

Barriers to clinical learning skills development among midwifery students and newly qualified midwives in Morocco: A qualitative study

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Abstract

Background: In Morocco, despite various initiatives to improve the quality of reproductive healthcare, the indicators remain unfavorable. To strengthen the skills of midwives and support the achievement of Millennium Development Goals (MDGs) 4 and 5 by 2030, Morocco has developed and implemented a competency-based training framework. However, there is a lack of information on the successful implementation of this program and its impact on the quality of student midwives' preparation for practice.

Objective: This study aimed to gain a deeper understanding and explore the barriers affecting the development of clinical learning skills among midwifery students and newly qualified midwives.

Methods: This study employed a descriptive, exploratory qualitative approach. Data were collected through nine focus group discussions with 30 midwifery students and 24 newly graduated midwives between April and June 2023 from six higher education institutions in northern and central Morocco. Inductive content analysis was used to analyze the transcribed discussions.

Results: The barriers varied between locations. Overall, the internship design was inadequate, and the clinical environment was insufficient. Participants highlighted limited opportunities to experience the full range of midwifery skills. However, most midwifery students and new graduates had deficient competencies in managing high-risk situations and emergencies.

Conclusion: This work provides an overview of the nature and extent of the challenges faced by many student midwives in Morocco, resulting in newly graduated midwives being poorly prepared for the full range of midwifery practice. These findings can inform various initiatives to strengthen midwifery education at the global, regional, and national levels.

Keywords

Morocco; midwifery; clinical learning outcomes; students; barriers; delivery of healthcare

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Background

Globally, approximately 800 women continue to lose their lives daily due to complications related to pregnancy, childbirth, and the postpartum period, translating to about one woman every two minutes ([World Health Organization, 2023](#)). Research indicates that the expertise of skilled midwives plays an essential role in mitigating preventable maternal and neonatal mortality across diverse economic settings, including high-income, low-income, and middle-income countries (LMICs) ([Renfrew et al., 2014](#)). As highlighted in The Lancet Series on Midwifery, adherence to international training standards could potentially avert up to 83% of maternal, stillbirth, and neonatal deaths ([Homer et al., 2014](#); [Renfrew et al., 2014](#); [Van Lerberghe et al., 2014](#)).

The foundation of high-quality midwifery care lies in comprehensive midwifery education, which is crucial for safeguarding the health and welfare of women, infants, and families ([United Nations Population Fund et al., 2021](#)). The

International Confederation of Midwives (ICM) has contributed significantly to this cause by creating two seminal professional resources: the Global Standards for Midwifery Education and Essential Competencies for Midwifery Practice. These documents emphasize competency-based education and enhance midwifery education worldwide ([International Confederation of Midwives, 2019, 2021, 2022](#)). The World Health Organization (WHO) has also released guidance materials to strengthen midwives' training and performance ([World Health Organization, 2019, 2021](#)). Together, these resources form a crucial framework supporting the cultivation of essential midwifery competencies as outlined in the framework proposed by [Renfrew et al. \(2014\)](#).

However, in LMICs, there remains a scarcity of health workers trained to meet international standards, even among those holding the professional title of midwife ([Hobbs et al., 2019](#); [World Health Organization, 2019](#)). Numerous midwifery institutions encounter difficulties in delivering high-quality teaching and learning experiences ([Sharma et al., 2021](#);

United Nations Population Fund et al., 2021; World Health Organization, 2019; Yigzaw et al., 2015), impacting the self-assurance and fundamental skills of midwifery students and recent graduates, particularly in critical obstetric domains (Ahmadi et al., 2018; Moller et al., 2022; Sharma et al., 2021). The quality of support provided by midwifery educators and clinical personnel poses a significant challenge to attaining excellence in midwifery education ((Berhe & Gebretensaye, 2021). Moreover, the inconsistent implementation of the Global Standards for Midwifery Education serves as a barrier, impeding the readiness of newly minted midwives to deliver the breadth and quality of care needed (Bharj et al., 2016).

In Morocco, a staggering 80% of deaths are preventable, with the primary factors contributing to hospital fatalities being 1) inappropriate treatment decisions, 2) inadequate risk assessment, 3) delayed or incorrect diagnoses, and 4) delays in healthcare delivery (Ministry of Health Morocco, 2015). Consequently, women may not receive the required quality care despite access to proficient medical personnel within healthcare facilities. This underlines issues and concerns regarding the standard of midwifery education in Morocco and comparable nations.

In alignment with achieving Millennium Development Goals (MDGs) 4 and 5 by 2030, the Ministry of Health in Morocco initiated an action plan to “strengthen midwifery” in 2008. This initiative led to educational reforms, including curriculum revisions and the introducing of a Competency-Based Education (CBE) program aligned with WHO and ICM standards, culminating in a bachelor’s degree (Abou-Malham, 2014). This transformation was part of a broader reform of the LMD (L = Bachelor, M = Master, D = Doctor) system in higher education in 2013. Subsequently, midwifery education has been incorporated into the Higher Institutes of Nursing Professions and Health Techniques (HINPHT) under the supervision of the Ministry of Health. The midwifery diploma program spans six semesters, comprising 1150 hours of theoretical instruction and 1040 hours of clinical practice. Clinical placements begin in the second year and extend throughout the duration of the program.

In Morocco, midwifery students undergo placements in various healthcare settings, including community health centers, community birth centers, rural community hospitals (primary care), and specialized hospitals (secondary and tertiary care), ranging from 3 to 6 weeks per rotation. The clinical teaching approach remains traditional, with students receiving supervision from institute faculty, practicing midwives, and nurses. The country has established a mechanism to evaluate graduates through licensing examinations before integrating into the healthcare system. However, this assessment primarily focuses on theoretical knowledge as a prerequisite for licensure, lacking comprehensive evaluation measures.

The existing literature indicates a dearth of evidence regarding midwifery outcomes, particularly in LMICs, necessitating urgent research in this area (World Health Organization, 2019). Moreover, many reports and studies evaluating training programs in LMICs have inadequate study designs and a tendency to overlook qualitative methodologies (Ameh & van den Broek, 2015). In Morocco, previous research has not explored the experiences of midwifery students during their placements following the implementation of the CBE

program. Abou-Malham (2014) assessed the implementation of the Ministry of Health’s action plan across three interconnected systems: practice, education, and regulation. Additionally, a scoping review of the literature on midwifery in Middle Eastern and North African (MENA) countries revealed limited information on the subject, with only two studies from Morocco, representing 1.5% of the total studies reviewed (Safari et al., 2021). Therefore, recognizing this research gap, this study aimed to explore the barriers influencing the development of clinical learning skills among midwifery students and newly qualified midwives. The findings will be a foundation for national, regional, and international research and interventions.

Methods

Study Design

This study employed a descriptive, exploratory qualitative approach. The qualitative descriptive design was chosen to facilitate a comprehensive exploration of the various aspects (Lincoln & Guba, 1985) influencing the development of clinical learning skills, aiming to achieve a deeper understanding of the phenomena through focus group discussions (Creswell & Creswell, 2018) involving newly graduated midwives and midwifery students. The research adhered to the guidelines delineated in the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007).

Participants

The study involved participants from six public institutions located in two regions in the northern and central parts of the country: Fez, Meknes, Taza, Tangier, Tetouan, and Al Hoceima. These regions were chosen due to their involvement in the curriculum review and implementation process of the Competency-Based Education (CBE) program in 2009 (Abou-Malham, 2014). To ensure a comprehensive understanding of the phenomenon under investigation, purposeful and snowball sampling techniques were employed to recruit participants from diverse backgrounds (Patton, 1990; Sandelowski, 2000). Purposeful sampling was utilized to select cases deemed to be information-rich for the study’s objectives, while snowball sampling was employed to identify additional information-rich key informants (Patton, 1990). Eligible newly graduated midwives were selected from the most recent graduating class, regardless of whether they had started working as qualified midwives. This criterion ensured that participants had sufficient experience to provide detailed insights into their educational experiences. Midwifery students included in the study were required to be enrolled in their second year or above and aged 18 or older. Recruitment was voluntary, with participants receiving invitations via email containing detailed information about the study.

Data Collection

A total of 9 focus group discussions (FGDs) were conducted between April 2023 and June 2023. The FGDs consisted of 5 sessions with midwifery students and 4 with new graduates, involving a total of 54 participants. Among these, 30 midwifery students were coded as MS1-1 (indicating Participant 1, FGD 1), and 24 newly graduated midwives were coded as NGM13-3 (indicating Participant 13, FGD 3). The institutes they

belonged to were coded numerically from 1 to 6 to protect their privacy.

Each FGD was conducted in French, and the interview guide, developed based on a literature review (a sample of interview questions is shown in [Table 1](#)), adhered to the interview protocol outlined by [Creswell and Creswell \(2018\)](#). The discussions were held in locations chosen by the participants. Before the discussions started, participants completed a brief demographic questionnaire. All group discussions were audio-recorded and transcribed with participants' consent, with durations ranging from 47 to 93 minutes. Recruitment ceased upon reaching theoretical saturation, signifying no emergence of new data ([Saunders et al., 2018](#); [Schreier et al., 2019](#)).

Before the formal interviews, pilot interviews were conducted with three newly qualified midwives and four student midwives to identify and address potential issues. Data from these pilot interviews were not included in the final analysis. The primary author (MM) collected, recorded, and transcribed the data. With experience in qualitative research and no prior relationship with the participants, she ensured impartiality in the process. The identified themes and subthemes were shared with the participants to validate and ensure that the data accurately reflected their experiences, and participants expressed satisfaction with the results.

Table 1 Examples of interview questions

Question examples
What elements of the clinical environment are barriers to the achievement of disciplinary competence?
How do you think these different professionals (midwifery educators and clinical midwives) helped or hindered your training?
Did the training program enable you to acquire the skills you need to practice as a midwife? What skills do you not have?
Is there anything you would like to add?

Data Analysis

The transcripts were analyzed using inductive qualitative content analysis ([Elo & Kyngäs, 2008](#); [Schreier et al., 2019](#)). Steps applied to the data included the preparation phase, the organization phase, and the reporting of the analysis process and results ([Elo & Kyngäs, 2008](#)). Developing categories and subcategories and coding the data occurred in several cycles. The analysis was a continuous process that involved constant feedback, discussion, and reflection within the research team.

Trustworthiness

To ensure trustworthiness, this study adhered to the criteria proposed by [Lincoln and Guba \(1985\)](#), focusing on credibility, dependability, confirmability, and transferability. Strategies employed to enhance credibility included member checking, peer debriefing, prolonged engagement, and consistent observation. Data analysis followed rigorous research procedures to ensure dependability. The entire research team thoroughly discussed and approved the results before being shared with participants to validate their accuracy and consistency with their experiences. To enhance transferability, detailed descriptions, and diverse representation were provided.

Ethical Considerations

Approval for this study was obtained from the Directors of the six HINPHT institutes, as well as from the institutional review board and local committee of the Fez Meknes regional health department, under reference number 7046-22-DRS-FM. Ethical approval for this study was also granted by Abdelmalek Essaâdi University with approval number CEHUT-58-24. The study adhered to all ethical rules. Data collection was carefully designed to ensure confidentiality. All data are securely stored in the first author's data system. Prior to participating in interviews, participants were required to sign an informed consent form. Midwifery students were invited to self-select by contacting the primary author. During the interviews, participants were informed that they had the right to withdraw or decline to answer specific questions without providing an explanation. They were assured that withdrawing from the study would not impact their academic or professional standing. However, none of the potential participants contacted refused to participate or withdrew from the study.

Results

Characteristics of the Participants

This study comprised 54 participants, with 55.6% being midwifery students and 44.4% being newly qualified midwives. The mean age of the participants was 22.2 years (± 2.04 SD). All individuals involved in this study were female, reflecting the exclusive nature of the midwifery profession in Morocco, which is limited to women. These participants were selected from six Higher Institutes of Nursing Professions and Technical Health (HINPHT) ([Table 2](#)).

Table 2 Participants' characteristics

Variable	f	%
Gender		
Male	0	0.0
Female	54	100.0
Age		
	Mean = 22.20, SD = 2.04,	
	Range = 20-25	
Location		
HINPHT institute 1	6	11.1
HINPHT institute 2	11	20.4
HINPHT institute 3	8	14.8
HINPHT institute 4	16	29.6
HINPHT institute 5	6	11.1
HINPHT institute 6	7	13.0
Position		
Newly graduated midwife	24	44.4
Midwifery student	30	55.6

Thematic Findings

"Inadequate internship design" and "Insufficient clinical facilitation" were two main dimensions identified in this study, including six subcategories describing the barriers affecting the achievement of clinical learning outcomes as perceived by midwifery students and newly graduated midwives. Barriers are closely connected and common to all participants. [Figure 1](#) demonstrates the complexity of the different barriers.

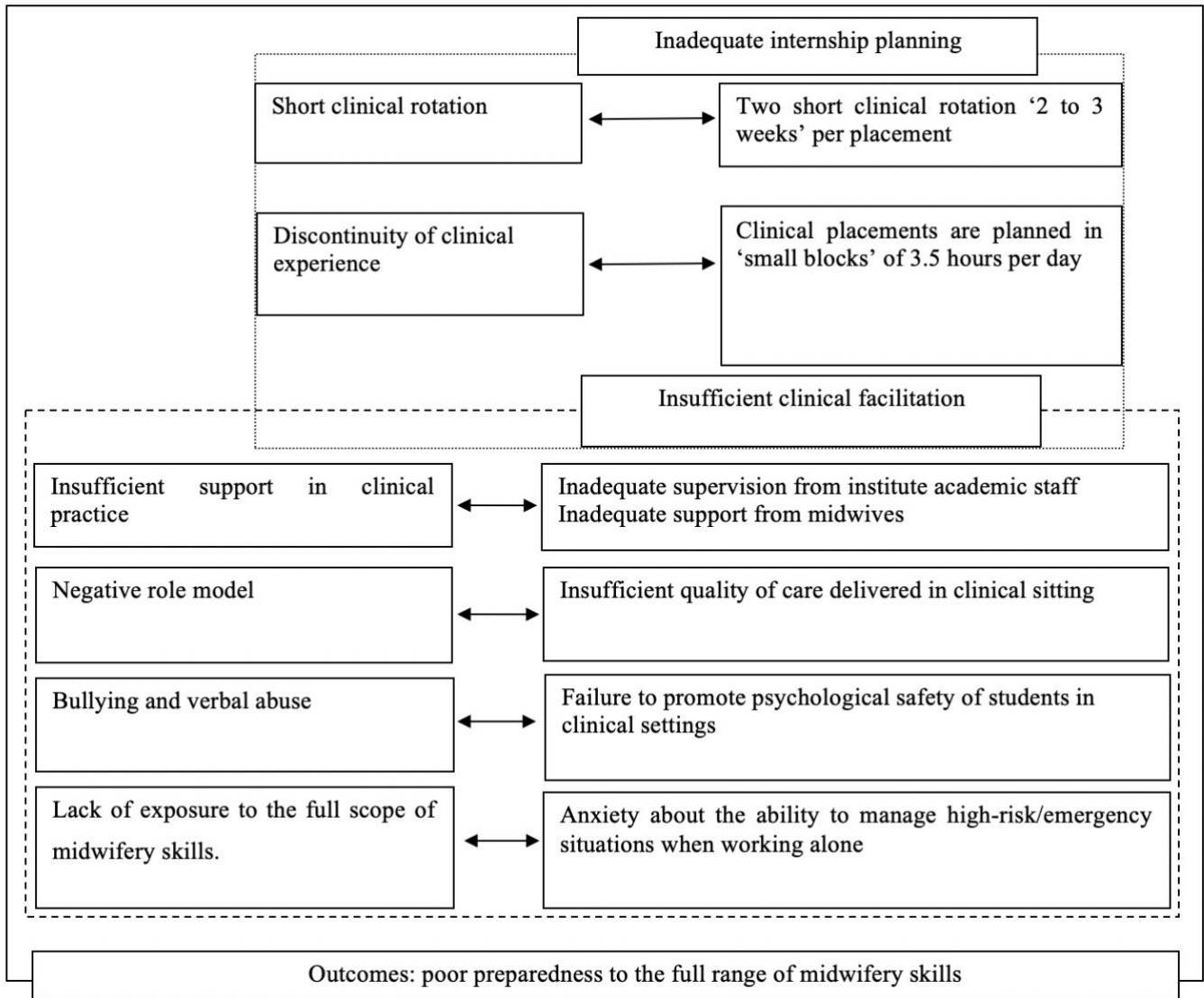


Figure 1 Illustration of barriers to clinical learning skills development among midwifery students and newly qualified midwives

Theme 1: Inadequate Internship Planning

The organization of placements emerged as a significant issue, as highlighted by most participants, and was perceived as inadequate for effective learning.

Short clinical rotation

Participants in the study expressed dissatisfaction with the clinical rotation model, particularly the short duration of placements, typically lasting '2 to 3 weeks'. They identified this short duration as a critical barrier to achieving the competencies outlined in the program. One participant, NGM28-5, remarked, "We don't achieve all our goals. In the fourth semester, I manage only one spontaneous vaginal birth because we don't spend enough time in the maternity ward. Also, the training period is not long enough". Another student, MS5-1, stated, "I'm going to semester 4, and I do not know how to suture an episiotomy".

Many participants elaborated on how short clinical rotations could affect skill acquisition, noting the significant time spent on "fitting in" and familiarizing themselves with the team, consequently impacting the learning process. MS41-7 said, "The first weeks are spent trying to settle in and build relationships with staff, which wastes time and affects the achievement of goals."

On the contrary, some participants mentioned that staff members take time to assess students' abilities before assigning tasks. They felt insecure about their knowledge and capabilities, which hampers their involvement in crucial tasks. MS53-9 commented, "Midwives first assess what students can do, usually delegating small tasks to us, because they think we are unqualified." Another new graduate, NGM29-5, added, "At the beginning of the internship period, the students are not allowed to work because the midwives are unaware of their abilities and their level of skills."

Discontinuity of clinical experience

Most participants mentioned the simultaneous planning of theoretical and clinical placements, arguing that dividing the time allocated to clinical training into 'small blocks' of 3.5 hours per day, from 8.30 am to 12.00 pm, interrupts ongoing clinical training and care protocols. MS50-9 expressed, "The scheduling of courses in the mornings, with lessons in the afternoon, makes continuity difficult and interrupts the process of caring for women. Sometimes, when a woman has reached an advanced stage of birth, we leave the ward".

The term 'short mornings' was used in this research to remind the educational coordinator that holistic and woman-

centered care requires longer clinical durations. Most participants stated that they could only perform small and fragmented tasks during the “short mornings,” which did not meet their learning needs. MS11-2 explained, *“In the mornings, we can only do small tasks requested by the midwives. Even if we manage a birth, we can’t provide postnatal care for women or newborns because we have to leave the ward at 12:00.”*

The majority of participants proposed the model of midwifery group practice placement with rotations between day and night shifts. The primary reason for most participants choosing this model was succinctly summarized by a new graduate, NGM17-3: *“Midwifery group practice placement makes the clinical learning experience more efficient, as it helps the student to settle in, build relationships with the staff and women, and offer the opportunity to provide ongoing care to women and newborns.”*

Theme 2: Inadequate Clinical Facilitation

The second theme that emerged in this study pertained to the experience of new graduates and students in the clinical environment. All participant groups discussed inadequate supervision and support for learners from both institute academic staff and midwives in clinical practice, describing the clinical environment as inappropriate for developing the skills outlined in the training program. Four sub-themes emerged: Insufficient support in clinical practice, Negative role models, Bullying and verbal abuse, and Lack of exposure to the full scope of midwifery skills.

Insufficient support in clinical practice

All participants mentioned the problem of lack of supervision and guidance by institute academic teachers due to a legislative issue in the country. MS40-7 stated, *“The teachers tell us that they can’t practice in the clinical environment because they have a legal problem; that’s why the staff supervises us.”* In contrast, most midwives do not accept teaching responsibilities due to their heavy workload and do not provide students access to execute essential tasks. At that time, some participants stated that they were used as an extra work resource. MS33-6 remarked, *“We do all the ward tasks and everything they ask us to do, and when it’s time to deliver, they put on the gloves and say they can’t take on the responsibility of teaching.”* Another new graduate, NGM28-5, added, *“Some midwives don’t allow students to manage a birth or conduct perineal suturing; they say they don’t have time to supervise.”*

In several group discussions, the participants reported being left to practice unsupervised and referred to being “alone in the ward.” They described the fear they experienced in the delivery room when the midwives left them alone. MS51-9 shared, *“Some midwives leave us alone in the ward without any supervision; I was really scared of committing mistakes.”* Even if they lacked support in their placements, third-year students were expected to demonstrate high-level skills, such as managing high-risk situations, during their placements and exam time. NGM16-3 expressed, *“In the six semesters, we were judged by the midwives and teachers as not ready for practice. I’m sorry, but they had to support us and help us develop the different skills of the profession before they could say that”.*

Negative role model

Most participants emphasized the importance of clinical role models, stating that they did not have an “ideal midwife” to follow or emulate. NGM29-5 remarked, *“We have never seen a practical demonstration by teachers, either in a clinical setting or in a simulation room.”* Although unintended, our study highlights the insufficient quality of care delivered. However, most participants reported that clinical practice does not meet standards of good practice and is not based on scientific evidence. MS5-1 noted, *“We are supported by midwives who don’t respect the standards of good practice, such as using drugs at inappropriate times to accelerate the birth and making septic mistakes.”*

On the other hand, the students had to imitate what the midwives were doing to be quick and avoid being criticized and misjudged. NGM46-8 shared, *“You have to work the way they want you to; otherwise, you may be misjudged because slowness is not accepted in a clinical environment.”*

Bullying and verbal abuse

Workplace bullying and verbal abuse were the most frequently discussed barriers to achieving clinical outcomes, participants reported. NGM22-4 stated, *“They (midwives) undervalue our efforts and skills, and they make verbal abuse several times in clinical settings. We spend all day doing work that doesn’t meet our objectives to satisfy them, and yet we are insulted.”* New graduates and midwifery students were exposed to the belittlement of their approach to patient care and disparaging comments about higher education, often in front of mothers. NGM15-3 shared, *“They criticize the way we work in front of women and their families. How do you think women can allow students who are deemed incompetent to care for them?”* Participants said that when they report forms of violence to their education coordinators, they advise them to put their heads down to learn. NGM29-5 mentioned, *“Our pedagogical coordinator and teachers said that it’s not surprising to get a bit of criticism in a clinical setting and that we should keep our heads down if we want to learn.”*

Lack of exposure to the full scope of midwifery skills

The issue of lack of exposure to the full range of midwifery skills was the dominant theme in all the group discussions. Participants highlighted that they compete with other students from private schools and medical students who also need to gain clinical experience, which limits the opportunities for learning and delays the acquisition of skills. NGM18-3 explained, *“We work with our peers, students from private schools, and doctors. Competition is strong; the short duration of the internship and the number of trainees impacted the acquisition of new skills”.*

According to most participants, students are not allowed to provide direct care to women and newborns in obstetric emergencies. They cited examples such as perineal and vaginal trauma suturing, neonatal resuscitation, management of postpartum hemorrhage, and eclampsia. NGM47-8 shared, *“In clinical placement, we’re not allowed to take part in the management of emergency and high-risk situations. I’ve never managed neonatal resuscitation, postpartum hemorrhage, or vaginal trauma suturing.”* As a result, most of the new graduates expressed anxiety about their ability to manage high-risk and emergency situations when working alone. They

stated that they were unable to acquire the full range of midwifery skills. NGM30-5 said, *"I developed many skills during training, but I'm scared of emergencies and situations at risk."*

Discussion

This study aimed to explore the barriers impacting the acquisition of essential competencies for midwifery practice, with implications for practice and education. The results revealed that the internship design was perceived as suboptimal, thus affecting learning outcomes. Reasons for this included the short duration of clinical rotations and the discontinuity of clinical experience. This finding aligns with previous research, which suggests that longer midwifery practice placements offer students a more comprehensive learning experience and aid in the development of their professional identity (Baird et al., 2022). Conversely, short clinical rotations appeared to hinder the establishment of familiarity between staff and students and influence their interactions with patients (González-García et al., 2021).

Furthermore, this study highlights the importance of continuity in clinical experience and the necessity for significant changes in clinical planning. However, discontinuous placements posed challenges to the learning process, as students could only undertake small, fragmented tasks that failed to meet their learning needs. This issue is particularly complex in hospital settings, where continuous care during labor and birth is essential. In such contexts, the learning process within relationships may be compromised, leading to gaps in students' skills upon completion of clinical placements. Thus, participants in this study strongly favored the group practice model of midwifery training, which involves rotations between day and night shifts.

Numerous international studies support these findings, highlighting the positive outcomes of continuity of care for both students and women (Baird et al., 2022; Kuliukas et al., 2023). The model of learning through continuity of care can inform the design of learning and assessment processes by developing measurable learning outcomes (Tierney et al., 2023). This approach has the potential to enhance the quality of care and reduce rates of maternal and neonatal morbidity and mortality (Nove et al., 2021). However, in countries like Morocco, where models of continuous midwifery care are limited, organizing such immersive experiences can be challenging. Therefore, policymakers and midwifery educators must collaborate to redesign clinical scheduling, which is identified in this study as a barrier to achieving clinical outcomes.

The results of two ICM congress workshops suggest that organizational constraints in many countries have resulted in a cessation or reduction in the involvement of midwifery educators in clinical practice (Bharj & Embo, 2018). Additionally, the World Health Organization (2019) indicates that midwifery educators in many countries, predominantly LMICs, are unable to access clinical sites for practical teaching. This finding is supported by the results of this study, leading to discussions about supervision and understanding that some qualified midwives are unwilling to take on the additional role of supervision due to the complexity of the task and their heavy workload. Similar results have been observed in other countries (Ahmadi et al., 2018; Zwedberg et al., 2020).

In such a poor educational environment, students are expected to develop essential competencies for midwifery practice without teaching or guidance, which may affect the quality of their preparation for the new midwifery role.

The State of Midwifery Practice in the World 2021 identified inadequate practical experience for students as one of the main issues affecting the quality of midwifery education (United Nations Population Fund et al., 2021). Results from this study also reported that students are exposed to several challenges, such as being assigned to less important tasks that do not meet their learning needs or, conversely, tasks beyond their level of competence. Similar issues were reported in other studies, which found that midwifery students were exploited to undertake menial tasks (McCarthy et al., 2018), used as an extra work resource (Zwedberg et al., 2020), and asked to work outside of their scope of practice (Simpson et al., 2023).

The quality of care provided in clinical placements is crucial in helping students become competent midwives (Dimitriadou et al., 2015; International Confederation of Midwives, 2022). However, in this study, discussions within the focus groups highlighted the poor quality of care provided to women and newborns as a characteristic of the negative role model. Results also revealed that students were expected to mimic the behavior of the staff to fit in, raising questions about the quality of midwifery training and emphasizing the urgent need for competent, trained preceptors to supervise students and oversee their learning in clinical placements.

Similar to studies in midwifery (Capper et al., 2020; McKenna & Boyle, 2016), the new graduates and students in our study highlighted that they were exposed to a range of workplace bullying and violence experiences during their clinical rotations, including intimidation, belittling students' approaches to patient care often in front of mothers, undervaluing effort and skills, and making disparaging comments about higher education. This may be partly due to the lack of recognition and formal training for midwives who take on teaching roles (Capper et al., 2020, 2021). Challenging students in their practice in front of women erodes their confidence in students and encourages mothers and their relatives to be aggressive. Bullying impairs women's confidence in the student and the profession (Capper et al., 2021). Therefore, midwifery educators are responsible for promoting students' psychological safety in clinical sites to enable them to engage in effective learning (International Confederation of Midwives, 2022).

The present study revealed that midwifery students are not allowed to provide direct care to women or newborns who present an obstetrical risk or emergency. However, the safety of the mother and the unborn child is imperative in a high-risk environment. As a result, very little teaching can be done during these emergency situations (Amod & Brysiewicz, 2017). Using simulation-based training to manage obstetric emergencies improves clinical skills, patient safety, and quality of care (Amatullah, 2018). Thus, several studies and reviews have demonstrated the value of simulations in preparing midwives for clinical practice (Amod & Brysiewicz, 2017; Stoodley et al., 2020). These findings support the need to improve investment in midwifery education to achieve the required outcomes.

This study offers valuable insights for midwifery program leaders, healthcare professionals, and midwifery educators in Morocco and similar countries, especially LMICs. To prepare a skilled workforce capable of managing high-risk situations, Morocco and similar countries should effectively translate evidence into practice by implementing a well-documented placement model supported by evidence and designed to promote continuity of care for learning and assessment (Baird et al., 2022; International Confederation of Midwives, 2022; Kuliukas et al., 2023). Additionally, this study supports the need for developing a valid and effective preceptorship program tailored to students' needs and aligned with international guidance for meeting the ICM Global Standards for Midwifery Education (International Confederation of Midwives, 2022). Eventually, simulation-based training is necessary to address issues in the clinical setting and prepare students for the full range of midwifery practice. This is particularly crucial in high-risk and emergency situations when teaching cannot be carried out to ensure patient safety. Strengthening the global midwifery workforce requires effective investment and coordination among stakeholders, including HINPHT institutes, clinical settings, and policymakers.

Strengths and Limitations

This qualitative study highlights the challenges facing Moroccan midwifery educators in preparing midwives for the full spectrum of midwifery practice. To our knowledge, this study is the first to examine the barriers affecting the achievement of clinical learning outcomes among midwifery students and new graduates. However, several limitations were identified in this study. One limitation is that it is confined to the Moroccan context, while another limitation is that the study was conducted in six institutions, whereas there are 24 institutes across the country.

Implications of the Study

This study highlighted several implications for midwifery education and practice, as quality midwifery education is essential to prepare competent midwives who can provide quality maternal and newborn care. However, the revision and implementation of a competency-based program as an isolated measure will not ensure the required outcomes; parallel interventions to improve clinical learning outcomes must be implemented. The preceptorship program can help overcome some of the challenges in the clinical environment, as 50% of the midwifery program is in the clinical environment with midwives. The evidence highlighted that trained preceptors are optimal for student confidence and competence (Ball et al., 2022). Another key solution to preparing competent midwives to provide quality maternity care is to invest in midwifery education (World Health Organization, 2019) by offering institutes and clinical placements with equipment and resources, including simulators, to enable effective teaching and learning.

Conclusion

Barriers to the achievement of clinical learning outcomes of midwifery students in Morocco include the internship design, insufficient support in clinical practice, negative role models,

bullying and verbal abuse, and lack of exposure to the full range of midwifery practice skills. This results in the inadequate preparation of newly qualified midwives to manage high-risk and emergency situations. This could explain the high rate of preventable deaths in Morocco previously explored in the literature. Effective implementation of the revised CBE program is suitable for strengthening the midwifery profession and enhancing the quality of care for childbearing women and newborn infants in Morocco and other countries with similar challenges.

Declaration of Conflicting Interest

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Authors' Contributions

All authors contributed substantially to the design, analysis, interpretation, and writing of the paper. All authors approve the final version to be published.

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Data Availability

The datasets generated during and analyzed during the current study are available from the corresponding author upon reasonable request.

Declaration of Use of AI in Scientific Writing

The authors have declared that no generative AI was used in writing.

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