Scientific Research Publishing

Open Journal of Nursing, 2025, 15(11), 1019-1036
https://www.scirp.org/journal/ojn
ISSN Online: 2162-5344
ISSN Print: 2162-5336

Evaluation of CSU Entry to Practice Midwifery Program and Graduates Since 1990

Linda K. Jones

School of Nursing, Paramedicine and Healthcare Sciences, Charles Sturt University, Wagga Wagga Campus, Wagga Wagga, Australia
Email: lindylookatherine@gmail.com

How to cite this paper: Jones, L.K. (2025) Evaluation of CSU Entry to Practice Midwifery Program and Graduates Since 1990. *Open Journal of Nursing*, **15**, 1019-1036.
https://doi.org/10.4236/ojn.2025.1511072

Received: October 19, 2025
Accepted: November 18, 2025
Published: November 21, 2025

Abstract

Introduction: This examined the career trajectory of people who had completed midwifery studies at Charles Sturt University since it started in 1990. Questions were also asked about the details of the midwifery education they undertook and if they had identified any issues that need addressing in future curricula. Methods: Qualitative exploratory descriptive methodology was employed with the development of an open-ended questionnaire distributed to CSU Alumni from 1990. Questions asked about various aspects of the course as well as what they had done since graduating. Results: There were 46 responses received. The majority were still working in midwifery in various roles. Generally, the graduates spoke favourable about the course for several reasons including, content relevant, and online was interactive. Though studying online was identified as being difficult for various reasons. The course itself was identified as being demanding, and intense. There were several comments about clinical experience including that it was the highlight of the course and being very valuable for developing knowledge and skills. These students also reflected on the benefits of being paid while undertaking the course. The issue of support and bullying in the workplace, however, was highlighted as a concern for many of the graduates. Conclusion: This was the first evaluation of the CSU entry to practice midwifery course which highlighted the need to increase support for students during the clinical experience.

Keywords

Midwifery Students, Education, Career, Evaluation

1. Introduction

There are currently 23 universities across Australia that offer entry to practice pathways for midwifery [1]. This includes three pathways, including Bachelor of Midwifery, and a double degree in nursing and midwifery and, a Graduate Diploma in Midwifery for people already nurses who want to be a midwife. There is

also a graduate entry Master of Midwifery [2]. The Bachelor of Midwifery (commenced 2002) and double degree are recent entry to practice pathways with the Graduate Diploma in Midwifery being the first program available to become a midwife in NSW.

Initially midwifery education was for nurses who wanted to be midwives [1]. Charles Sturt University (CSU) was the first one of two universities in NSW that commenced the pathway for nurses to become midwives in 1990. The University of Technology, Sydney (UTS) was the other university. Charles Sturt commenced with a Graduate Certificate in Midwifery with an enrolment of four students from one regional hospital maternity unit [3]. The aim of the program was to enable registered nurses to study and gain midwifery clinical experience while living and working close to their homes and communities [4]. UTS focused on three metropolitan hospitals from one area health service initially. Both programs were organised with the affiliated maternity units to employ the midwifery students during their clinical experience four days per week.

The CSU program was then restructured in 1999 as part of the university wide initiative to provide for the education needs more adequately for health professionals [5]. From this initiative, the Graduate Certificate became the Graduate Diploma in Midwifery. The focus of recruitment and enrolment continued to be rural hospitals in NSW. From this humble beginning and initial focus of partnering with NSW hospitals, CSU now enrols up to 150 midwifery students annually with two intakes per year and partnering with maternity services across Australia who are accredited to employ Charles Sturt University midwifery students. This has also continued to be an employment model of four days per week for undertaking their clinical experience.

There are 33 years of midwifery education that CSU has provided. There is little information about the career trajectory of these graduates or whether the graduates continued to be employed in midwifery. This research aims to examine the career trajectory of people who had completed entry to practice midwifery studies at CSU since it started in 1990 as well as evaluating the course generally.

2. Methodology

Qualitative exploratory descriptive research facilitates the exploration of an area where no research has been undertaken and is the methodology used for this project [6]. Ethics approval was obtained through CSU Ethics Committee H23928.

2.1. Sample

All midwives who had graduated from CSU University from 1990 onwards were invited. Using a convenience sampling method, an invitation was disturbed through the Alumni to 731 graduates. This included a plain language statement outlining information about the research and ethical considerations.

2.2. Data Collection Procedure

A questionnaire was developed consisting of a series of open-ended questions ask-

ing participants about various aspects of the course as well as their career trajectory since graduating from CSU. This was then distributed to graduates from CSU using survey monkey. Questions included when and why they decided to study at CSU, their thoughts about various aspects of the curriculum, what hospital they undertook their clinical at and how they felt about this experience, where they had worked since graduating and in what positions, whether they had undertaken other study and finally whether they were still working as a midwife.

2.3. Data Analysis

Data was exported from survey monkey into Word. This data was then read through with the focus to undertake thematic analysis and coding, as an inductive, data reduction process. Thematic analysis is a systematic process that allows the researcher to go through three major steps of: identifying patterns in the data; classifying or encoding the patterns; and interpreting the patterns [6]. The process involved first reading and then re reading the responses to questions; data was then assigned to categories which had meaning with quotes identified to illustrate this; this was then categorized into themes which were then refined following another reading of the responses to finalise the themes and quotes used [7]. Triangulation occurred through combing different individual responses to different questions to ensure rigour [6].

3. Results

The questionnaire was opened by 330 graduates. Of these there were 46 responses yielding a response rate of 14%. Not all the participants answered each question, however. From these responses the range of years participants graduation was between 1998 and 2024, with most graduating in 2019 (n = 12 or 26%) (see **Table 1**). Participants were all female, aged between 26 to 55, predominantly from rural locations in NSW (78%).

Table 1. Year graduated from CSU.

Year	Number
1998	1
2005	1
2015	3
2016	6
2017	2
2019	12
2020	4
2021	5
2022	4
2023	4
2024	2
Not provided a year	1
	46

Participants were asked to identify why they choose to undertake an entry to practice midwifery course at CSU. The majority identified that CSU was the preferred course by the hospital they had applied to undertake midwifery clinical placement and the fact that they lived in a rural area which made the flexibility and the course being online, a more attractive proposition. Specifically, the flexibility referred to as not having to attend weekly classes face to face. Being an online course was also mentioned in other responses together with being a 12-month course and having a mid-year intake. The fact that graduates had undertaken their Bachelor Nursing course at CSU was also expressed as another reason for doing further study at CSU (see Table 2).

Table 2. Reasons for choosing CSU to undertake Grad Dip Mid.

Reason for choosing CSU	Numbers
Did Bachelor at CSU	6
Preferred course by hospital/midstart	12
Working at Wagga/closest university	3
Always dreamed of being a midwife	2
One year course, support from hospital, online	2
Live rural area, offered online, flexibility	10
Online, minimal residential	1
Could work as RN while doing placement	1
Mid year intake, accepted by hospital	4
Had to redo mid as registration lapsed	1
Travel contracts and OS opportunities	1
Credit applied for Grad Dip Mid	1
Flexibility to work in Sydney while doing residential rather than travelling for weekly classes	1

Participants had undertaken their clinical placement mostly in rural maternity units (78%) across NSW with some in Sydney, both private and public maternity units and in Canberra. Specific numbers and which hospitals is not presented here to prevent potential identification of participants.

3.1. Career Outcomes

Most of the participants worked in a maternity unit (90%) after graduation in various hospitals across NSW mainly, including both rural and metropolitan. The remainder worked in nursing roles. For 28% of the graduates, they stayed working in the same hospital they started at as a student. Since graduation many expressed that they had worked in many different roles in maternity as a midwife, either in the same hospital, in different hospitals and even in different jurisdictions. Not all identified specific roles but those that did included continuity of midwifery care (13%), teaching (10%), management (6%), air ambulance (6%), overseas (6%) or

research (3%). There were some participants who had time out of midwifery to have a family or for other reasons but have since returned to work as a midwife (10%).

Some of the participants were not working in midwifery at the time of completing the survey (10%). This was for a number of reasons including (see Table 3): opted out of shift work due to family and now working in child and family health; working casually; working as a nurse at the same time; research role; considering career change in next 5 years; yes but not for long. There were several comments made that illustrated why participants were considering a career change indicating issues in maternity services: *last 18 months have killed my passion, actively seeking to leave; felt too stressed, under supported and not valued as employee; and I would love to work in antenatal and postnatal but not possible in smaller facility.*

Table 3. Whether still working as a midwife and why if not.

Still working as a midwife		Not working as a midwife	
36		4	
Working parttime and nurse	2	Trying to get midwifery position	2
Research/university	2	Opted out of shifts for family reasons, MCHN	1
Management	2	Felt too stressed, unsupported and not valued	1
Casually	1		
Considering career change	2		

Table 4. Further education undertaken.

What further study was undertaken	Number (n = 43 responses)
No	24
Plan to in the future	6
Masters and PhD	1
Master Advanced Nursing	1
Master Midwifery	4
Master Global Health	1
Master Primary Maternity Care	1
Graduate Diploma Clinical Education	1
Graduate Diploma Diabetic Education	1
Graduate Diploma/Cert Child and Family Health	4
Graduate Certificate Leadership and Management	2
Graduate Certificate Maternity Critical Care	1
Certificate IV training and assessment	1
Immunisation Certificate	1
Prescribing course	1

Most of the participants (53%) had not undertaken any further education since graduating from CSU. Table 4 illustrates the range of further education that had been undertaken or is planned.

3.2. The Course Itself

The questionnaire asked the participants what they thought about the course and these responses have been themed into "course overall", "residential" and "clinical experience". Generally, participants commented that this was a good course, commenting that they *"really loved the course"* or *"enjoyed the course"*. There were several reasons expressed as to why this was the case, including the fact that the course was *"straight forward"* because it was *"very structured and easy to follow"*. Overall, the course was *"well planned and easy to work around schedule"* with some participants commenting that there was nothing that needed improving.

Content was one aspect that contributed to the course being good because the *"content of course was relevant"*, referring to the relevance to their clinical practice. Though there was a suggestion made that there was a need for *"consistency with teachers, marrying up textbook with reality of practice"*. The theory practice gap is something that there has been a lot of discussion in the literature about regarding university education [8]. In contrast participants commented that the *"learning and teaching materials were of good quality"* and *"well written"* and there was a *"well supported online component"*. The course content was also considered to be *"interactive"*. Having interactive course content has been documented to assist with student engagement and is obviously a positive here. This course material was also enhanced by *"the lecturers being inspiring"* as well as being *"hilarious and engaging"*. As a result, participants commented that they had *"learned a lot"*.

Another positive aspect identified by the participants was the fact that they were *"able to work while doing it online"*. Obviously being able to work also meant the midwifery students were earning an income to support them through the course. Not all entry to practice midwifery courses employed students during their clinical placement. In other universities, students had to work in nursing to gain an income which added an extra aspect to the already busy process of undertaking the course.

Participants also felt that the course was a *"very hard year working and studying but worth it"*. Others commented that the course was *"rewarding and enjoyable"*. It was a *"full year but enjoyable course and content"*. There was, however, a dichotomy of feelings about the course which can be summarised by it being *"stressful, chaotic but overall rewarding, amazing and empowering"*. Maybe a reflection of the intensity of the course explains why some participants believed that a favourite part was actually *"finishing the course"*. This could also be because they could then be employed as a midwife but there was no evidence in the data to clarify this statement. One of the issues with university study expressed by participants was *"it was expensive"*. This is something that has been highlighted in the literature about higher education generally [9].

There were, however, some comments expressed that provides some insight into why some participants describing the course as stressful saying that *"all work done by coursework online was difficult"*. The alternative would have been potentially weekly face-to-face sessions at the university which was highlighted earlier as something students preferred not to do and why they choose CSU. There is no doubt though that students believed that it *"would have been good to have more face to face time with other students"*. In other words, *"more interaction with other students"*. This reinforces the comments students made about the residential sessions and how useful these were in sharing experiences and gaining support from their colleagues. This was also about the contribution that this residential has to their learning. Learning online can be a lonely experience and requires motivation on the part of the student to undertake the online work in the first place which contributes to the difficulties students expressed.

The flexibility of being online was identified as an advantage but also presented difficulties from comments being made such as the need for *"more support navigating the site to begin with"*. This identified the difficulties that students had understanding how the online site could be best used for learning. Having consistency across subject sites may help with this but also more time spent on orientating students to the site. Another aspect of the online component that participants commented about was that they wanted *"less participation in online forums as part of coursework"*. This may refer to requirements that students have to answer questions about subject content online or make comments about a discussion point. Again, this was not clear in the data. There were also comments made about the desire to have *"more regular catch up on zoom"*. This is an interesting comment to make as there is reported to be a lack of attendance of students at zoom sessions but possible reflects individual learning needs.

Assessment was the other component that students commented on, specifically wanting *"less assignments"* and the fact that *"3 essays for one subject is too much"*. The other area that was not favourably commented on was *"group assignments difficult to achieve online"*. This is a constant point of contention for academics as many students" dislike group assignments yet the skills of learning to collaborate with others is an important skill to develop. Ultimately, participants believed that *"follow through and hands on experience is worth so much more value than assignments, feel more emphasis should be on hands on learning"*.

There were also some comments made about the midwifery academics and the need for *"teachers being more reachable"*. In addition, was the suggestion for there to be *"more connection between educators at university and at placement"*. It is crucial for universities to have a close relationship with hospitals to enhance the overall education experience, something that is discussed more under the clinical component.

There were a lot of components to this course which contributed to it being considered by some of the participants as being *"one of most stressful periods of life"* and being "demanding and challenging", taking *"a lot from me emotionally and mentally"*. This could be explained as resulting from the course requirements

of "study, continuity of care experiences and work". In other words, "*challenging in terms of workload* (20 CCE, 0.8 clinical and FT study)". The juggle between these requirements resulted in a *"lot of work and little time to do everything"* as well as being *"very busy"*. The consequence was that this *"involved a lot of personal/family sacrifice"* and *"very little time to actually live life outside of university and work"*. Many participants expressed that they were *"glad it was only 12 months"* rather than being longer. Other universities Graduate Diploma in Midwifery courses were between 18 to 24 months. Despite comments about the intensity and hard work of the course, participants commented that this *"prepared me to work as a midwife"*. In contrast, there was also some positive comments made by participants about the workload resulting in them saying that the *"course made me a better midwife due to having a higher number of continuity of care experiences"*. Despite being *"quite intense ... we were well supported by staff hospital and by lectures at university"*. Not all participants agreed about being well supported in the hospital, however, discussed below.

A suggestion was made as to how to help make the course less intense which was to have *"more flexibility with work, study and continuity of care requirements"*. A suggestion as to how this could occur was to have *"more time spent supernumerary as it can be incredible hard to meet course expectations like CCE appointments and births when the ward expects you to be at work with a patient load"*. The problem with this suggestion, however, is that there is a shortage of midwives making this difficult to achieve but in an ideal world, is how clinical placements could be.

3.3. Residential/Intensive

One of the positive aspects of the course identified by participants was the residential, now called intensive, face to face sessions as the *"block education days being most rewarding"*. There were several reasons identified including because this helped *"consolidate learning"*. In addition, participants liked the residential because this meant *"meeting other students in person and collaborating"*. It was also because they were *"able to connect with wonderful bunch of students that were able to support each other"*. This related to having a shared experience and *"feeling like they all understood what you are going through"*. Many students may have been the only student working at one hospital or were the only one on a shift so did not necessarily see other students at all or infrequently, making this a lonely experience. Being together during residential also meant that the students could *"get together and share our experiences"* and was *"excellent for networking"*.

Not all agreed the residential was positive reflecting that there was a need for an *"improved block experience"*. The following provides some insights into what was needed:

Labs at Albury were average. It would have been better to have funding for entire week. It would have been better if there were more facilitators and improved equipment. Prior to labs would have been good if staff sent out for suggestions to what students needed to learn.

Ultimately participants believed that there was a need for more face-to-face time as indicated in this quote and echoed by other participants who basically wanted *"another residential"*. It was not clear from the data, however, whether this was a reflection on the need for more content or the value the students placed on the networking and support they received from other students during these sessions.

There was, however, some suggestions for what specific adjustments to content needed to help improve the residential such as *"Obstetric emergencies, neonatal care and high-risk pregnancies were not covered enough"*. This indicated that some of the content needed developing more and spending more time on. In addition, there were suggestions of other content that needed including such as on *"education on advocacy and how to approach emergency situations with a focus on reducing birth trauma for women"*. Residential content is continuing evolving over time with some of these suggestions already being incorporated.

The location of the residential was viewed as contentious by some participants because it *"seems ridiculous that it is in Albury when Dubbo would make it easier for all students"*. This is referring to the fact that Dubbo is central NSW with students undertaking their clinical placements from as far north as Tweed Heads, south as Bega and east metro Sydney would have similar distances to travel. In other words, *"move residential school to more central location of state like Dubbo"*. This was echoed by another participant wanting the *"residential closer to home. Was long way to go"*. Having students across NSW would have in fact made this difficult to achieve, however. There was a suggested compromise to this though that may help address this issue, *"varying location of residential to cater for all students travelling from northern NSW to Wagga and Albury is a long way"*.

3.4. Clinical Experience

Overall, there were more positive than negative comments about the clinical experience with it being described as *"the highlight of the course"*. This was because of the *"On job learning"* through the *"48 weeks clinical"*. This was because the *"employed model of training was an excellent experience and ensured max engagement from myself"*. In other words, *"being on wards was most valuable experience"*. It was more than just being on the wards as identified from this comment, *"working in industry while studying, getting paid to learn"*. This further emphasises the importance of being paid for this clinical experience and, therefore, enabling the students to be more focused on midwifery rather than having to work in nursing at the same time to gain funds (Geraghty *et al*., 2025).

Various aspects of this clinical contributed to this positivity and included the *"continuity of care experiences"*. This was not just about the learning that this opportunity provided but also because *"being able to meet and join 10 mums to be on their newest journey was so amazing to be a part of. Women are amazing"*. The other positive aspects of the clinical included the births, specifically the *"first spontaneous vaginal birth"* and *"watching normal birth with no interventions for*

first time". This can be summerised from the following comment, *"practice side where we were able to assist women during this vulnerable period of life and empower them"*.

There were also aspects related to individual students" circumstances that made clinical positive, such as the advantage of the clinical being *"local to where I live"*. This was an important aspect of studying at a rural university and having local placements as the student is more likely to stay at the same hospital after graduation. For some of the students one of the advantages was that the hospital where they undertook their clinical was *"my place of employment before started, know staff"*.

Another positive aspect of clinical expressed by the participants was they *"got wide range of experiences"* plus that they had *"ample opportunity to get required skills"*. Depending on the hospital the student was employed at they generally worked in one specific area for a period. For example, postnatal ward for 6 weeks and then rotate to another area. Other hospitals did not have rotations like this and instead the student was rostered into a different area each day they worked. For some this was seen as an advantage because they *"did everything all together. Going from clinic days to births is good for continuity"*.

Some Local Health Districts rotated the students between the various hospitals in that district. This meant that students would rotate from bigger to smaller hospitals but meant the student had to travel and but away from home at times. This was seen as an advantage but not without its difficulties as illustrated here:

"it was a diverse experience with different models of care and different challenges in each hospital but outstanding staff with decades of experience. Accommodation in nurses home at each place and rostered day or evening shifts Monday to Friday. Was ideal but did have husband at home caring for kids".

The other advantages identified by the students that undertook their clinical at this LHD was the *"ability to upskill in larger facility"* and the ability to *"learn being a referral service for smaller communities - good mix of normal, complex experiences"*. The problem identified with this placement was, however, it *"would be a challenge for those with families who did not have support to be away from home"*. This ability to rotate to other hospitals was identified by participants to improve clinical and be proactive instead. In other words, *"having a placement in city included. Because it was such a rural hospital with low births, it became a bit of a panic towards end to get 40 births. Places with low births should include rotation"*. Taking this further was another suggestion, *"offer placement for rural students to attend larger hospital and vice versa"*. This certainly would help address some of the issues identified here but also comes with its own problems such as accommodation, travel and family that would need to be addressed with funding to support student.

Achieving the clinical requirements needed to graduate was identified as an issue by some students who were employed in a small, usually rural hospital. This was because

"I moved from small remote to a larger hospital half way through due to feeling that there were not enough births to facilitate two students and a very junior workforce who largely only experienced low risk births".

As can be seen from this quote it was not just about the clinical requirements either and is a common problem in maternity units with shortage of midwives across the sector resulting in a loss of senior experienced midwives. There is, however, another side to this as hospitals receive pressure to employ more students than they probably should due to the shortage of midwives generally. The result is expressed here *"there was definitely some teething issues related to hospital taking on so many midwifery student"*.

In contrast, was the experience students had in larger hospitals which had advantages and disadvantages. The advantages of a larger hospitals were that there was *"many pregnancies, births and ability to provide care and gain experiences"*. The disadvantages with larger hospitals were *"Incredibly tertiary with little option for midwifery led care"*. Larger hospitals are usually referral hospitals which tends to mean women with complexities are referred there. The implication is that students *"did not experience a lot of normal physiological labour and births"*. Consequently, some students used their own initiative to gain more *"normal" experiences was to recruit women who birthed at [small rural hospital] or at home"*. There was also a suggestion made by another student to help address this issue generally *"make it possible to link with private practicing midwives and be able to experience normal physiological labour and birth, being with women"*. The problem with this of course is the insurance cover necessary. Some universities actually do collaborate with private practicing midwife business to accommodate this. Since many of these have graduated, there has been a change in the insurance issues to the better which may make this feasible but would need to be addressed at the university level.

For some students what helped the clinical experience is illustrated here as they *"found support I received at hospital made it work"*. This included the midwives they worked with on each shift as *"midwives were supportive and had vast variety of skills and knowledge. Allowed me to learn what normal, women centred care actually was"*. In addition, participants said they had "absolutely amazing supportive staff, educators and management". In other words, *"I was really lucky to have an amazing education team at hospital. Some people struggled"*. There were many comments from the participants about the issues they encountered where there was not such good support in the hospitals. Many stating there was a need for *"better support in hospitals"*. As discussed earlier, this is a very intense course with students having to learn a lot of new knowledge and skills, embrace a different philosophy of care and learn a whole new language. It was, therefore, important to *"ensure students are supported, supervised and feel safe"*. This is an important issue that has been identified for retention [10].

Students provided excuses as to why they were not receiving the support needed. This included that *"hospital educators are understaffed and too over-*

worked to support students". There were also general issues such as *"under staffing and unit issues made it challenging"* and therefore difficult to provide the support. What these unit issues were was not clear from the data but could be explained by the following comment, *"maternity unit did not have stable management and very much affected our placement"*. This would create a level of uncertainty and change for all staff in the unit making it difficult for them to support students as they are busy dealing with these changes themselves. Rather concerning, however was the potential consequences from this as identified here as students were *"continuously pushed into postnatal. Extremely unsafe situations for both women and confronting for students"*. This was referring to the lack of midwives in postnatal to support the students meaning that they were likely to be unsupervised caring for women and their newborn.

This was not just about the availability of midwives/educators who could provide support. For some students *"at times educator was horrible"*. There were unfortunately some students who commented that *"the educators were bullies"*. It would appear from the data, however, that this was not just the educators as illustrated here *"some elements of bullying with cliques at hospital"*. Plus being *"bullied and hearing what is being said about you behind your back"*. This sentiment was so strong that a suggestion was made to, *"have placements vetted to make sure they are actually fit to mentor and facilitate students"*. As well as the suggestion that there *"needs to be closer monitoring to ensure students is not treated as a staff gap filler and actually supernumerary so they get the learning they need"*.

There were several other suggestions to help overcome the lack of support in the hospital. This included: *"would have been good to have been assigned a mentor from the uni to debrief and clarify learning from the clinical setting with"*. This would not help support the student from the hospital side or resolve that issue but would provide an avenue for the students to discuss their concerns and help support their learning. Another suggestion made was that the

University could send out facilitator a few times throughout the year to make sure students are supported enough by their employers! Often students who report system problems get targeted. So I believe this would be good way to demand compliance by employers!

This quote also identified another issue that students may experience as they try to address the issues directly through the hospital themselves, that is, they become "targeted". In other words, the student is intimidated, annoyed or degraded, all forms of bullying.

4. Discussion

Being aware of the graduates' views of a course can help provide academics with valid information to help improve the experience for the student, produce strong graduates who provide optimal care to people receiving maternity care. Generally, the graduates spoke favourable about the course for several reasons including, being structured, easy to follow, content relevant, online was good quality and in-

teractive, lecturers were inspiring and learned a lot, and being able to work while doing online study. Though studying online was identified as being difficult, and they would have liked more face to face and more interaction with other students. The course itself was identified as being demanding, challenging, and intense. This response was similar to another study's findings [11]. Residential was identified as a positive aspect for several reasons including, helping consolidate learning, connecting with peers and sharing experiences, location of residential was controversial, and suggestion for development of some content. Evaluation of this course generally was favourable and reflects other entry to practice midwifery course evaluations [12]. This course, like any other, evolves each time it is evaluated during the accreditation cycles and therefore many of the issues identified by these participants would have been addressed in subsequent iterations.

A significant component of the entry to practice midwifery courses is the clinical placement enabling the transfer of knowledge, skills and to become socialised into midwifery practice culture/profession [10]. This makes the quality of this clinical experience critical to becoming a midwife. There were lots of comments in this evaluation about clinical including that it was the highlight of the course and being very valuable for learning knowledge and skills, the positive side of working with women, and that they had wide range of experiences. These students also reflected on the benefits of being paid while undertaking the course which is something that has only recently been evaluated [13] and supported as an issue by others [14] [15]. This recent research also commented on the challenges students had though regarding lack of exposure to experiences, something also highlighted in students comments here [13]. Concern was expressed about achieving the requirements in smaller hospitals, and on the other hand placement in larger hospitals restricted the exposure to normal experiences. The support students received from midwives and educators was a bonus with many students, however, reflecting on the lack of support they received as well as bullying.

Support has been identified as a significant contributor to how students gain knowledge and skills and become a midwife [10]. It is critical that students are supported through this experience and respected [16]. Having a positive learning environment encourages students to develop knowledge and skills [17]. Support is twofold and includes taking responsibility for students' progress but also to some extent protecting them from situations that they should not be exposed to [18]. This includes bullying in workplace which has been highlighted as an ongoing issue [19]-[21]. Students are often the target of this bullying [21] [22]. This contributes to stress, fatigue, poor mental health and poor job retention [21]. There is, therefore, a need for formal education on workplace bullying in the course to better prepare midwifery students for clinical placement and help them manage this [22] [23]. Having a positive workplace culture where students feel a sense of belonging and inclusion would also help [24]. Being employed during their clinical placements contributes to this sense of belonging [13] but there also is a need for a cultural shift in the sector.

Students experience stress from clinical placements due to several things such as achieving their requirements, the change of role to being a student, the change of sociocultural context, bullying, being thrown in with minimal support/supervision and a poorly prepared workforce [21] [24]-[26]. Shortage of midwives and stressful learning environment help students develop self-efficacy and the ability to overcome challenges [10]. Self-efficacy affects the motivation for learning and is necessary to perform the necessary skills but can add to the stress [27]. As described eloquently here, "... placements provided extremely useful education opportunities not just in the exposure to desirable practices, but also to undesirable practices and environments" [11]. The added problem here is that there is a high level of stress and burnout among midwives which in turn affects their ability to support students [28] [29]. Feeling safe increases the trust students need to learn [17] and needs to be fostered in all midwives to adequately support students. Providing midwives with recognition and educational preparation to adequately support midwifery students may help but the situation is compounded by the shortage of midwives across the sector [22].

What adds to this stress for students is the inconsistency they experience during their clinical placement, a lack of application of theory to practice resulting in a theory/practice gap [30]. There is also competition with their peers as they chase the clinical requirements, especially with births for instance. This tends to result in students prioritising these requirements and completing their clinical book rather than focusing on learning [30]. This was echoed in a recent paper [31]. Midwifery students also experience educational contrasts and confusion due to theory being provided at the university and on the other hand they encounter midwives and educators in the hospitals whose knowledge and skills/performance is contrary to the theoretical preparation [12]. This emphasises the importance of having face to face sessions with students during intensives or debriefing sessions during clinical to share experiences, discuss things and provide students with an avenue to vent and be supported [32].

Finally, identified was the need for more connection between the university and hospitals. The fundamental issue of having a close relationship between university and hospitals and theory practice gap is ongoing and continuously needs to be addressed through the midwifery academics [8]. The issues of support from hospital can be assisted through close relationships and support from the university and therefore become more collaborative courses with hospitals becoming partners with the university in providing education. Faculty practice, facilitation by university academics or at least regular site visits would help address this juxtaposition.

From the graduate perspective it is interesting to note that the majority were still working as a midwife in various positions. Encouragingly, there were some graduates who were working in a midwifery continuity of care model of some type, in education and research roles. The difficulties of graduates working in midwifery models of care has been discussed elsewhere in the literature [11]. The rate presented here, however, reflects what others had recorded [33]. Unfortunately, there appeared to be a level of unhappiness reflected in the comments, however,

with some wanting to leave the sector due to the level of stress and not being valued. This level of unhappiness was also found in the recent midwifery workforce report which described the Australian midwifery workforce as being in crisis [29] [33]. Reasons for this included widespread shortage of midwives as well as the maternity services culture which is in need for systematic changes. Many midwives were identified as considering leaving because of poor workplace culture and shortage of midwives making it difficult to provide safe midwifery care [33]. Several recommendations were made including the need to support midwifery workforce and change the culture to help retain both midwives and students.

There are some limitations with this research, specifically the small sample size due to few responses which affects its generalisability. This research, therefore, presents only a few students perceptions of the course and is not necessary the opinion of all graduates from this course and only reflects those students potentially with strong opinions with level of self-selection. In addition, due to the time period of graduates, there may be a level of recall bias. The analysis of the data was undertaken by one researcher who potentially may have been involved in the education of some of these graduates which could add a level of bias to the process. A strength, however, is that this is the first evaluation of CSU course from graduate perspective.

5. Conclusion

This research examined the career trajectory of people who had completed entry to practice midwifery studies at Charles Sturt University since it started in 1990. Questions were also asked about the details of the midwifery education they undertook and if they had identified any issues that needed addressing in future curricula. This helps inform any future entry to practice curriculum development but also provided an outline of the career trajectory of CSU midwifery graduates. Generally, participants reflected that the course was good but intense and the clinical experience was very worthwhile and rewarding, helping to develop their knowledge and skills in providing midwifery care. Being employed in a maternity facility while undertaking their course was identified favourably. A number of issues where identified with the course and the clinical experience, primarily related to support and culture. Midwifery students need to be supported more during this their clinical experience and there is a need to change the culture.

Ethics Approval and Consent to Participate

Ethical approval was granted by CSU Ethics Committee H23928. Participation was voluntary and gave implied informed consent by completing the anonymous questionnaire.

Author Contribution

The author confirms sole responsibility for the design, data collection, analysis and interpretation of results as well as manuscript preparation.

Acknowledgements

Like to acknowledge the midwifery academics at Charles Sturt University for study conception and providing expert panel re questionnaire development.

Funding

There was no specific funding for this research achieved while being employed at CSU.

Availability of Data

The data supporting the findings from this article are available from the corresponding author upon reasonable request.

Conflicts of Interest

The author confirms that there is no conflict of interest related to the preparation of this manuscript financial or otherwise.

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