for Students

Please tick the collect answer in the corresponding box

Participant Code..... College..... Date.....

Section A: Demographic Data

Gender: Male ☐ Female ☐

Age in years: less than 20 ☐ 20-30 ☐ 31-40 ☐ 41-50 ☐ Over 50 ☐

Section B; Competencies, teaching strategies and challenges faced when teaching MMH

Tick in the appropriate box. 1= strongly disagree; 2= Disagree; 3= Uncertain; 4 = agree; 5= strongly agree.

As a student, I was taught the following competencies in maternal mental health care:	1 SD	2 D	3 UN	4 A	5 SA
1.Management of maternal women with common mental health problems.					
2.Screening of maternal women with common mental health problems.					
3.Psychological support to maternal mothers with mental health problems					
4.Counselling skills in the management of maternal mothers with mental health problems.					
5.Communication skills in the management of maternal women with mental health problems					
6.Application of ethical decision-making when managing maternal					

mothers with mental health problems.					
7.Application of critical thinking in the management of maternal mothers with mental health problems					
8.Referring maternal mothers with mental health problems for specialized care					
9.Collaboration with other healthcare providers in the management of maternal mothers with mental health problems					
10. Documentation of patient care in the case files					
Clinical teaching strategies utilized in maternal mental health practice	1 SD	2 D	3 UN	4 A	5 SA
11. Learning objectives were shared before ore clinical practice					
12. Orientation was done to me on the clinical objectives					
13. Encouraged me to develop daily objectives from the course objectives.					
14. The teacher demonstrated the following skills for the following conditions before clinical practice:					
15. Screening skills for maternal Anxiety					
16. Screening skills for maternal depression					
17. Counselling skills					
18. Communication skills					
19. I was given a chance to do a return demonstration					
20. I was encouraged to discuss skills and practice demonstrated skills.					
21. I was given a patient to take care of as a case study					
22. I was encouraged to make a case study presentation.					
23. I was encouraged skill practice in the skills laboratory.					
24. I was encouraged to learn from patient experiences					
25. I was coached by the teacher when not sure					
26. I was given timely feedback immediately after a skill was done					

by the teacher					
27. I submitted a portfolio after clinical placement					
Challenges in Classroom learning for maternal mental health care	1 SD	2 D	3 U	4 A	5 SA
28. I did not understand maternal mental health topics					
29. There was little content in the nursing curriculum on maternal mental health conditions					
30. The teaching methods used did not help me to understand maternal mental health care					
31. Lack of maternal mental health screening tools to use during clinical practice.					
32. Shortage of clinical teachers to teach maternal mental health-related topics					
33. Inadequate skills in the curriculum for students to practice maternal mental health competencies in the skills laboratory.					
Challenges in the clinical area of maternal mental health practice	1 SD	2 D	3 UN	4 A	5 SA
34. The time allocated for clinical student supervision was not adequate to support us					
35. Large numbers of students in the clinical area affected me to achieve maternal mental health competencies					
36. I don't like learning maternal mental health care					
37. Lack of assessment tools to evaluate my performance on maternal mental health competencies					
38. Lack of maternal mental health guidelines and standards for student teaching and learning					
39. Inadequate clinical sites for student placements affected me to achieve maternal mental health competencies					
40. Lack of knowledge on maternal mental health care					

Appendix 8: Interview Guide for Key Informants

Participant Code..... College..... Date.....

Gender: Male ☐ Female ☐

Professional qualifications: PhD ☐ MSc ☐ Bsc. ☐ Diploma

Age in years: 20 – 30 ☐ 31-40 ☐ 41- 50 ☐ over 50 ☐

Occupation: Nurse educator ☐ Preceptor ☐

Starting time of the interview: _____ Finishing time: _____

INTERVIEW QUESTIONS

1. Which maternal mental health competencies are covered in the NMT curriculum?
2. Which clinical teaching methods do you use when teaching students MMH competencies in the classroom?
3. Why did you use such teaching methods?
4. Do take third-year students to the skills laboratory to practice MMH?
5. If yes, what clinical teaching methods do you use to help students develop MMH competencies?
6. If no, why?
7. In clinical practice, what clinical teaching methods do you use to support students in developing MMH competencies
8. Why do you use those methods?
9. How effective were the methods that you used?
10. How do you teach students maternal mental health topics to promote their understanding of maternal mental health care?
11. Could you explain your experience in teaching students MMH competencies?
12. How do you support students in the clinical area for them to attain MMH competencies?
13. What challenges do you face when teaching students MMH competencies in the classroom and clinical setting?

Appendix 9: Interview Guide for Focus Group Discussion

Name of the college _____ Date _____

Number of participants: _____ Females: _____ Males: _____

Name of the facilitator: _____

Starting time for interview: _____ Finishing time for Interview _____

Date of the interview: _____

Interview Questions

1. Which topics did you cover on maternal mental health?
2. Could you explain clearly your experiences in learning MMH competencies in the classroom?
3. Describe the teaching methods that were used by the nurse educator to help you attain MMH competencies.
4. Which teaching methods were effective in building MMH competencies
5. Could you share your experiences in learning maternal mental health in the skills laboratory?
6. Describe the support you received from nurse educators in the clinical setting for you to achieve maternal mental health competencies.
7. What challenges did you face when learning MMH in the classroom?
8. What challenges are faced by nurse educators when teaching MM competencies
9. What challenges did you face when learning MMH competencies in the clinical setting?
10. What is your experience in the attainment of MMH competencies in the clinical area in terms of knowledge, skills, and attitudes?

Appendix 10: Sample of Codes, Categories and Themes

Code	Subtheme	Theme	Quotes
Puerperal psychosis (maternal depression, schizoaffective, mania), Psychological well-being, Legal issues in maternal mental health, Anxiety, Collaboration, It's just puerperal psychosis	Topics taught in maternal mental health care	Management of women suffering from maternal mental health	We do teach the students so that they should be able to handle a student with mental health issues) (Participant # 1- M-17-12) there is only about maybe puerperal psychosis which has been taught, also known as maternal depression (participant # 2- F-1-12) I always tell my students that anxiety is a priority when we are to identify three priorities anxiety should be number 3 (participant # 4-F- 19-12). According to the curriculum for NMTs, there is anxiety and there is depression which comes in as postpartum depression and postpartum psychosis. We also teach legal issues that we are supposed to follow when we are managing or assessing people with mental health problems (participant #7-M-25-1). We have other topics like the psychology of the first stage of labour, second stage labour, and psychology of puerperium (participant #-3-M-1-12). In class we learnt about postpartum depression, we also learnt about mania, and lastly we learnt about schizoaffective. (Student# 2). All those topics were combined into one topic which is puerperal psychosis (Student # 4). They are also encouraged to consult but if not sure to the clinical staff that they are going to meet there (participant #2)

			I have never taught depression in pregnancy but depression in general. We were taught how to assess a woman when we are examining a pregnant mother during antenatal, labour and after postnatal. We were taught how to ask questions during history taking to identify some problems, maybe also if the woman is facing some anxiety. During objective data, we assess head to toe, you assess the general condition to which if the woman is having problems and also assess if there are signs of violence, she might be having some bruises or else (student #9-M) Students are taught in terms of knowledge on puerperal psychosis as well as what areas to know that this client has symptoms of puerperal after delivery.
Communicational skills Counselling skills Recognition of maternal mental health patient	Skills taught in maternal mental health	Assessment of women suffering from maternal mental health (related skills)	We teach how the student can interact with a person with mental health issues, and also how the student can recognize a client or a patient who is having mental health issues. (Participant # 1- M-17-12) On skills we have counselling skills so we teach our students how to counsel patients that have or clients that have anxiety, problems depression. You know every condition that the client will come up with has their specific causes so we teach our students to target those specific causes so we counsel them (participant #7).
Lecturing	Teacher-centred teaching strategy	Classroom-based learning and teaching	Basically, for anxiety which I think is united from the year of general nursing 1 practice, so in 3rd year I usually involve the students with learner-centred teaching methods actively involving. The students to develop nursing diagnoses and interventions to address anxiety. But for

			puerperal psychosis, I taught using the lecture method because it is a new topic to the students (participant # 4- F-19/12)
Group assignments Roleplaying Video Discussion/group discussion Brainstorming Problem-based learning Question and answer	Student-centered teaching strategies		In learner-centred teaching, I am usually involved in group discussion, and class discussion brainstorming at some time we also role-play, a mother walking into the labour ward and nurses shouting at them. On anxiety issues, I also role-play problem-based learning just to give them a scenario and then let the students find information students (participant # 4- F-19/12) We feel lecturing, discussion, question and answer are important because as I have already said this group the NMT program, also did mental health psychiatric nursing on the general nursing part of it, so we feel these students still have some knowledge and they can apply. Not only that, their clinical practice for midwifery science part 1, which we also take as normal midwifery, exposes the students to what they might have encountered so there is sharing of experiences we feel asking questions is good, allowing students to discuss is good, giving views of what they had experienced before is good so it cannot be lecturing throughout students (participant # 10- F-25/1).

Appendix 11: Published Paper

Received: 8 January 2023 | Revised: 15 August 2023 | Accepted: 18 September 2023
DOI: 10.1111/jpm.12992

REVIEW ARTICLE



Clinical teaching practices in maternal mental health care: An integrated review

Chrissie Rashidi Hussein | Masumbuko Baluwa | Thokozani Bvumbwe

Department of Nursing and Midwifery,
Mzuzu University, Mzuzu, Malawi

Correspondence

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Accessible Summary

What is known about the topic?

- Mental health-related problems in pregnancy are now becoming a global health concern. However, most studies have reported that midwives are unable to assess and support maternal mothers due to poor preservice education. The findings of these studies needed to be explored further from the available literature to address the gap.

What does the paper add to existing knowledge?

- The paper has identified maternal mental health core competencies and innovative clinical teaching strategies that nurse educators can utilize when supporting students theoretically and during clinical practice so that students should be adequately prepared for maternal mental health practice.
- Challenges and recommendations for clinical teaching were also identified. However, there are still gaps in the literature related to the effectiveness of teaching strategies to promote competence acquisition in maternal mental health.

What are the implications for education?

- The study results can be used by nurse educators to develop effective clinical teaching practices in maternal mental health care. The findings can be used in the development of best clinical teaching guidelines for maternal or perinatal mental health to be used by nurse educators for the undergraduate midwifery training programmes.

Abstract

Introduction: Maternal mental health problems are commonly experienced by women; however, they are usually not adequately recognized and treated by midwives in Malawi. Evidence suggests poor preservice education by nursing colleges which affects the development of essential maternal mental health competencies.

Aim: The aim of the study was to review existing evidence on clinical teaching practices by nurse educators in teaching student midwives maternal mental health care.

Method: Integrative review method was used, and various databases were searched. Out of 1768 articles, 27 research articles met the inclusion criteria. The critical appraisal skills programme checklist tools were used to assess data quality. Thematic analysis was done by comparing, grouping and integrating data.

Results: Six themes emerged, namely: core maternal mental health competencies, professional regulation, interactive teaching strategies, collaborative partnerships, capacity building and shortage of resources.

Discussion: Clinical teaching is an important aspect of midwifery education. Utilizing student-centred teaching approaches helps students acquire competencies in maternal mental health care. Further research is required to identify the effectiveness of the clinical teaching methods.

The Implication to Practice: The study results can assist nurse educators to provide comprehensive clinical teaching practices in maternal mental health care which will aid in the development of maternal mental health competencies among student midwives.

KEYWORDS

clinical teaching, maternal mental health, nursing education, perinatal mental health

1 | INTRODUCTION

The public's concern about mental health problems during pregnancy or within the first year after birth has increased the need for competent midwives to provide maternal mental health (MMH) care and support (Danasekaran et al., 2015). Globally, one in five women is affected by stress, anxiety and depression and the prevalence is estimated to be high in low-income countries (National Institute for Health and Care Excellence (NICE), 2022; Royal College of Obstetricians and Gynaecologists (RCOG), 2017). Specifically, relating to Malawi and Sub-Saharan Africa, the prevalence rate is estimated at 19%–26% (Acheanpong et al., 2022; Chorwe-Sungani & Chipps, 2018b). Poverty, intimate partner violence, substance abuse and an increase in physical diseases, and pregnancy itself, all contribute to mental health-related problems during pregnancy or after childbirth (Engle, 2017; Howard & Khalifeh, 2020). However, untreated MMH problems can lead to an increased risk of obstetric and neonatal complications, maternal and neonatal mortality which are reportedly high in Malawi and sub-Saharan Africa (Balkus et al., 2021; Mitchell & Goodman, 2018; Patabendige et al., 2020; World Health Organization, 2019).

Considering the seriousness of mental health problems among maternal women, the International Confederation of Midwives (ICM, 2018) and RCOG (2017) have recommended routine screening using standardized tools for mental health-related problems during pregnancy in order to promote awareness and reduce the burden of MMH problems through timely interventions. This recommendation promotes the integration of mental health services into primary care, maternal and child health services (Rahman, 2015; WHO, 2022). However, a shortage of mental health experts, unclear service delivery pathways, a lack of screening tools, stigma and discrimination were noted as barriers to the integration of mental health services into primary care (Adjorlolo & Aziato, 2020; Baron et al., 2016). The global shortage of qualified mental health professionals and the stigma surrounding mental health disorders are still putting

great pressure on midwives to screen and take initial steps to treat mental health problems in order to promote awareness and reduce the burden of MMH problems (Kulisewa et al., 2022; WHO, 2022). Although midwives are aware of their roles to routinely screen and manage MMH-related problems in maternal women, studies have reported that they lack the necessary competencies in MMH care (McCauley et al., 2019; Ng'oma et al., 2019; Noonan et al., 2019; Shahmalak et al., 2019).

The World Health Organization (2016) and the International Confederation of Midwives (ICM) (2018) recommend high-quality training for health workers through classroom and clinical teaching to promote competence development so that health workers can respond adequately to the demands of the public. Students need to be prepared theoretically and through clinical practice for them to gain competencies required in the nursing profession. As the backbone of the nursing and midwifery profession, clinical teaching practices of nurse educators complement classroom teaching and facilitate students' integration of theoretical knowledge into practice. Despite the importance of clinical teaching in midwifery, there is a dearth of literature on clinical teaching practices in MMH care. Reviewing the literature on clinical teaching practices will expose MMH competencies to be achieved, teaching strategies to be used in MMH and also the guidelines to be followed when teaching students in order for them to achieve competencies in MMH care.

2 | BACKGROUND

2.1 | Nurse midwife technician education programme

The training of nurse-midwives in Malawi is done through two pathways namely: Nurse Midwife Technician (NMT) and Registered Nurse-Midwife (RNM). The majority (87%) of the nursing and midwifery

workforce is made-up of NMTs who provide essential health services across Malawi, and are supposed to work under the supervision of RNM (Ministry of Health, 2017). However, they often work alone due to a shortage of RNMs in Malawi (Phuma-Ngaiyaye et al., 2017).

Globally, midwifery educational programmes are also failing to produce skilled and effective healthcare providers in the provision of mental health services (Carroll et al., 2018; McCauley et al., 2019). Some of the cited reasons include; less content on mental health-related topics in the nursing and midwifery curriculums, a lack of MMH care policies and guidelines to support student teaching and learning, a shortage of nurse educators and unclear treatment pathways (Higgins et al., 2018; Legere et al., 2017; McCauley et al., 2019). Although studies have explored less content in the nursing curriculum, none mentioned the competencies specific for midwives in MMH and also the approaches which are to be done to help students acquire competencies in MMH care (Adjorlolo & Aziato, 2020; Legere et al., 2017).

2.2 | Clinical teaching practices in mental health nursing

Clinical teaching practices of the nurse educator help students to integrate learned knowledge, skills and attitudes into practice by teaching, supporting, stimulating and motivating the student in the various clinical setting (Oermann et al., 2022; World Health Organization, 2016). The role of the teacher is to transfer knowledge, skills and attitudes to the student so that they can integrate theoretical knowledge into practice (Gcawu & van Rooyen, 2022; Satoh et al., 2020). Conversely, students learn skills through reflection, observation and interaction with qualified staff and fellow students (Soroush et al., 2021).

Compared to other nursing specialties, mental health clinical practice places more emphasis on communication skills to support women using MMH services through therapeutic relationships and reducing stigma (Wenzel et al., 2022). Even though communication skills are regarded as a core component of quality nursing and patient-centred care, literature has reported on the difficulties faced by students in framing questions and speaking in a way that a client can understand (Furnes et al., 2018). The inability to communicate effectively with clients creates students' fears and low self-esteem and disrupts the nurse-patient relationship (Moagi et al., 2013; Wenzel et al., 2022). In light of this, Furnes et al. (2018) recommend nurse educators to use teaching strategies like role play and video recordings in order to allow students to reflect and gain communication skills before interacting with patients in the clinical setting.

Studies suggest that clinical teaching in mental health nursing can be effective if nurse educators use different teaching approaches like interactive, student-centeredness and blended teaching approaches to stimulate, motivate and engage students to take a leading role in their learning process and be critical thinkers (Goh et al., 2021). On the other hand, using such approaches also encourage nurse educators to coach, supervise and provide timely feedback to students (Soroush et al., 2021).

The use of clinical teaching models on the other hand, such as preceptorship, educational units, secondment and faculty supervision models have been associated with quality clinical teaching as they act as a guide for nurse educators to teach relevant content which is relevant and aligned with the student's learning goals (Leonard et al., 2016; Luhanga, 2018; Maginnis & Croxon, 2007). Although the preceptorship model is recommended because it tailors clinical teaching to the needs of the individual student, the faculty supervise model, which is preferred because of its efficiency in allowing dual responsibilities and peer learning, limits the student-nurse educator relationship and requires more nurse educators with the necessary formal training in clinical teaching and expertise, which are not readily available in low-income countries. (Bvumbwe & Mtshali, 2018; Bweupe et al., 2018; Luhanga, 2018). Previous integrative reviews have focused on the general classroom and clinical teaching practices of nurse educators; however, such studies were not specific to clinical teaching practices in MMH care (Gcawu & van Rooyen, 2022; Njie-Carr et al., 2017). Conducting an integrative review of clinical teaching practices in MMH care would assist nurse educators to identify relevant clinical teaching strategies to support students in building MMH competencies thereby promoting standardization of clinical teaching practices. This review will also identify the clinical teaching guidelines to be followed by nurse educators for students to achieve MMH learning outcomes. Furthermore, there is limited evidence of an integrative review published on clinical teaching practices in MMH care and this observation has indicated the need to have one.

3 | METHOD—INTEGRATIVE REVIEW

An integrative review was used because there was insufficient evidence-based information on clinical teaching practices by nurse educators in MMH care (Whittemore & Knafl, 2005). The integrative review used studies of MMH care with different research methods such as qualitative, quantitative and systematic reviews to gain a broader understanding of clinical teaching practices in MMH care. Researchers were guided by the work of Whittemore and Knafl (2005), which are in five phases, namely: problem identification, literature search, data evaluation, data analysis and presentation.

3.1 | Problem identification

The problem for this review came from study reports and anecdotal notes from experts that identified poor MMH coverage in Malawi as a result of midwives' lack of skills in screening and treating maternal mothers with mental health disorders (Chorwe-Sungani & Chipps, 2018a; Ng'oma et al., 2019; Stewart et al., 2015). The following research questions guided the review: What MMH competencies are taught in nursing and midwifery schools? What clinical teaching strategies do nurse educators use when teaching students MMH competencies? And what challenges do nurse educators face when teaching students MMH competencies in a clinical setting?

3.2 | Literature search strategy

3.2.1 | Inclusion criteria

This integrative review included all articles related to maternal or perinatal mental health psychiatric nursing education, clinical teaching practices in mental health and psychiatric settings and challenges faced by nurse educators in clinical teaching practices. The included articles were in English and included qualitative, quantitative, systematic and integrative reviews with implications for clinical teaching practice in mental health nursing. Peer-reviewed articles published between 2013 and 2022 were selected because they had already undergone some scrutiny as such they provided the integrity of findings. The grey literature was included in the study based on the information it had in response to the research questions.

3.2.2 | Exclusion criteria

The study excluded all articles that were not responding to the research questions, for example; studies that did not describe maternal or perinatal mental health competencies, clinical teaching strategies and challenges faced by nurse educators when teaching students in the clinical setting were excluded. All articles written in other languages apart from the English were also excluded from the study.

3.2.3 | Database searching

The data search was performed using the following keywords; clinical teaching practice; mental health classroom training, perinatal mental health education, MMH education, mental health education, clinical skills and clinical training. A search for articles was conducted from PubMed (88), Google Scholar (66) and Research4Life (637), EBSCO's host (968), and nine papers were manually searched by using citations. Boolean operators and MeSH terms were used to identify relevant studies (See [Appendices 1 and 2](#)). The review process was guided by the PRISMA flow chart, which shows the number of articles retrieved at each stage of the review (Moher et al., 2009). Initially, research records were selected based on their titles, and abstracts of selected titles and then their bibliographies were examined for relevance to the research questions. Only abstracts that focused on the core competencies in either perinatal mental health or MMH clinical teaching strategies, clinical teaching practices or challenges faced by nurse educators or clinical teachers were subjected to a full-text review.

Preliminary data searches returned 1768 articles; however, 60 duplicate articles were removed to clean the data because they had similar titles and abstracts. The remaining 1708 articles were scrutinized based on the relevance of their titles and abstracts. This exercise resulted in excluding 1650 articles since they did not meet the inclusion criteria. The remaining 58 articles were subjected to a full-text review, yet still, 31 articles were excluded for not meeting the inclusion criteria. The remaining 27 articles were included in the study ([Figure 1](#)).

3.3 | Data Evaluation

Data evaluation was performed by assessing the accuracy of the studies, the quality of the methods used and their impact on nursing education. A form was extracted from the Critical Appraisal Skills Programme checklists and was used to record the extracted information (CASP, 2018). Twenty six articles were assessed using the Critical Appraisal Programme Checklist, and 26 articles and all of them were of good quality as evidenced by their rating range of 7/10 to 10/10 during the evaluation ([Appendices 2, 3 and 4](#)). Only one grey article was not quality-checked because it did not fit the checklist.

3.4 | Data Analysis

Data analysis followed the integrative review process of Whittemore and Knafl (2005). Firstly, the data were divided into categories based on the research questions; imparted competencies in MMH care, strategies for clinical teaching practices and challenges faced by nurse educators when teaching MMH care. Data reduction was then performed, which involved extracting and coding data into a manageable framework to simplify and organize the data, thereby improving the accuracy of the study results (Whittemore & Knafl, 2005). After data reduction, the extracted and coded data were displayed by specific variables or subgroups to see the pattern of items and their relationship across data sources. Then the extracted data were compared item by item to ensure similar data was considered and grouped to facilitate the differences in patterns, themes, variations and relationships (Whittemore & Knafl, 2005). To ensure the reliability of the data analysis and to prevent the researchers from being biased about the results, two colleagues independently went through the data evaluation process and analysis. The researcher's and the independent reviewers' findings were compared and discussions were made to reach a consensus. This iterative process resulted in the identification of six themes from the review, namely MMH core competencies, professional regulation of nursing and midwifery education programmes, clinical teaching strategies, collaboration and partnerships, capacity building and shortage of resources.

Two examples of labelling and constructing the subcategories from the text followed. Example 1, on the theme of competencies taught in MMH care, was extracted from the text: *It was decided, where possible, to involve service users and specialist mental health practitioners in developing and teaching relevant topics within the module* (Davies et al., 2016, p. 120). Example 2: On the theme collaborative partnership was extracted from the text: *their need to build good relationships and maintain cooperation with the clinical staff* (Yang & Chao, 2018, p. 5). The conclusion drawing and verification exercise is the final phase of data analysis that moves the interpretive effort from the description of patterns and relationships to higher levels of abstraction, subsuming the particulars into the general summary (Whittemore & Knafl, 2005). After completing each subgroup analysis, the final step in data analysis for an integrative review was to generate the key points or conclusions of each subgroup into an

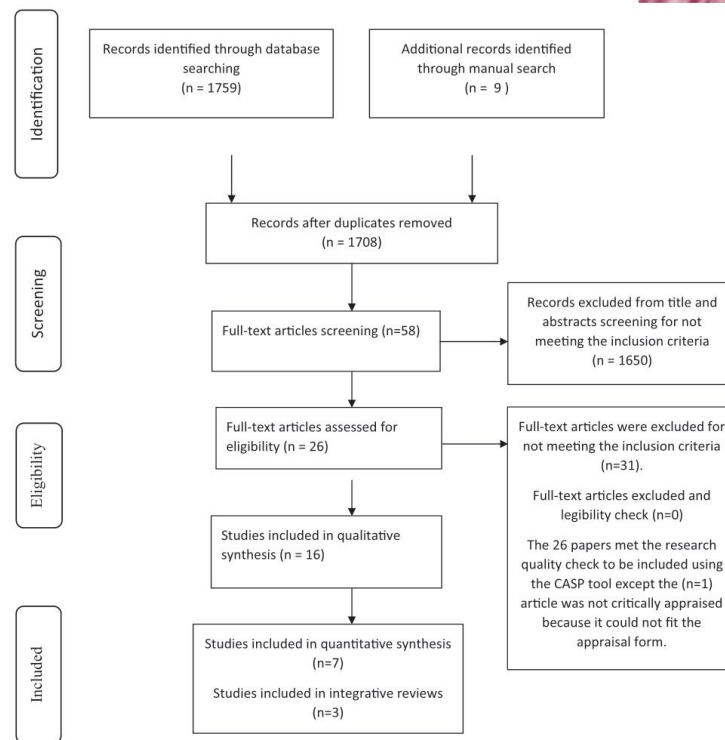


FIGURE 1 The review process. Prisma flow diagram adopted (Moher et al., 2009).

integrated summary of the topic regarding clinical teaching practices in MMH care. To incorporate as much data as possible, the developed conclusions found as themes were continuously revised. The review process was completed when the subcategories were conceptualized into a thorough portrayal of the topic of MMH competencies to be achieved and clinical teaching strategies to be used in MMH.

4 | FINDINGS

4.1 | The Characteristics of the Study Articles

The 27 papers reviewed were from the United States of America (USA), Europe, Asia and Africa. Out of the 27 articles, five articles identified the core competencies in MMH, 17 articles explained the clinical teaching methods and clinical teaching practices that need to be carried out to achieve the development of MMH competencies, and finally, six articles identified challenges educators' face when teaching students in the clinical setting. A grey document was included in the discussion because it highlighted the core MMH competencies for midwives to achieve successful management of mental health issues during the perinatal period. The majority of articles highlighted clinical teaching strategies in which student-centeredness was found effective in achieving the development of

MMH competencies. The study setting for the papers varied from classroom teaching to a hospital setting.

4.2 | The Overall Arrangement of Findings

The results were arranged using an inductive method, in which a thematic data analysis was carried out. The findings were then aligned with the research questions to improve the accuracy of the data namely what competencies are taught in MMH care?, What clinical teaching strategies are used in MMH care? and what are the challenges faced by educators when teaching students MMH care. Six themes emerged namely core competencies in MMH care, interactive teaching strategies, professional regulation, collaborative partnerships, capacity building and shortage of resources see [Appendix 6](#).

5 | SYNTHESIS OF FINDINGS

5.1 | Competencies taught in MMH Care

The review identified several key competencies that midwives should be taught to foster confidence and competence in dealing with common MMH problems. Competencies include screening for

common mental health problems using standardized tools, management of common mental health problems, psychological support and communication and critical thinking skills just to mention a few (Davies et al., 2016).

The review has identified a core competency framework for professionals working with women who experience mental health problems during the perinatal period (Health Education England and The Tavistock and Portman NHS Foundational Trust, 2018). The framework was designed to help healthcare providers working with women with mental health problems in the perinatal period develop multiple competencies in MMH care. From the perspective of perinatal mental health training, Davies et al. (2016) developed a module for midwifery students covering 15 mental health and psychology topics to educate midwives on the importance of managing MMH issues affecting women and their families. A pre-post evaluation module survey study was done on the impact of perinatal mental health education on student midwives' knowledge, skills and attitudes (Higgins et al., 2016). The module was found effective in building competence and confidence in screening and dealing with women with mental health problems because there was a statistically significant increase in knowledge, skill and attitude for every topic taught and students were able to identify and report cases (Higgins et al., 2016).

However, despite having the competency framework, Dias et al. (2022) observe that the framework has some challenges in its implementation. The review found that countries using the competency framework have inconsistencies in student clinical teaching (Dias et al., 2022). Most undergraduate clinical placements were found to be of short duration, averaging 1 day to 6 weeks, resulting in students failing to master mental health skills (Acharya et al., 2017; Davies et al., 2016; Dias et al., 2022; Legere et al., 2017; Yang & Chao, 2018). The findings revealed that countries in Africa have not fully incorporated the competency framework despite having a high burden of MMH problems during the perinatal period, which demands a competent healthcare workforce (Adjorlolo et al., 2019; Ambikile et al., 2020; Brown & Sprague, 2021b). The study findings also show that students learn a few mental health-related topics which do not prepare them adequately for screening and managing MMH conditions (Brown & Sprague, 2021b; McCauley et al., 2019). Other studies have indicated a lack of policies and political will, referral pathways and stigma, as challenges in the incorporation of the framework in preservice education (Baron et al., 2016; Legere et al., 2017).

5.2 | Clinical teaching strategies in MMH care

The complexity of mental health nursing demands that midwives should have communication, critical thinking, empathy and mental health nursing competencies to respond adequately to the needs of maternal women (Downes et al., 2017). According to the review, student-patient interaction and innovative teaching strategies were found to be important in the preparation of a competent mental health nursing workforce through active student engagement, development of communication, interpersonal and empathetic skills

(Everitt et al., 2022; Happell et al., 2019; Jones et al., 2015; Sammut et al., 2021; Wenzel et al., 2022).

5.2.1 | Theme 2: Interactive clinical teaching strategies

The review emphasizes the use of student-centeredness teaching strategies such as structured simulations, group discussions, case studies, role-plays, experiential experts, recorded video recording and reflective practice, as practice-based strategies to be used in mental health and MMH practice because they help students develop communication, interpersonal, problem-solving, critical thinking and empathetic skills, which are necessary for the provision of mental health services (Happell et al., 2020; Jones et al., 2015; Murray, 2014; Wriedt et al., 2014). Among other advantages, group discussions and structured simulations also improve communication and empathetic skills needed to screen and support mothers with mental health problems (Everitt et al., 2022; Sammut et al., 2021). The use of technology, on the other hand, helps clinical educators to expose students to clinical situations which might not be available in the clinical setting (Njie-Carr et al., 2017).

Furthermore, the review has found that nurse educators can use blended learning, in which students, nursing educators and patients work together to improve mental health skill development and promote understanding of mental health nursing concepts (Happell et al., 2019; Larkin et al., 2013). Through blended learning, users of mental health services share experiences of their condition thereby, expanding students' understanding, interest and positivity, and further facilitating the integration of theory into practice (Happell et al., 2019; Larkin et al., 2013). During clinical practice, the review has found that students must be given sufficient time for clinical practice in mental health for at least more than 6 weeks to help students to develop and master mental health competencies (Davies et al., 2016). For this reason, the nurse educator must identify the best teaching strategy depending on the level of the students, the learning goals, the learning outcome and the clinical setting (Jones et al., 2015). Furthermore, we have found that teaching strategies can be combined so that didactic and student-centred approaches can be used in a lesson to achieve learning outcomes and further help students understand MMH care (Jones et al., 2018).

5.3 | Challenges Faced by Nurse Educators when Teaching Students MMH Competencies

5.3.1 | Theme 3: Profession Regulation on Nursing and Midwifery Education

The review has also identified the need to revise the professional regulations for nursing and midwifery training. The review found that MMH competencies are not emphasized in nursing and midwifery

education programmes in most African countries because they contain less content in MMH care leading to a mismatch between the competencies acquired in MMH and what is expected of students during practice (Adjorlolo & Aziato, 2020; Brown et al., 2020). Such inconsistencies can create gaps in the integration of theory and practice and also hinder the development of the necessary skills. The review establishes that there are no assessment tools to evaluate student's competence achievement in MMH care and inconsistencies in teaching students from countries. The review results indicate that in some countries students are being prepared theoretically but there is minimal evidence of student clinical practice in MMH care (Dias et al., 2022).

Additionally, Morton and Rylance (2019) express that the perinatal mental health competency framework developed by Health Education England is not well aligned with the practice standards of the majority of Nurses and Midwives Councils across countries to guide educators in teaching and assessing student MMH competencies during clinical practice. Furthermore, there are no clear guidelines for clinical teaching in mental nursing to be used by nurse educators when teaching students in the clinical setting (Choi et al., 2016; Wenzel et al., 2022). All these factors are calling for a review of the nursing and midwifery curriculum to enable midwives to achieve the necessary competencies.

5.3.2 | Theme 4: Collaborative and Partnerships in Teaching Students

Collaboration is important in nursing as it improves adherence to midwifery standards, implementation of curriculum, sharing of best practices and finding solutions to midwifery practice challenges (Bvumbwe & Mtshali, 2018). The review has discovered that for an effective mental health clinical teaching practice, there is a need for close collaboration and a coordinated approach between nurse educators, hospital staff and students (Asirifi et al., 2017; Günaydin & Arguvanli Çoban, 2021; Needham et al., 2016). The study results shows that there is a poor collaboration between nurse educators and clinical teachers in terms of a mismatch between skills taught in mental health and the needs of the public (Brown & Sprague, 2021b; Gcawu et al., 2021; Legere et al., 2017). This discrepancy creates confusion and further distracts students from developing the necessary competencies in MMH care. The study has also identified a shortage of teaching and learning resources to build collaborative partnerships, language differences and patient conditions as challenges in collaborative learning in mental health (Happell et al., 2020; Larkin et al., 2013).

5.3.3 | Theme 5: Capacity Building for Nurse Educators

Effective clinical practice in MMH requires nurse educators to be familiar with teaching strategies and the course to be taught so

that they can teach effectively and provides students with current and evidence-based information (Goh et al., 2021; Leonard et al., 2016). According to the review, most nurse educators lack confidence and competence in clinical teaching and mental health practice because of poor preservice preparation, as such they also fail to support students adequately (Gcawu et al., 2021; Legere et al., 2017; Ndayisenga et al., 2020; Vuckovic, Carlson, & Sunnvist, 2021). The review has identified the need for training institutions to employ well-trained teachers to support students in the classroom and clinical teaching (Yang & Chao, 2018). Training institutions are being encouraged to have well-formulated policies on staff recruitment and continuous professional development policy to ensure a competent workforce that supports students accordingly.

5.3.4 | Theme 6: Shortage of teaching and learning resources

One of the most important aspects of effective clinical teaching practices is the availability of resources. The study results indicate that both nursing colleges and teaching hospitals are under resourced in terms of skilled mental health educators and materials to support student teaching (Asirifi et al., 2017; Günaydin & Arguvanli Çoban, 2021; Ndayisenga et al., 2020). A severe shortage of skilled staff has led to students being used as a helping hand, and a shift in duties to non-specialized nurse educators, resulting in poor classroom presentation and students not fully understanding the content (Günaydin & Arguvanli Çoban, 2021; Ndayisenga et al., 2020; Yang & Chao, 2018). Findings also indicate that there are no guidelines for MMH competencies to standardize care and a lack of screening tools for MMH conditions (Adjorlolo et al., 2019; Brown et al., 2020).

6 | DISCUSSION

6.1 | Core Competencies in MMH Care

This integrative review shows that the MMH competency framework for healthcare workers exists but is unevenly integrated into the core curriculum of nursing and midwifery education programmes across countries (Dias et al., 2022; Health Education England, 2018; ICM, 2018). The findings from this study are consistent with findings from other studies in this review (Morton & Rylance, 2019). Although the core competencies were developed, the study discovered that the competencies were designed only for health providers working in England. The WHO has indicated that the competencies developed by Health Education England can also be incorporated in low-income countries too so that non-specialized healthcare providers should have basic knowledge of the management of common mental health conditions, screening of the mental health conditions and offer psychological support, treatment and referral services

(WHO, 2022). Midwives have always wanted to have competencies in MMH care, however, the competencies taught were not adequate to support clients and mentor students (Bayrampour et al., 2018; Noonan et al., 2017). Morton and Rylance (2019) assert the need to review the preservice nursing curriculum so that MMH competencies should be aligned with the standards of practice. The nursing curriculum as the heart of nursing and midwifery education serves several roles among which is to guide nurse educators and students on the learning outcomes to be achieved (Chaudhary, 2015). Muraraneza et al. (2017) argue that the curriculum should not be content-based but competent-based to address primary healthcare needs. If midwives are to be adequately prepared for MMH services, the nursing and midwifery curriculum should have MMH competencies which will address primary healthcare needs. Adding a module to the curriculum will not only promote competence in MMH care but will also guide nurse educators and students on the clinical learning objectives which are to be taught and those to be achieved by students in the clinical practice (Lenburg et al., 2009). Otherwise if unknown, students and nurse educators might consider them as not important in their clinical practice. Therefore training them in MMH care will facilitate quality and holistic care for maternal women and reduce the burden of MMH problems.

6.2 | Interactive student-centeredness teaching methods

Quality clinical teaching practices in MMH require the use of innovative student-centred teaching strategies such as expert through experience, simulation, role-play and reflection, which facilitate students' integration of theory into practice and encourage confidence, reflection and student satisfaction (Sinaga & Stickley, 2020). The study has identified several practices which are to be done if MMH competencies are to be achieved by students such as student preparation before clinical practice, and teaching strategies to be used. These findings are consistent with studies from this review (Everitt et al., 2022; Larkin et al., 2013; Sammut et al., 2021). Muraraneza et al. (2017) report that in African countries, nurse educators prefer to teach the way they were taught and the lecture method is commonly used which does not support critical thinking and problem-solving skills. Student preparation in MMH care demands nurse educators to relieve student fears and anxieties, the stigma associated with mental health practice (Wenzel et al., 2022). Thus utilizing student-centeredness teaching methods and interactive teaching methods would help to address students' concerns. Additionally, there is a need to have pre-conference meetings with hospital staff and students, where orientation and sharing of learning objectives can be done, clarifying roles and expectations and addressing any challenge that the students might face in the clinical area, will clear out negative attitudes, fears and concerns from the students which will later promote their interest in mental health nursing (Wenzel et al., 2022).

The use of interactive learning, on the other hand, allows students and nurse educators to build a partnership in knowledge

transmission and engagement through critical dialogue, guiding and translating theory into practice (Bvumbwe & Mtshali, 2018). Furthermore, it also helps students learn communication, critical thinking and empathetic skills, which are important in identifying and managing MMH conditions (Furnes et al., 2018). Sammut et al. (2021) emphasize that nursing educators should not only rely on students' theoretical preparation but should also assign students to clinical practice so that they can build multiple skills. Nurse educators should provide a supportive role by always being available so that they can address any concerns and help students to achieve their learning outcomes.

6.3 | Capacity Building for Nurse Educators

Nurse educators are supposed to be current so that they can teach effectively and provide students with up-to-date relevant content and skills (Leonard et al., 2016; World Health Organization, 2016). The findings from this study are in support of the recommendation made by WHO (2016). Results of this study have indicated that there is less content in the undergraduate nursing curriculum and that nurse educators are not aware of the clinical teaching strategies to be used when teaching students MMH competencies (Dias et al., 2017; Legere et al., 2017). Less content on MMH and a lack of knowledge of teaching strategies can negatively influence student teaching and increase stigma and discrimination towards MMH care. If student midwives are to be competent in MMH care, nurse educators should know the competencies to be taught, the teaching approaches required for students to gain such competencies and also strategies required to evaluate students' competence acquisition in MMH care (Everitt et al., 2022). As such, training nurse educators on MMH care and its clinical teaching strategies is significant in improving nurse educators' skills so that they can ably teach and support MMH care accordingly. Capacity building in MMH care can be done by organizing and encouraging nurse educators to participate in continuous professional development activities so that they can have current information on MMH care and its teaching strategies. Adding a module on MMH care in preservice education is also important because the module will prepare nurse educators in advance on the basic skills in MMH care.

6.4 | Profession Regulation

Nursing and midwifery as a profession have their own set of rules and principles to govern their members and demonstrate their social responsibility (Bogren et al., 2020). The study's findings indicate that competencies for MMH are not aligned well with the nursing and midwifery competencies across countries (Adjorlolo et al., 2019; Brown & Sprague, 2021a; Legere et al., 2017; Morton & Rylance, 2019). Midwives are expected to acquire essential midwifery competencies namely; general competencies, pre-pregnancy and antenatal care competencies, labour and birth, ongoing

care of women and newborns competencies to ensure that they are providing holistic and quality care to the public (ICM, 2018). However, the provision of comprehensive and holistic care cannot happen in the absence of MMH care (Mcnab et al., 2022). Midwives need to modify their scope of practice to address MMH issues and be well-positioned in task shifting in order to address the shortage of skilled mental health experts (Hauck et al., 2015; Kulisewa et al., 2022; WHO, 2022). Bogren et al. (2020) argue that a change in midwives' scope of practice should come from the midwifery education programmes which are regulated by Nurses and Midwives Councils. If student midwives are to respond adequately to MMH practice, the Nurses and Midwives Councils should incorporate a module of MMH competencies in the nursing and midwives curriculum. They should also define basic skills to be acquired by students like: screening for MMH problems, provision of psychological care and referral of such cases for further management (Davies et al., 2016). In addition, they should define clinical hours for that module so that students should not only be prepared theoretical but also through clinical practice.

6.5 | Collaborative and Partnership in Teaching Students

Collaboration among healthcare professionals is necessary in both clinical practice and education (WHO, 2013). Mental health nursing demand that educators, students, patients and clinical staff should work as a team to promote quality care and patient recovery (Happell et al., 2020). Evidence suggests that there is a good outcome when students are mentored by healthcare providers because it improves relationship-based engagement, interaction and planning between the sectors of education, health and other areas (Green & Johnson, 2015). The study findings indicate that there is a poor collaboration between nurse educators and hospital staff which is preventing students from achieving MMH competencies. The findings of this study are in support of findings from other studies (Bvumbwe & Mtshali, 2018; Yang & Chao, 2018). Poor collaboration between nurse educators and hospital staff found in this study may be attributed to a conflict in roles and responsibilities, as nurse educators may consider classroom teaching to be their primary responsibility rather than clinical teaching, whereas hospital staff may consider patient care to be their primary responsibility rather than clinical teaching. To ensure that students get the most out of their training in MMH care, regular meetings with students, hospital staff and nurse educators are important because they can clarify roles and expectations, prepare students on the type of cases available in hospitals and build a strong relationship in student supervision (Wenzel et al., 2022).

The findings indicated that there is a gap in the competencies taught to students and what is expected of the student during clinical practice (Legere et al., 2017). To prevent a mismatch between theory and practice gap, there should be consistency in nursing and midwifery practice between nursing educators and hospital staff which can be achieved through sharing of student learning objectives and

expectations with hospital staff to enable them to understand areas into which they can supportively supervise students. Anarado et al. (2016) advocate for regular in-service training on the importance of collaboration, mentorship and sharing collaborative guidelines between nurse educators and hospital staff to build capacity for action on effective collaborative partnerships.

6.6 | Shortage of Teaching Resources and Learning Resources

Availability of teaching and resources is paramount for effective clinical teaching practices because it promotes a positive and conducive environment for teaching and student learning. The study findings are in support of findings from other studies in this review (Günaydin & Arguvanli Çoban, 2021; Yang & Chao, 2018). Experience has shown that the number of students enrolled in colleges has increased tremendously while the number of nurse educators and clinical sites has remained the same. This has increased workload, task shifting and poor student supervision in the clinical sites which affects clinical teaching practices (Bvumbwe & Mtshali, 2018). Everitt et al. (2022) argued that with limited resources, there is a need to use innovative teaching strategies where nurse educators can embrace online teaching for student's development of competencies. Furthermore, the findings also indicate that there are no guidelines for MMH competencies to standardize MMH care, a shortage of skilled mental health teachers and a lack of screening tools for MMH conditions (Adjorlolo et al., 2019; Brown et al., 2020). Evidence is showing that mental health services are poorly funded as a result resources to support training are not readily available (Mutahi et al., 2022; Stewart, 2017). If students are to develop competencies in MMH, there should be adequate resources to support student teaching and learning through the availability of skilled clinical teachers, skills laboratories for student practice and teaching hospitals with mental health services for maternal women. Nurse educators should identify teaching hospitals that are providing MMH services so that students can observe, emulate and have an opportunity to practice for the development of MMH competencies. If students are allocated to practice in teaching hospitals which are not prioritized MMH services, it might be difficult for students to develop competencies in MMH care.

7 | CONCLUSION

The integrative review aimed at summarizing the best clinical teaching practices for Nurse educators in MMH care. The study has identified core competencies for midwives in MMH and clinical teaching strategies to be used when teaching students MMH care. The study has also identified challenges that educators face when teaching MMH in the clinical area, including the need for a collaborative partnership between educators and clinical staff, capacity building

for nurse educators, professional regulation and shortage of teaching and learning resources. To ensure quality education and care, MMH topics should be included in nursing and midwifery curricula. Furthermore student or interactive teaching strategies should be used when teaching students MMH competencies. During clinical practice, student competency performance should be assessed to validate the development of competencies. Furthermore, capacity building for educators and midwives and more resources for teaching and learning materials are all priorities. Further research can be done to explore the effectiveness of student-centeredness in MMH care.

8 | RELEVANCE STATEMENT

Midwives are expected to care for pregnant women who often seek mental health services. While midwives acknowledge their role in treating MMH problems, they also complain a lack of competence. The review has uncovered MMH competencies, clinical teaching methods and challenges that nursing educators face when teaching students. The review has discovered important themes that can be used to improve the competence of midwives in Malawi and other Sub-Saharan countries.

AUTHOR CONTRIBUTIONS

Chrissie Rashidi Hussein, Masumbuko Baluwa and Thokozani Bvumbwe conceptualized the study, collected and analysed the data. All the authors drafted and approved the final manuscript.

ACKNOWLEDGEMENTS

Many thanks to Saint John of God College of Health Sciences Lecturers who participated in the study appraisal during the review. The author is a student at Mzuzu University pursuing a Master of Science in Nursing Education Clinical teaching, and the other two authors are supervisors for the candidate.

CONFLICT OF INTEREST STATEMENT

The authors declare that they have no competing interests.

OPEN RESEARCH BADGES



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DATA AVAILABILITY STATEMENT

The data sets used and/or analysed during the present study are accessible from the corresponding author upon request.

ETHICAL APPROVAL

Since this was an integrative review study, ethical approval was not required because no humans participated in the study.

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How to cite this article: Hussein, C. R., Baluwa, M., & Bvumbwe, T. (2023). Clinical teaching practices in maternal mental health care: An integrated review. *Journal of Psychiatric and Mental Health Nursing*, 00, 1–20. <https://doi.org/10.1111/jpm.12992>

APPENDIX 1

Search terms for the review.

Clinical instructor OR	teaching practice
Clinical teacher OR	perinatal mental health education AND competencies
Nurse educator OR	mental health education AND curriculum
Student OR	maternal mental health
Midwi*	perinatal depression AND training
Train*	blended learning AND psychiatric teaching
Undergraduate	OR perinatal depression AND preservice preparation
Trainer*	OR perinatal anxiety
Clinic skill*	OR" screening" perinatal depression"



APPENDIX 2

Quality appraisal of the qualitative studies (CASP, 2018).

Questions	Davies et al. (2016)	Acharya et al. (2017)	Choi et al. (2016)	Yang and Chao (2018)	Wriedt et al. (2014)	Asirifi et al. (2017)	Ndayisenga et al. (2020)	Happell et al. (2020)
Was there a clear statement of the aims of the research?	Cannot tell	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is the methodology appropriate	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the research design appropriate to address the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the recruitment strategy appropriate to the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the data collected in a way that addressed the research issue?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Has the relationship between the researcher and participants been adequately considered?	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Have ethical issues been taken into consideration?	Cannot tell	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes
Was the data analysis sufficiently rigorous?	Not clear	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is there a clear statement of findings?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
How valuable is the research?	Valuable	Valuable	Valuable	Valuable	Valuable	Valuable	Valuable	Valuable
Total	7/10	9/10	10/10	10/10	9/10	10/10	10/10	10/10
Impression of the appraisal	Include	Include	Include	Include	Include	Include	Include	Include



Needham et al. (2016)	Wenzel et al. (2022)	Günaydin and Arguvanli Çoban (2021)	Brown and Sprague (2021b)	Lateef and Mhlongo (2019)	Jones et al. (2015)	Sinaga and Stickley (2020)	Vuckovic, Carlson, Sunnqvist, and Carlson Rn (2021)
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Valuable	Valuable	Valuable	Valuable	Valuable	Valuable	Valuable	Valuable
10/10	10/10	10/10	10/10	10/10	10/10	10/10	10/10
Include	Include	Include	Include	Include	Include	Include	Include

APPENDIX 3

Quality appraisal for quantitative studies (CASP, 2018).

Questions	Kitaba et al. (2021)	Dias et al. (2022)	Happell et al. (2019)	Adjorlolo et al. (2019)	Murray (2014)	Grawu et al. (2021)	Maddeshat et al. (2018)
Did the study address a focused issue?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Did the authors use an appropriate method to answer their question?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Were the cases recruited acceptably?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the exposure accurately measured to minimize bias?	Yes	Yes	Yes	Yes	No	Yes	Yes
Aside from the experimental intervention, were the groups treated equally	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Have the authors take account of the potential confounding factors in the design and/or in their analysis?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
How large was the treatment effect?	47% had effective clinical teaching practices	Not define	89% of 27 points of change reflected more favourable and accepting attitudinal change	The results showed that the majority of the participants (94%) indicated they were involved in promoting maternal mental health	Not well defined	The results showed that 37% (n=25) of the nurse educators had above 10 years of clinical teaching experience. Of the 66% (n=45) who had formal education in clinical teaching practices, 49% (n=33) received in-service education	70% of the students have been satisfied with the method of conducting the teaching
How precise was the estimate of the treatment effect?	Less than half of midwifery educators at Ethiopian Public Universities had effective clinical teaching practices	Not defined	There was a statistically significant increase in preparedness for practice in the mental health field in each of the three countries	Knowledge about maternal mental health correlated significantly with involvement in promoting maternal mental health ($p < .05$), whereas attitude towards maternal mental health did not	Not defined	In-service education was positively correlated to best clinical teaching practices (Chi-square (d.f. = 2, n = 68) = 7.24; $p = .027$; $V = 0.33$ Medium)	Their mean self-confidence score was 18.33 ± 1.69 , and the mean score of their performance in the study was evaluated to be 93.74 ± 5.3 from 100 points
Do you believe the results?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Do the results of this study fit with other available evidence?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Total	9/10	9/10	10/10	10/10	8/10	10/10	10
Impression of the appraisal	include	include	include	include	include	include	include

APPENDIX 4

Critical appraisal checklist for integrative studies.

Questions	Legere et al. (2017)	Morton and Rylance (2019)	Goh et al. (2021)
Did the review address a focused question?	Yes	Yes	Yes
Did the authors look for the right type of papers?	Yes	Yes	Yes
Do you think all the relevant important, papers were included?	Yes	Yes	Yes
Did the review authors do enough to assess the quality of the included studies?	Yes	No	Yes
If the results of the review have been combined, was it reasonable to do so?	Yes	Yes	Yes
What are the overall results of the review	Lack of formal training in perinatal mental health	Curriculums are not preparing adequately midwives for perinatal mental health practice	Lecturers should encourage in-depth discussion, reflection and learning from real-life experiences as teaching methods
How precise are the results?	Cannot tell because it is not indicated	Cannot tell	Cannot tell
Can the results be applied to the local population?	Yes	Yes	Yes
Were all important outcomes included	Yes	No	Yes
Are the benefits worth the harm and cost	Yes	Yes	Yes
Total	8/10	8/10	9/10
Impression of appraisal	Include	Include	Include

APPENDIX 5

Summary of articles reviewed.

Research questions	Author and year	Country	Title	Contribution to nursing education
What clinical competencies taught to student midwives in MMH	Health Education England (2018)	England	The Competency Framework for Professionals Working with Women who Have Mental Health Problems in the Perinatal Period	All preregistered midwifery education programmes should include a core training module on perinatal mental health to equip health providers with multiple competencies in perinatal mental health i.e. history taking, screening and offering psychological support and management of perinatal mental health disorders
	Davies et al. (2016)	Britain	Developing a perinatal mental health module: An integrated care approach	The module covers 15 mental health and psychological topics to be covered in 6 weeks to be learned by student midwives and its teaching pedagogy to be used by nurse educators
	Dias et al. (2022)	Across Europe	Psychiatric training in perinatal mental health across Europe	Core curricula and training standards must include enough knowledge and clinical skills in perinatal mental health to enable healthcare workers to care for clients with mental health problems to ensure universal access to care during the perinatal period. Perinatal mental health training is different between countries. In other countries, theory and clinical practice are compulsory while in other countries only theory is considered and clinical practice is not compulsory

(Continues)

APPENDIX 5 (Continued)

Research questions	Author and year	Country	Title	Contribution to nursing education
	Acharya et al. (2017)	Nepal	The mental health education gap among primary health care providers in rural Nepal	There is little content on mental health in the undergraduate curriculum. Adequate content in the mental health curriculum, continuous development training, and continuous supportive supervision should be provided to primary health workers to improve their competencies in mental health education. The clinical practice was brief with an average of 1–15 days
	Adjorlolo et al. (2019)	Ghana	Promoting maternal mental health in Ghana: An examination of the involvement and professional development needs of nurses and midwives	No MMH Curriculum for nurses and midwifery education. Stakeholders to plan and develop training and capacity-building programmes in MMH as part of nursing and midwifery training and or continuous professional development
What Clinical teaching practices are used in teaching Maternal mental health courses	Choi et al. (2016)	Korea	Clinical education in psychiatric mental health nursing—overcoming current challenges	Develop core clinical practicum competencies, standardized tools for student assessment and student-centred teaching strategies such as structured simulations for core competencies and tools for evaluating learning outcomes to achieve the quality of mental health clinical practicums
	Wriedt et al. (2014)	Australia	Perinatal mental health cultural responsiveness training—an evaluation	Online face-to-face training facilitates the development of the perinatal mental health curriculum. The curriculum offered both didactic teaching and student engagement through case scenarios
	Larkin et al. (2013)	Britain	Exploring maternal perinatal mental health using a blended learning package	Teachers should use a blended learning approach when teaching students mental health care using interactive teaching strategies, recorded videos, case studies and presentations. Students, service users and teachers should work in collaboration using customer narratives, students' reflective activities and face-to-face class delivery
	Sammut et al. (2021)	USA	Which Violence Against Women Educational Strategies Are Effective for Prequalifying Health-Care Students?: A Systematic Review	Students prefer their learning to be practice focused rather than strictly theoretical. This can be achieved by teachers encouraging standardized patient–student interactions, roleplaying, group discussions and interactive online classes
	Happell et al. (2020)	Ireland	It is much more real when it comes from them: The role of experts by experience in the integration of mental health nursing theory and practice	Learning from experts by experience brings theoretical concepts to life for students and enhances the integration of theory into practical skills
	Jones et al. (2015)	USA	Exploring changes in health visitor's knowledge, confidence and decision-making for women with perinatal mental health difficulties following a brief training package	Participants gained knowledge, skills and attitude, following the in-service through an interactive slide presentation with direct instruction, application-based discussion and questions
	Happell et al. (2019)	Ireland	Changing Attitudes: The Impact of Expert by Experience Involvement in Mental Health Nursing Education: An international survey study	Consumer involvement in professional education is an effective strategy in facilitating attitudes required in the nursing workforce and prompting interest in mental health nursing as a career



APPENDIX 5 (Continued)

Research questions	Author and year	Country	Title	Contribution to nursing education
	Günaydin and Arguvanli Çoban (2021)	Turkey	Experiences of nursing students during clinical education in mental health clinic: a phenomenological study	Students should be given more hours for clinical practice. Patient–nurse interactive videos, roleplay and case studies should be used for cognitive and emotional preparation
	Needham et al. (2016)	Australia	Best practice in clinical facilitation of undergraduate nursing students	Clinical teachers should be invited to the University regularly for formal and informal sharing of clinical knowledge with academic staff. Collaboration promotes sharing of best practices in undergraduate nursing education
	Wenzel et al. (2022)	Canada	Clinical instruction in mental health nursing: students' perceptions of best practices	Prepare students adequately before clinical placement through pre and post-clinical placements conferences, assignments, orientation programmes and focused direction learning. Provision of learning objectives. The provision of learning objectives, supportive supervision, al or informal feedback and role modelling should be encouraged
	Gcawu et al. (2021)	South Africa	Clinical teaching practices of nurse educators at a public college of nursing in South Africa: A survey study	Nurse educators must match their clinical teaching practices to the nursing programme's requirements to produce competent nurses. Professional development for nurse educators, such as in-person workshops, could be beneficial to clinical teaching practices
	Maddineshat et al. (2018)	Iran	The effectiveness of clinical teaching of mental health courses in nursing using clinical supervision and the Kirkpatrick model	There is a need to use appropriate evaluation methods for mental health education programmes. Kirkpatrick's model provides Kirkpatrick's a new method to supplement traditional methods by closing the gap between theory and practice in teaching students how to deal with mental health problems
	Murray (2014)	Columbus	The Use of High-fidelity Simulation in Psychiatric and Mental Health Nursing Clinical Education	Nurse educators should include well-designed simulated activities in their students' curricula because they improve learning quality and enable learners to practise safely and effectively while also ensuring high-quality nursing education
	Lateef and Mhlongo (2019)	Nigeria	Factors Influencing Nursing Education and Teaching Methods in Nursing Institutions: A Case Study of South-West Nigeria	Create working conditions that allow nurse educators to student-centred teaching and learning methods to support nursing students' learning
	Vuckovic, Carlson, Sunnqvist, and Carlson Rn (2021)	Sweden	Working as a real nurse': nursing students' experiences of a clinical education ward in Psychiatric Care	Nursing students require clinical education that is planned and organized by health care and nursing training programmes working together to clarify their roles and responsibilities in preparing and supporting students during their clinical education
	Kitaba et al. (2021)	Ethiopia	Effective Clinical Teaching Practice and Associated Factors Among Midwifery Educators in Public Universities of Ethiopia: Institution-Based Cross-Sectional Study	It is necessary to follow effective clinical teaching practice guidelines, such as keeping class sizes to a minimum to provide effective clinical teaching
	Sinaga and Stickley (2020)	Indonesia	Perceptions of Pre-Registration Mental Health Nurse Educators on the Delivery of Mental Health Nurse Education: A Qualitative Study	It is necessary to utilize student-centeredness approaches such as media, films and video clips to improve students' analytical reasoning, problem-solving and decision-making skills, which will improve their practice

(Continues)

APPENDIX 5 (Continued)

Research questions	Author and year	Country	Title	Contribution to nursing education
What challenges are faced by clinical teachers when teaching students maternal mental health care	Brown and Sprague (2021b)	South Africa	Healthcare Providers' Perceptions of Barriers to perinatal mental healthcare in South Africa	There is a mismatch between what is learned in medical colleges to what is found in practice. Both the content learned and clinical rotations are less and brief not adequately preparing students for perinatal mental health practice
	Morton and Rylance (2019)	England	Perinatal mental health: preparing the future nursing workforce	The preregistered nursing and midwifery curriculum is not aligned specifically with the perinatal mental health competencies and nurses and midwifery standards as such nursing students lack clear guidance to enable them to be competent in perinatal mental health and meet the needs of the public
	Legere et al. (2017)	Europe	Approaches to healthcare provider education and professional development in perinatal depression: a systematic review	There is little education and continuous professional development activities in perinatal mental health and this negatively affects students' competence acquisition
	Ndayisenga et al. (2020)	Rwanda	Nurse and midwife educators' experiences of translating teaching methodology knowledge into practice in Rwanda	New nurse educators, should have opportunities for professional growth in the classroom and clinical instructional as well as teaching methods. Classroom and clinical teaching practices require sufficient resources. There is also a need to review workloads
	Yang and Chao (2018)	China	Clinical nursing instructors' perceived challenges in clinical teaching	Teaching outside one's field of knowledge, use of students as nursing staff, improper clinical practices by qualified nurses and negative attitudes by staff towards students are all obstacles in clinical teaching
	Asirifi et al. (2017)	Ghana	Assessing challenges of clinical education in a baccalaureate nursing programme in Ghana	There is a need to build students' competencies, adequate equipment, meaningful evaluation of student's performance, a positive clinical environment, the collaboration between school and clinical setting and to reduce the time used to travel to clinical sites

APPENDIX 6

Study findings (categories and subcategories).

Categories	Subcategories (themes)
Competencies taught in maternal mental health	Theme 1: Core competencies in MMH
Clinical teaching strategies used by nurse educators when teaching maternal mental health	Theme 2: Interactive clinical teaching strategies
Challenges faced by nurse educators when teaching students maternal mental health	Theme 3: Profession regulation on nursing and midwifery education Theme 4: Collaborative partnership in teaching students Theme 5: Capacity building for nurse educators Theme 6: Shortage of teaching and learning resources