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Exploring the Challenges of Senior Midwives in Providing Mentorship to Pre-service Student Midwives at Women and Newborn Hospital, University Teaching Hospital, Lusaka, Zambia

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Abstract

The aim of this study was to explore the barriers and strategies experienced by senior midwives in mentoring pre-service student midwives during clinical placements at the Women and Newborn Hospital within the University Teaching Hospital in Zambia. An existential phenomenological design was used. Data were collectively engaged in employment when analyzing the qualitative data obtained from the interviews and focus group discussions. Senior midwives reported multiple barriers to mentorship, including overwhelming student numbers, short clinical rotations, staff and resource attitudes, inconsistent use of supervision manuals, limited time for feedback, and overcrowded clinical spaces. Patient care responsibilities were frequently prioritized over mentorship, limiting opportunities for guided learning. Despite these challenges, midwives employed adaptive strategies such as improvising with limited resources, encouraging students to bring their own equipment, and mentoring during less busy shifts. This study underscores the importance of addressing barriers and innovating current strategies in daily nursing midwives' routines. The key results highlight the need to create a sustainable, continuous mentoring process. Further research should focus on developing frameworks to improve mentoring for senior midwives.

Keywords: Midwifery education, Mentorship, Clinical mentorship, Midwives, Senior midwives, Zambia, challenges, Qualitative study.

INTRODUCTION

Midwifery education is critical for reducing maternal and neonatal mortality in sub-Saharan Africa, where maternal health challenges remain acute. In Zambia, the persistently high maternal mortality ratio underscores the need for competent midwives to deliver safe, skilled, and evidence-based care. A significant deficit of midwives exists, especially in Africa and

Southeast Asia, with projections indicating minimal improvement by 2030 without substantial investment [1].

Clinical mentorship is central to preservice midwifery education, supporting students in bridging the gap between theory and practice, developing confidence, and acquiring professional identity [2–6]. Structured mentorship has been shown to enhance skill acquisition and professional development, whereas insufficient mentorship weakens student preparedness for independent practice [7,8]. Effective mentorship is also influenced by workforce capacity and strategic planning, as highlighted in Australian projections that emphasize the need to build a sustainable midwifery workforce [9]. Despite its importance, mentorship in many African settings is constrained by systemic and institutional barriers, including inadequate resources, inconsistent feedback, limited clinical placements, and weak supervision frameworks [3, 4,10]. Overcrowding, resource shortages, and short clinical allocations have been reported in Malawi, Kenya, Uganda, and Ethiopia, compromising the quality of clinical training [11,12]. In Zambia, although the Nursing and Midwifery Council introduced mentorship guidelines in 2010 [13], gaps persist, including insufficient mentor training, high workloads, poor feedback structures, and limited use of supervision manuals [5, 14].

Relational factors also affect mentorship quality. Negative attitudes among staff and students, hierarchical communication, and a lack of openness hinder effective engagement and create suboptimal learning environments [15, 16]. Short clinical rotations limit exposure, reducing opportunities for skill consolidation and competence development [6]. Resource constraints, particularly shortages of essential equipment and consumables, remain persistent barriers across clinical teaching sites. [9]

This study explored the challenges senior midwives face in providing mentorship to preservice student midwives during clinical placements at the Women and Newborn Hospital, Zambia's largest referral maternity hospital, and the University Teaching Hospital.

METHODS

Research Design

A qualitative, phenomenological, exploratory design was used. An existential qualitative phenomenological exploratory design to present the findings from a first-person perspective to present the findings from a first-person perspective, since phenomenological approaches explore the bodily and emotional experience of a senior midwife and emotional experience of a senior midwife to allow the researcher to present the findings from a first-person perspective, since phenomenological approaches explored bodily and emotional experience of a senior midwife'sto present the findings from a first-person perspective, since phenomenological approaches explore the bodily and emotional experiences of Senior midwives' life worlds and lived experiences. Martin Heidegger posits that there is a way of describing the human existence in a social world (Dasein), or literally 'actual being' of the researchers, which could analyse the structures of our experience and their intentional contents as they manifest themselves [1]. When applying existentialism within the scope of Dasein, the researchers were able to analyse human reality at the level of its ontological structure rather than merely describe it across various fields of thought [2, 17]. This orientation emphasizes meaning-making, context, and interaction between researcher and participant.

Researcher Characteristics and Reflexivity

The research team comprised midwifery educators and qualitative researchers experienced in maternal health and professional development. The principal investigator maintained reflexivity by recording assumptions, methodological decisions, and reflections throughout data collection and analysis. Peer debriefing was conducted to minimize bias and enhance credibility.

Study Site

The study took place at the Women and Newborn Hospital (WNH) and the University Teaching Hospital (UTH) in Lusaka, Zambia. As the country's largest maternity referral hospital and the primary training site for student midwives, WNH provided an appropriate setting for exploring mentorship dynamics in a high-volume, resource-constrained environment.

Participants and Sampling Strategy

Criterion I in the sampling process was used to recruit senior midwives with extensive midwifery experience. This entailed enrolling senior midwives with 2 years or more of work experience, who had been involved in mentoring pre-service student midwives and had an induction in clinical instruction. The exclusion criteria were senior midwives who had not undergone clinical instruction. Twenty senior midwives participated in the study. Recruitment was coordinated by the nurses in charge, who assisted in identifying eligible participants.

Data Collection

Data were collected between May and November 2024 through phenomenological interviews and phenomenologically led Focus Group Discussions. To the meaning and application of phenomenology in data collection, the researchers took cognizance of the fact that the 'objects' studied (senior midwives) were in fact 'subjects', in the sense that they have consciousness and agency. Moreover, unlike physical objects, they produce accounts of themselves and their worlds [7]. The researchers were, as such, studying autonomous subjects, capable of producing accounts of themselves and their nursing and mentoring worlds (*Dasein*). This allowed the researchers to engage in an ever-evolving conversation. In order to generate the knowledge aimed for in the interview and focus group discussions. The researchers assumed a second-person perspective. This means taking up an empathic position in which the researcher's experience and understanding as interviewer and interviewee resonate [18]. According to Zahavi [8], the prime point of a second-person perspective is reciprocity and an experience of mentoring. The interviews lasted 45–60 minutes, while Focus group discussions (FGDs) lasted 60–90 minutes. All interviews and FGDs were conducted in English, audio-recorded with participant consent, and supplemented with field notes documenting nonverbal cues and environmental context.

Data Management and Analysis

Recordings were transcribed verbatim and reviewed for accuracy. Data were analyzed using Braun and Clarke's six-step thematic analysis framework: familiarization, coding, theme generation, reviewing, defining, and reporting. NVivo 15 software was used to analyze data. Themes were developed inductively to reflect participants' narratives. Coding was verified using the inter-coder agreement technique. To uncover nuanced and in-depth understandings of what was happening in the lifeworld of senior midwives as mentors and to ensure the

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trustworthiness of the analytic process, the researchers coded the data separately using an agreed codebook. The team later converged to agree on the outcome of the coding. Interpretive Phenomenological Analysis (IPA) and Thematic Analysis (TA) were employed to yield a more comprehensive understanding of the senior midwives' lived experiences and lifeworld. Thematic analysis was employed to identify broader patterns and categories of phenomena, and IPA was used to offer a deeper, individual-level interpretation.

Trustworthiness

Rigor was ensured in accordance with Lincoln and Guba's criteria for trustworthiness.

- Credibility was achieved through triangulation of data sources, member checking, and peer debriefing.
- Dependability was maintained through detailed documentation of methodological steps and coding processes.
- Confirmability was supported by reflexive journaling and audit trails.
- Transferability was promoted through rich contextual description of the study setting and participants.

Ethical Considerations

Ethical clearance was obtained from the University of Zambia Biomedical Research Ethics Committee (UNZABREC) and the National Health Research Authority (NHRA**)** (protocol references 4788-2023 **a**nd NHRA1109/09/04/2024), respectively. Written informed consent was obtained from all participants. Confidentiality was maintained through the use of unique participant codes and secure data storage.

The Standards for Reporting Qualitative Research (SRQR) were followed to ensure methodological rigor and transparency[19].

FINDINGS

Mentorship Challenges

The senior midwives, pre-service student midwives, and nurse mentoring programs were designed to build on equal relationships among mentees and mentors and to generate further substantial benefits for all involved. However, the programme was riddled with mentorship challenges. The challenges included a large number of students, attitudinal barriers, students' unpreparedness/lack of pre-clinical skills, and a lack of availability of learning resources and equipment. These challenges are outlined below.

Large Number of Students:

Senior midwives reported being overwhelmed by the large number of students, making personalized mentorship impossible. Short ward rotations further limited opportunities for meaningful supervision.

> *"One-on-one mentorship is impossible with the current numbers. We try to manage by splitting students into smaller groups, but even that is not sufficient." [SM08]*

> *"Most of the time, you find about 50 or 60 students from five schools. It is tough to know who is learning and who is not." [SM15]*

Attitudinal Barriers:

Midwives also cited attitudinal barriers from both staff and students. Some colleagues were reluctant to teach, while some students were described as unapproachable or lacking professionalism.

> *"Some of my colleagues do not want to teach; they think it is a waste of time. It is just an attitude problem." [SM04]*
>
> *"Students sometimes judge us based on appearance. They will not ask for help because they assume we are not approachable." [SM07]*
>
> *"Attitude is a barrier. Some students lack etiquette and professionalism, which makes mentorship challenging." [SM12]*

Student's Unpreparedness/ Lacking Pre-Clinical Skills:

Midwives further noted that some students arrived in clinical areas unprepared or lacking basic skills, thereby increasing the burden on mentors and widening the gap between theory and practice.

> *"Some students come to the ward very blank. Even basic skills like recording temperature are a challenge, and it feels like we are starting from scratch." [SM15]*
>
> *"Students are not prepared for clinical areas. In our time, instructors demonstrated everything in class before we practiced in the ward." [SM07]*

Availability of Learning Resources and Equipment:

Staffing shortages and equipment shortages were cited as significant barriers. Midwives reported frequent shortages of gloves, sterile delivery packs, forceps, syringes, and even basic trolleys, which made it challenging to demonstrate procedures.

> *"We lack instruments to use in the ward. Even making a proper vaginal examination set is difficult; you have to improvise." [SM18]*
>
> *"We do not have enough equipment like forceps, syringes, and even speculums." [FGD2, SM8]*
>
> *"There is no trolley, no sterile delivery pack. It is hard to perform procedures without these things." [SM10]*

Some midwives added that there were no dedicated cupboards or storage spaces for students' practice equipment, further limiting their learning opportunities.

> *"Students do not have a cupboard or proper access to equipment for practicals." [SM13]*

Strategies to Overcome Constraints:

Despite these challenges, midwives developed coping mechanisms to sustain mentorship. They improvised with available resources, encouraged students to bring their own supplies, and used less busy shifts to dedicate time to teaching. Senior midwives employed five strategies, including: providing and receiving feedback; managing overcrowding in clinical placements;

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short clinical allocations; using guidelines and evaluation manuals; and balancing patient care and mentorship. Below are notable experiences.

Providing and Receiving Feedback:
Midwives acknowledged that providing constructive feedback was difficult due to workload, high student numbers, and absenteeism. They noted that overcrowding and a shortage of clinical instructors further strained their ability to provide detailed evaluations.

> *"You find yourself alone with many students, so it is difficult to mentor everyone." [SM12]*
>
> *"Giving constructive feedback is a challenge because many students are absent, and when I want to evaluate them, they are not there." [SM4]*
>
> *"Time is a big challenge. Some students come for a few days out of their allocated time, making it hard to assess and give meaningful feedback." [SM16]*

Overcrowding in Clinical Placements:
Overcrowding in wards was a recurring challenge. With too many students and limited space, not all could observe or participate in procedures. Patient privacy was also compromised.

> *"You find that maybe the same room you are using is crowded. Others are inside, others are in the corridors. Only the ones in the front benefit." [FGD6, SM2]*
>
> *"Sometimes we have more students than patients, and everyone wants to do the procedure. In the end, some of us do not get a chance to teach." [SM2]*
>
> *"We value privacy in procedures. If there are too many students, I restrict access to small groups, but this deprives others of learning opportunities." [SM4]*

Short Clinical Allocations:
Midwives expressed concern that the two-week clinical rotations were too short to build competence, noting that students barely had time to settle before leaving.

> *"The students are here for very short periods. By the time they are settling in, it is time for them to leave." [SM19]*
>
> *"Short durations make it hard to learn midwifery skills because the time is not enough." [SM9]*

Use of Guidelines and Evaluation Manuals:
Learner's guides and evaluation manuals were inconsistently used. Some students carried them only when they needed signatures, undermining structured mentorship.

> *"To be honest, I have never seen a student carrying an evaluation manual or procedure manual." [SM7]*
>
> *"They only bring them when they want to have them signed." [SM18]*
>
> *"Most students come without their guides, which makes it difficult for us to supervise them effectively." [SM14]*

Balancing Patient Care and Mentorship:

Midwives described constant tension between managing patient care and teaching students. In many cases, patient care took precedence, leaving students to observe rather than actively engage in learning.

> *"When the ward is busy, we attend to patients first. The students can wait, but the patient's condition cannot." [SM06]*
>
> *"We multitask. As I admit a patient, I explain to the students, but it is not the same as sitting down and teaching them properly." [SM13]*
>
> *"Major ward rounds take up most of the shift. If you have students, it becomes hard to spare time for them." [SM18]*

DISCUSSION

Mentoring is an integral strategy for pre-service student midwives undergoing clinical learning. Clinical mentoring for pre-service student midwives has significant potential to support their professional development. The findings of this research provide insight into the challenges inherent in operationalizing the pre-service student midwives programme at the Women and Newborn Hospital, University Teaching Hospital, in Zambia. This study highlights the multifaceted barriers senior midwives face in mentoring preservice students. Mentorship was constrained by structural, institutional, and relational factors that could limit the quality of student learning. The overwhelming number of students — sometimes up to 60 from multiple schools — coupled with short 2-week clinical rotations, makes individualized mentorship nearly impossible. These findings align with studies from Malawi, Kenya, and Uganda, which show that overcrowding and brief placements compromise skill consolidation and competence [4, 6, 11, 16]. Extending placement durations and redistributing students across clinical sites could enhance learning outcomes.

Resource and staffing shortages further restricted mentorship. The frequent lack of essential equipment, consumables, and clinical materials forced improvisation, thereby limiting procedural demonstrations. Similar challenges have been reported across sub-Saharan Africa and Southeast Asia, highlighting systemic weaknesses in resource-limited settings [8, 9, 11, 12, 14, 15]. Investment in human resources, equipment, and infrastructure is essential to strengthen mentorship and ensure alignment with global workforce development initiatives, such as Australia's Midwifery Future programs [9, 14, 15].

Heavy workloads and competing responsibilities also compromised the quality of mentorship. Patient care understandably took priority over teaching, thus reducing opportunities for active student participation. Comparable tensions have been documented in Zambia, Ghana, and Kenya [6, 8, 14], highlighting the need for protected mentorship time within duty rosters.

Relational and attitudinal barriers were evident, including negative staff attitudes and students' limited confidence or approachability. Such hierarchical and tense dynamics hindered open communication and trust between mentors and mentees [5, 15, 16]. Fostering professional, supportive relationships is essential for improving the learning environment.

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Inconsistent use of learning guides, evaluation manuals, and feedback tools limited structured supervision and accountability. These gaps, also noted in the Zambian and Kenyan contexts, reduced the availability of systematic assessment opportunities [13, 14]. Strengthening the consistent use of supervision tools and embedding structured feedback in mentorship frameworks could enhance quality and equity.

Overcrowded clinical spaces forced midwives to limit student access to procedures, thereby compromising hands-on learning and patient privacy. Studies from South Africa and Nigeria highlight similar ethical and practical concerns [12, 15], underscoring the importance of equitable student distribution and adherence to privacy protocols.

Despite these challenges, senior midwives demonstrated resilience through adaptive strategies, such as improvising with resources, scheduling mentorship during quieter shifts, and encouraging students to bring their own equipment. While effective in the short term, these approaches cannot substitute for systemic reform. Evidence from Malawi, Uganda, and Kenya indicates that improvisation is a common coping mechanism that masks underlying deficiencies [4].

LIMITATIONS OF THE STUDY

This study was conducted only in one nursing institution. This, however, limits the generalizability of the findings to other training schools. However, the findings and recommendations of this research can be applied in other campuses in Zambia. Describing the setting and findings in detail would enable other researchers to apply them, thereby enhancing their transferability.

CONCLUSION

Senior midwives at WNH face significant barriers in providing mentorship, including overwhelming student numbers, staff and resource shortages, short clinical allocations, and inconsistent use of supervision tools. While adaptive strategies are employed, sustainable improvements require institutional support, structured mentorship frameworks, and policy-level reforms. Improving mentorship in midwifery education is essential to developing future healthcare leaders, and this requires a collaborative approach to address systemic challenges. This collaboration must involve educational institutions, healthcare organizations, and policymakers to create a cohesive and supportive environment for mentorship. Effective mentorship not only enhances midwifery students' skills but also contributes to better patient care outcomes and a more robust healthcare system overall. This study underscores the importance of addressing barriers and of integrating current strategies into daily mentoring routines. The key results highlight the need to create a sustainable, continuous mentoring process. Further research should focus on developing frameworks to improve mentoring for senior midwives.

IMPLICATIONS FOR PRACTICE AND POLICY

To strengthen mentorship and improve pre-service midwifery education, the training institution should consider:

- Extending clinical placements to allow meaningful engagement.
- Allocating protected time for senior midwives to balance patient care and teaching.
- Ensuring adequate staffing and provision of essential equipment.

- Reinforcing consistent use of learners' guides, logbooks, and structured feedback tools.
- Maintaining enrolment and placement guidelines to reduce overcrowding while distributing students equitably across clinical sites.

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CONFLICT OF INTEREST

The authors have not declared any competing interests.

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Appendix

Table 1: Themes, Barriers, and illustrative quotes from senior midwives

Theme	Key Issues Identified	Illustrative Quotes (Senior Midwives)
Mentorship challenges	Overwhelming student numbers, short rotations, negative staff/student attitudes, and a lack of preparedness among students	*"One-on-one mentorship is impossible with the current numbers." [SM08]* *"Most of the time, you find about 50 or 60 students from five schools." [SM15]* *"Some of my colleagues do not want to teach; they think it is a waste of time." [SM04]* *"Some students come to the ward very unprepared." [SM15]*
Resource and staffing shortages	Lack of midwives, equipment, consumables, and space; improvisation is common	*"We lack instruments to use in the ward. Even making a proper vaginal examination set is difficult." [SM18]* *"There is no trolley, no sterile delivery pack." [SM10]*
Strategies to overcome constraints	Improvisation, encouraging students to bring equipment, and mentorship during less busy shifts	*"Even without equipment, mentorship shouldn't stop. You can improvise while following the principles." [SM08]* *"We tell the students to come with their own equipment if they want to perform certain procedures." [SM11]*
Feedback challenges	Limited time for constructive feedback; absenteeism; high student–mentor ratios	*"You find yourself alone with many students, so it is difficult to mentor everyone." [SM12]* *"Giving constructive feedback is a challenge because many students are absent themselves." [SM04]*
Overcrowding in placements	Too many students for limited patients; competition for procedures; compromised privacy	*"Sometimes we have more students than patients, and everyone wants to do the procedure." [SM02]* *"We value privacy in procedures. If there are too many students, I restrict access to small groups." [SM04]*
Short clinical allocations	Two-week rotations are too brief to gain competence	*"The students are here for very short periods. By the time they are settling in, it is time for them to leave." [SM19]*
Inconsistent use of guidelines/manuals	Manuals/logbooks are often absent or only presented for signatures	*"They only bring them when they want to have them signed." [SM18]* *"Most students come without their guides, which makes it difficult for us to supervise them effectively." [SM14]*
Balancing patient care and teaching	Heavy workload forces prioritization of patient care over mentorship	*"When the ward is busy, we attend to patients first. The students can wait, but the patient's condition cannot." [SM6]* *"We multitask. As I admit a patient, I explain to the students, but it is not the same as sitting down and teaching them properly." [SM13]*

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