Midwifery 30 (2014) e169–e176

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

Knowledge and reported confidence of final year midwifery students regarding giving advice on contraception and sexual health

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ARTICLE INFO

Article history:
Received 19 September 2013
Received in revised form
16 December 2013
Accepted 11 February 2014

Keywords:
Postnatal
Contraception
Confidence
Education

ABSTRACT

Objective: this study explored the views of three cohorts of final year midwifery students, regarding their confidence in giving advice to women on contraception and sexual health in the postnatal period. The project also investigated knowledge of contraception using a factual quiz, based on clinical scenarios regarding contraception and sexual health in the postpartum period.
Design: a mixed method design using qualitative data from focus groups, and mixed qualitative and quantitative data from a paper based questionnaire was used.
Setting: the project was carried out in one higher educational institution in England.
Findings: findings demonstrate that expressed confidence varies according to contraceptive method, with most confidence being reported when advising on the male condom. The findings of the factual quiz indicate that students applied theoretical knowledge poorly in a practically oriented context. These findings also indicated that most students limited advice to general advice.
Key conclusions: the paper concludes that midwifery students need more practically oriented education in contraception and sexual health, and that the role of mentors is very important in helping students feel confident when giving advice in this area.

Introduction

The giving of advice on contraception and the planning of future pregnancies is part of the midwifery role and competencies in the UK and Europe (Nursing and Midwifery Council (NMC), 2009, p. 24, 26; Fullerton et al., 2011). The standards for pre-registration midwifery education are based upon the European Union Directive Recognition of Professional Qualifications 2005/36/EC Article 40 which makes it incumbent upon member states to ensure that midwives are able to, at the point of registration, 'provide sound family planning information and advice' (NMC, 2009, p. 65). The focus of this paper is on advice and information giving only. Prescribing or fitting of contraceptive methods and devices is an advanced skill, and not one which is covered in this paper.

In the last 50 years the range of contraception available to women has increased and most forms of contraception are suitable for use in the post-natal period, and during breast feeding. This paper reports on research which examined the attitudes of final year pre-registration midwifery students regarding giving contraceptive advice, in particular the degree of confidence they felt in supplying contraceptive advice to women in their care, including their confidence in giving advice on specific methods. The research sought to determine the factors that students felt would increase their confidence and to explore those factors that prevented them from feeling confident in performing this skill. It also sought to determine the competency of final year students, in giving contraceptive advice, by means of clinically based practice scenarios.

A short section outlining methods of contraception is included below as background to the study. The research literature is then considered and the research methods and findings from this study are then reported.

Background

There are 13 methods of reversible contraception available to postnatal women including the use of the lactational amenorrhoea method (LAM), which relies on breast feeding to suppress ovulation, and emergency post coital contraception.

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http://dx.doi.org/10.1016/j.midw.2014.02.002
0266-6138

These can be divided into non-hormonal, barrier methods (cap, diaphragm, male and female condoms), intrauterine methods (copper-bearing intrauterine devices (IUDs)) and progesterone bearing intrauterine systems (IUS or Mirena™), oestrogen containing systemic methods (combined oral contraceptive pill (COCP), combined contraceptive patch or combined contraceptive vaginal ring), and progesterone only systemic methods (progesterone – only pill (POP), implant and contraceptive injection).

Oestrogen containing methods (COCP, patch or vaginal ring) are not suitable for breast-feeding women, because they have the potential to suppress milk production (Faculty of Sexual and Reproductive Healthcare (FSRH), 2011a). In the non-breast-feeding woman, oestrogen containing methods should not be started prior to the 21st day post partum, because oestrogen increases the risk of developing a deep venous thrombosis (DVT). After 21 days the risk in the post natal woman is thought to be sufficiently reduced to allow the use of an oestrogen containing method (FSRH, 2011a). Progesterone only methods (POP, implant and injection) do not interfere with breast milk production and do not increase the risk of DVT. For this reason they can be used by breast-feeding women and should be started by Day 21 post-childbirth (FSRH, 2008). They can also be safely started earlier than the 21st day after childbirth, although this is outside the product licence for the methods, which shifts the medico-legal burden from the drug company onto the prescriber.

Insertion of intra-uterine methods must be delayed until 28 days after childbirth, to avoid perforation of the uterus during insertion (FSRH, 2007). Diaphragms and caps cannot be fitted until six weeks post partum, to allow time for the vaginal tissues and cervix to stabilise in size and shape (FSRH, 2012). Male and female condoms can be used immediately intercourse resumes, but these methods have high failure rates (18% per couple/year) and couples may be unfamiliar in their use (Trussell, 2011)

The earliest date of ovulation post partum is thought to be Day 28 (FSRH, 2009). Emergency contraception is not a long term contraceptive method but can be used post-coitally in the event of a failure of another method or an act of unprotected intercourse. Emergency contraception is not required until 21 days after childbirth, but any unprotected intercourse after this time carries a risk of unplanned pregnancy. Emergency hormonal contraception (Levenolle™ One Step/Levonelle™ 1500) can be safely used after an episode of unprotected intercourse, even in breast-feeding women, but may not be required if the baby is less than 21 days old (UKMEC, 2010, p. 114; FSRH, 2011b).

Knowledge of these basic facts about contraception in the post-natal period is needed to advise women appropriately, in terms of preventing an unplanned pregnancy and/or safely resuming their previous contraceptive method or establishing a new method.

Literature review

The challenges of translating theoretical knowledge, gained in a classroom setting, into practical clinical competence have been much debated in the literature surrounding professional education in recent years (Corlett, 2000; Corlett et al., 2003; Smeby and Vågan, 2008; Davis, 2010; Sangestani and Khatiban, 2013). Factors affecting confidence and competence in newly qualified practitioners have also been explored (Stewart et al., 2000; Farrand et al., 2006; Donovan, 2008; Roberts and Johnson, 2009; Liaw et al., 2012). Skirton et al. (2012) undertook a UK study of the perceived competence of the newly qualified midwife in relation to the pre-registration programme they had undertaken. Their findings support the value of the pre-registration programmes in promoting autonomous practice in the newly qualified midwife. However there is considerable discussion regarding the difference between being competent in carrying out skilled behaviours, and being knowledgeable in the professional practice role. For example, the development of registered midwives who are fit for practice in Australian midwifery education is reviewed by Pincombe et al. (2007). The need for a model which recognises that competence is a complex process of relating knowledge to practical skills, beyond the mere demonstration of skills and a prescribed minimum number of clinical encounters, was identified. There was also recognition that complex decision making and confidence are skills which are developed after registration.

McIntosh et al. (2012) in their study of 120 final year midwifery students identified what they describe as dissonance between what the midwifery student considers is needed, and what the university provided, to enable them to become confident practitioners on qualification as a midwife. Their paper suggests that some of the student midwives considered they needed more knowledge, as a buffer against anxiety and uncertainty. It highlighted the philosophical gap between adult centred learning, and the need of student midwives to know 'the right way of doing things'. The discussion highlighted the importance of mentors in practice who could enable the students to develop confidence in the use of their knowledge through a range of practice settings. The issues therefore appear to be the need for competence on registration, but also the need for confidence developed through suitable clinical experiences with appropriate mentorship and guidance, and for this to continue, albeit in a more distanced way, on qualification.

Some of the literature also discusses the notion of safe practice. For example, Butler et al. (2008) undertook research with qualifying midwives and their mentors and teachers. They describe that one of the competencies regarded as essential on qualification as a midwife is to be a safe practitioner. The study reports self-sufficiency, self and professional awareness and using up to date knowledge in practice, as components of safety, but does not explore the concept of 'being safe' from the point of view of patient outcomes. 'Safe' practice can be construed in a positive sense of doing the woman no harm. However, there is a need to consider whether this could also be construed in a negative sense of deciding not to act because of a fear of doing harm. For the students in our study this negative application of 'safe practice' would result in the inexperienced midwife taking the safest option of declining to offer advice, rather than deciding on an action which would require the confident application of knowledge in practice.

We could find no studies exploring the effects of contraception and sexual health education upon practice in midwifery students, despite the importance of this area in terms of core competencies for midwives. Some studies explore issues of sexual health in nursing and sexual health education in nursing students (Dattilo and Brewer, 2005; Johnston, 2009; Thurston and Walker, 2011; Tsai et al., 2013). Dattilo and Brewer (2005) note that sexual health assessment is often omitted both from the nursing curricula and from the practice behaviour of nurse educators. In a phenomenological study of the views of nursing students in the USA, they found that nursing students recognised sexual health assessment as part of nursing practice but expressed discomfort with exploring clients' sexual health and viewed this assessment as less important than other assessments, and only warranted if tied to a medical diagnosis (Dattilo and Brewer, 2005). Johnston (2009) notes that although child branch nurses, working as school nurses, are frequently involved in the delivery of sex and relationships education, research on the coverage of sexual health issues within the child branch curricula is limited. Her qualitative phenomenological study of third year nursing students found that students received little formal sexual health education in their curriculum, which decreased their confidence in dealing with sexual health issues in a professional role (Johnston, 2009). Thurston and Walker