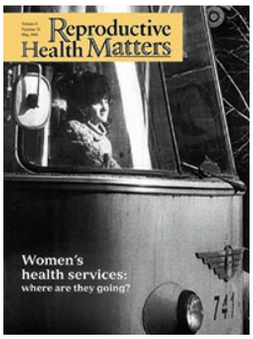

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Midwifery in Australia and Surrounding Regions: Dilemmas, Debates and Developments

Lesley M Barclay

This paper discusses the professional issues currently facing midwives and maternity services in Australia and the Pacific region, which are influenced by midwifery being predominantly a women's profession and by working in health systems that are dominated by medicine and nurses. In Australia, the educational preparation of midwives has recently shifted from hospitals to universities, and only nurses can train to be midwives, even though urban midwives rarely work as nurses during their careers. This situation is different in rural Australia and the Pacific islands, where nurse-midwives may be the only health workers for whole villages and towns, yet the need for a dual system of training has not been accepted anywhere in Australia. This paper argues for the incorporation of research into practice; the use of high quality, research-based materials to guide the provision of safe, women-centred, midwifery care; and improvements in the profile, quality and contribution of midwifery to maternal and child health services throughout the region.

IN April 1997, the 10th biennial conference of Australian midwives took place, which was attended by colleagues from other countries in the region and which stimulated a reflection on professional issues. This paper developed from an invitation, following the conference, to contribute an editorial on these issues to *Midwifery*, the only international, peer-reviewed journal for midwives and the avenue used by the International Confederation of Midwives to communicate with its members.

It has now been nearly three decades since midwives in Australia began organising together as a group and 20 years since the first national meeting of Australian midwives as an association. I was part of the group in the late 1970s that helped to form what is now called the Australian College of Midwives (ACMI), and I have been involved in national and international midwifery affairs as a midwifery teacher and researcher ever since. For the last decade, I have been privileged to work with colleagues in a number of Pacific and South East Asian countries. In particular, my role has been to help them strengthen education systems and standards for the various categories of workers involved in health services and maternity care.

While the resource base between the so-called developed and developing countries is vastly different, many of our experiences and priorities are similar. We share responsibility for promoting and implementing 'Safe Motherhood' and are recognised in World Health Organization policy as a key group in reducing unacceptably high rates of death and injury in women as a result of childbearing. We also share membership of a predominantly female profession, and we bring to midwifery the advantages and limitations of being women and working in today's world.

The priorities we share include providing the appropriately skilled and qualified practitioner for the type of care required, delivering services in ways that are culturally and socially acceptable, using available resources efficiently to improve the health of women and children and preventing or minimising illness or trauma that can arise as a result of reproduction. At the midwives' conference, it became clear that to

achieve these goals certain professional issues still need addressing, including appropriate role development and education that permit midwives to practise safely, using research rather than tradition as a foundation.

Professional issues

In the late 1970s, our first task as midwives was to recapture and take pride in the title 'midwife'. This was not just a semantic exercise. Midwifery practice, though now recognised and valued, had almost disappeared and been replaced by obstetric nursing. In Australia, midwives had been a very important feature of the health services until World War II, with a high proportion employed in home deliveries[1] and cottage hospitals,[2] that is, small hospitals that provided care in the local community, including maternity care. The unionisation of nursing, a rapid upsurge in the numbers of obstetricians, increasing hospitalisation and an emphasis on technology and technical intervention all contributed to the decline of midwifery.[3]

Single registration midwives, who were not nurses, were trained in specific programmes until the 1960s in Australia and many were still practising until quite recently.[4] These non-nurse midwives, whose education was of one year's duration only, came to be regarded as less qualified practitioners. The demise of their limited form of training was part of a legitimate attempt by nursing leaders to improve the standards of nursing education and professional practice.

At the same time, however, a dated, 'North American' understanding of nursing began to gain a foothold among Australian nursing leaders. In North America midwifery was abolished early in this century. As maternity care became focused on medically-managed birth, births began to be assisted by generalist nurses with a limited experience of maternity and obstetrics. The incorporation of North American values resulted in midwifery being defined as a second certificate for the general nurse. This certificate, essential for promotion in nursing, did not necessarily lead to long-term practice in the field.

This situation is different for those communities and countries where nurse-midwives often provide the only available health care. Australian midwives in rural communities, as well as midwives in many other less developed countries in the region, particularly the small islands of the Pacific, share a tradition of combining nursing and midwifery skills in one category of health worker. Nurse-midwives may be the only health workers available for hundreds of kilometres, providing care that ranges from public health to trauma management for road traffic accidents, infant and child health care to palliative care for dying or elderly people. They may also undertake the full range of pregnancy and post-natal care.

However, despite the need for nurse-midwives in isolated communities, in most urban centres of Australia, where the majority of the population lives, midwives do not work as nurses but solely as midwives throughout their careers. Hence, it is costly and unnecessary for the vast majority of them to become nurses first. Unfortunately, there has been no opportunity under Australian regulations or in professional thinking for a dual system, as in the United Kingdom, where the health system has continued to rely on midwives in both hospital and community practice in a manner that is more European than North American,[5] and where midwives can be educated and practice after becoming nurses or through direct entry, that is, without needing a nursing qualification.

Midwives in Australia and elsewhere need to create a strong, credible, political and professional profile that will protect the public and the profession from inadequately prepared practitioners, be they nurse-midwives or overseas-trained midwives who are not general nurses. Poor and unsafe practice can originate through either route. A general nursing qualification does not protect the public from inappropriate midwifery care.

To influence the thinking of those in power requires strong professional organisations that can speak for their members. Professional nurses' organisations are often struggling in our region as well, despite their bigger resource base, to become viable leaders for women professionals who are much lower in status than their (mostly male) medical colleagues. Midwives are even fewer in number in most countries than their colleagues who are nurses and have even less influence.

The Australian midwifery association, the ACMI, is a case in point. The ACMI has not been sufficiently powerful to mandate appropriate standards of midwifery education or practice on the various state registration or licensing boards.

This may not be surprising, given that Australia has a relatively small population and ACMI a limited membership and means to generate funds. The actual number of midwives practising in Australia as a whole is not known. In New South Wales, Australia's most populated state, there were 87,391 deliveries in 1995[6] and 3,228 midwives were practising.[7] Unlike in larger countries, midwives' salaries and ACMI membership fees are insufficient to generate an infrastructure that could run an independent licensing system. We have only one full-time national officer and an elected executive whose time is limited. We do not have the skills and lobbying capacity to use politically on behalf of women and the profession. In many of the countries in the region, there are very limited or no resources to support paid infrastructures or organisations representing nurses – let alone midwives.

Through enquiries and reports, state governments in Australia and the World Health Organization (WHO) internationally have promoted midwifery services on the basis of consumer preferences, better quality of care and cost-effectiveness. Extensive, excellent work has been done within the WHO Safe Motherhood initiative, designed to educate, support and promote the work of midwives. In Australia, a number of states have reviewed their maternity services. For example, the Shearman Report[8] examined maternity services in New South Wales and emphasised the need to introduce strategies to improve them, recommending the expansion of the midwife's role. In particular, it promoted the midwife's capacity to provide safe, consistent and familiar care.

Having a Baby in Victoria,[9] the report of a review of maternity services in Victoria, recognised the need to better orientate services to meet the needs of women and families while maintaining a high level of safety and efficiency. Again, this report emphasised the midwife's role and pointed out that current organisational systems, dominated by an obstetric model of care, were inhibiting the capacity of midwives to contribute fully. It also brought up the importance of direct entry into midwifery. Such an initiative remains unrealised in this or any other Australian state, despite the resurgence of such programmes in the United Kingdom in the last decade and the clear cost-benefit of a three-year as against a five-year preparation.

A recent National Health and Medical Research Council (NH&MRC) review detailed how maternity services could be improved by expanding the role of the midwife and the general practitioner in the care of pregnant women.[10] It concluded that continuity of care, in which a woman is provided with care consistently by the same practitioner throughout pregnancy, labour and delivery, and the postpartum period, should be the goal for all models of maternity care. In Australia, this is currently the exception for non-insured women. In the rest of the region, it is unheard of except for the very few women who can afford or find private obstetrician care. Most women have to wait hours in large clinics to receive a ten-minute antenatal examination from someone they have never met before and are unlikely to meet again.

Another NH&MRC document, currently in draft form, discusses giving midwives limited prescribing rights, eg. for iron supplementation in pregnancy. This would make newly developing models of midwifery services more efficient as women would not need to see a medical practitioner for certain prescriptions.[11] All these documents have emphasised the importance of the midwife in providing innovative services that better meet women's needs. These policies, however, assume that there are sufficient numbers of well-educated and skilled midwives to undertake a broader range of roles. This assumption is questionable and likely to become more so in the future, given the current state of midwifery education.

Midwifery education

It is over a decade since any substantial national examination of Australian midwifery education has been undertaken. I believe it is necessary to do so again in the immediate future. Australia has moved more rapidly than most countries from hospital-based education programmes, run by those close to clinical practice, to universal university education for nurses, where the universities regulate the course content. This was followed by almost universal university education for midwives – but only as a post-graduate course for registered nurses.

This move has been a great achievement. Yet even as government reports suggest that the role of midwives should be expanded, there is increas-

ing uncertainty and concern over the quality and nature of the training that is available for midwives. Employers, educators and others have concerns that the shift to total university education appears to have resulted in significant variability in the quality of midwifery education,[12] and that insufficient attention seems to have been paid to monitoring the programmes that prepare midwives.

At a national level, this concern is being expressed by the directors of nursing and midwifery services of the Women's Hospitals Australia, the single largest group of employers of midwives, who have been grappling with the consequences of the changes and may be commissioning research to track their effects.

The broad range of clinical experiences accepted as sufficient by Australian states and territories with reciprocal licensing arrangements is one aspect that is causing disquiet. In a few areas and courses, clinical experience is now well below international standards, and substantially less than has been required in Australia in the past.[12]

The consequences of having to pay for university education have been profound, as neither nurses nor midwives in Australia previously had to pay to be educated. The fees for a first-degree course in nursing are lower than the substantially higher, post-graduate fees for midwifery training, making post-graduate university places even more vulnerable. Many undergraduate nursing students have to work part-time to survive financially. Many midwives, including myself, believe that general nurses will be reluctant to pay the higher sums for midwifery courses after having paid for a three-year nursing degree course.

Midwifery service providers are being profoundly affected by these changes in govern-ment policy. Australia was already facing a shortage of midwives in a number of states, and this appears to be becoming more acute. When health services relinquished responsibility for midwifery education, no one ensured that sufficient numbers of places were made available in university programmes, and shortages have consequently been exacerbated. This situation has been compounded by new laws and regulations in some states, which have made it possible to employ registered nurses to undertake midwifery functions if enough midwives are not available.[13] Many midwives are concerned that this is the 'thin end of the wedge'. They argue that it is not a viable solution for those health services who were already having great difficulty filling midwifery posts, including in rural areas, where the availability of appropriately skilled and competent nurse-midwives is even more crucial.

Instead, the current increasing shortage of midwives makes the option of direct-entry midwifery education programmes even more worthy of consideration, as the courses would be offered at undergraduate level and would require lower fees than post-graduate programmes. Unfortunately, the leadership of professional nursing associations is highly resistant to the notion of direct-entry midwifery education, which makes this issue extremely challenging for midwives in Australia. Further, in the current economic climate in Australian universities, the number of courses is contracting; hence, expanding undergraduate courses to include midwifery, even if this were accepted by the nursing profession, would be problematic.[12]

Issues in Pacific and Melanesian countries

In Pacific and Melanesian countries the population distribution is opposite to that of Australia. Most people live in villages and small towns, often widely dispersed because of geography, with heavy seas or mountains separating health workers and their services. In these settings, the priority is for a nurse-midwife, who can provide the full range of public health care required by a small community. These practitioners often work alone or with minimal assistance from lesser-qualified health workers. Nurse-midwives in these countries may also work in central hospitals, where they are expected to support a range of treatment-oriented services. Most graduates, however, will need to work effectively at village or district level, manage the 'normal' well, recognise and refer problems and be competent in an unavoidable crisis. Educational programmes therefore need a strong base in the social and biophysical sciences, a public and primary health care orientation, a midwifery and child health focus, and education and skills development in the management of simple illnesses and trauma.

In the Melanesian part of the Pacific, malaria and hookworm are endemic and nutritional problems exist alongside parasite-induced

anaemia. This means that even small blood losses during delivery or post-partum can be catastrophic, as women do not have the resilience to withstand shock and survive. In Papua New Guinea immunisation levels are as low as 20 per cent, and even worse in some provinces.[14] Unless educational programmes for nurse-midwives assist them to work on these sorts of public health problems and with village leadership effectively, high levels of avoidable deaths in women and infants will continue to take place.

Papua New Guinea and the Solomon Islands, two of Australia's closest neighbours, rank amongst those with the highest maternal mortality rates in the world.[15] During the 1997 ACMI conference a Papua New Guinean midwife, Rosaline Lapan, described the consequences of medical and midwifery colonialism in her country. A video used in Papua New Guinea to train village birth attendants (VBAs) to deliver babies shows a birthing woman lying flat on her back. The delivery of the head and shoulders occurs using much pressure on the perineum, the shoulders are rotated and the placenta is delivered using controlled cord traction. The only clue that this was a village delivery is that the woman is lying on clean banana leaves, not a bed sheet.

This style of birthing is the result of western influence. Upright birthing positions have been the normal practice in Papua New Guinea for hundreds of years. Senior colleagues in Papua New Guinea have told me they remember how women would deliver either semi-seated with support from behind or hanging from a rope suspended from the rafters. Yet VBAs are now being taught a mode of delivery that not only differs from what they have used in the past, but may also introduce risks that would not have occurred without this 'training'.[16]

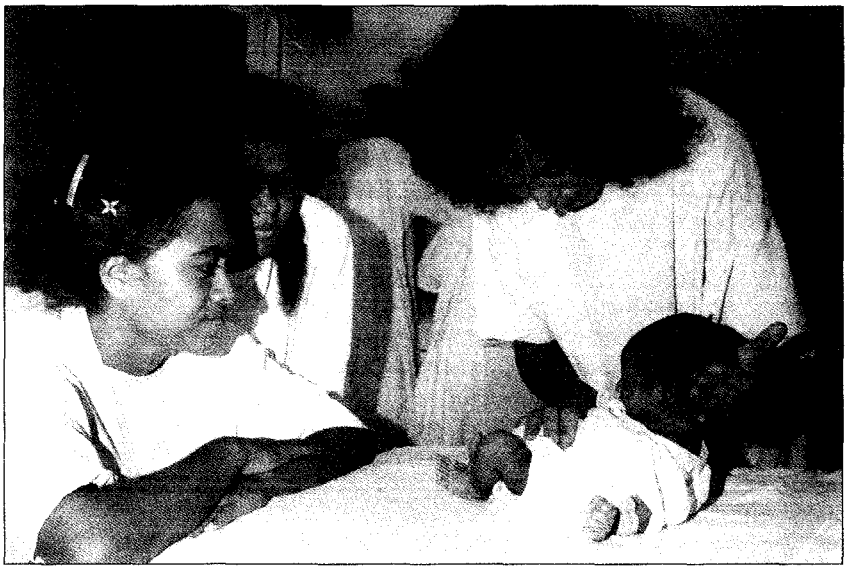
The supine delivery position originated in Europe, where it was introduced to allow people to observe the birth, rather than for the comfort or safety of mother and baby. Not only is it a very immodest and highly uncomfortable position, which exacerbates pain and slows the descent of the baby, but it also compromises the circulation of blood through the placenta to the baby. This has only recently become understood in the West, yet this and other western cultural rituals surrounding birth have been imposed on others without questioning whether they are based on sound scientific principles.

Countries such as India, the Solomon Islands and Papua New Guinea still frequently suffer from Western medical hegemony and outdated teaching, even though the colonial powers may long ago have departed. For example, in many places I have visited as a consultant over the last decade, episiotomy, shaving and giving enemas remain routine practice, and modesty and privacy are absent. Many countries in this region of the world are still teaching and practising from outdated 'missionary' curricula and those introduced by colonial governments. These are often not only deficient in good science and research, but also often culturally confronting and alienating. Family members are still not permitted inside delivery rooms with labouring women, even though there are insufficient staff to provide supportive care, which means that women often labour alone.

A recent WHO publication entitled *Care in Normal Birth: A Practical Guide*[17] makes it clear that most of these techniques and practices are not supported by evidence, are ineffective or may even be harmful, and should be used with caution or eliminated until research clarifies the issue. To teach these practices to village women, who have no understanding of anatomy or physiology, no gloves, limited access to clean water and no means of pharmacological assistance in managing post-partum haemorrhage, would seem to add to, rather than minimise, risk. Midwifery curricula need to inculcate respect for safe traditional practices and enable midwives to work effectively with communities, families and individuals to improve health and safety for women and children.

Most midwifery education programmes in so-called 'developing' countries in our region lack libraries with up-to-date texts, journals or computer resources which would inform them of the research that has been instrumental in changing the face of midwifery elsewhere over the last 20 years or so.

Finally, midwifery staff shortages are acute in some countries in our region and likely to be worse in rural areas. In some provinces in Papua New Guinea, for example, there are only one or two nurse-midwives with post-basic skills and qualifications in midwifery, for some hundreds of thousands of people.[18]



PENNY TWEEDIE / PANOS PICTURES

Fiji

Incorporating research into practice

An issue that faces all midwives in this region is the incorporation of research into practice. It is reasonable to assume that countries without libraries and 'on-line' resources and databases might have difficulty doing this. WHO has undertaken very important work in this regard in the collection of Safe Motherhood materials now available to health services free of charge or at minimal cost. The recommendations it contains are research-based and of very high quality. The language is easily understood. *Care in Normal Birth: A Practical Guide*[17] provides an excellent compilation of the research base that should guide the management of normal labour and delivery. It is invaluable as a resource in countries where textbooks are in short supply and journals may be non-existent or unavailable to nurses and midwives. A similar publication is available for the provision of antenatal care.[19]

A sophisticated analysis of systems and institutions controlling maternity services is beginning to emerge among midwives in Australia, often informed by sociology and organisational theory. The aim of this work is to ensure that we all contribute to, and achieve, sustained improvement. For example, at our recent national conference Pat Brodie analysed negative organisational responses to innovative models of midwifery care, that focus on women and their needs.[20] The brave visionaries who are pioneering a range of flexible maternity services for women, run the risk of 'burnout' unless we analyse and understand their experiences. In particular, we need to understand the power and economic self-interest of medicine that is threatened by well-educated, assertive midwives who can provide excellent care for the majority of women. The fact that nurses and midwives are most often women means that they are seen in most parts of this region, even more so than in Australia, as a 'lesser category' of health worker. Thus, resources, opportunities for education and authority mostly pass them by.

However, there also still remains some romantic rhetoric that demonstrates a missionary zeal for championing midwifery for its own sake. This runs the risk of serving midwives' need to be needed and to become important, rather than centering on the priorities of the pregnant woman, her family and their rights. Women's rights to a safe, efficient, socially supportive and accessible maternal and child health service must be the first priority. These are the mountains that must be moved. Our enthusiasm as committed midwives and midwifery leaders needs to be tempered with the wisdom of experience that informs us how to move these mountains in ways that ensure they stay moved and do not collapse.

We remain very good at defining what we think women want, from our own perspectives as midwives, but we can be poor at listening to women about their needs. We are good at criticising our medical colleagues and health services when they do not give us the prominence or resources we believe we deserve, but unless we become politically astute, skilful and well-informed, there is no chance for us to influence these institutions to change. We criticise

educational systems and professional bodies that do not provide us with the quality of leadership and programmes we want, but we do not necessarily put in the time and effort personally to help them to improve. Our preoccupations are often self-interested and self-absorbed. In short, we run the risk of creating 'midwife-centred' rather than 'women-centred' care.

The principle of listening and becoming active holds for those of us presuming to work with our midwife colleagues from other cultures as well. By listening and watching we can learn much that might help us to improve the care we provide to women in our own countries. We must not export our own limitations and weaknesses. Currently, these are too often imposed on countries already reeling from the loss of women's lives through depleted and often ineffective health systems. It is time we began to identify the underlying principles holding us together in our practice and use these to unite us across cultures. Women and their families should be respected and encouraged to construct the social rituals and cultural elaboration of the birthing experience in their own way.

Childbirth in 'developed' and 'developing' countries has become the stage where the professional midwife performs and takes control. The issue of women's own needs and priorities for services is often secondary. Unfortunately, too few of these professionals are sufficiently aware of where science and art overlap. They rely on the culture of hospitals and being a professional, rather than the culture of families, to create a style of birthing that owes too little to research and too much to practices that enhance the importance of the professional.

Similarly, we too often presume that traditional birthing practices in developing countries are flawed and harmful and need to be changed. While at times this may be so, eg. the practice of placing cow dung poultices on infant cord stumps, many of the so-called scientific, western-introduced practices have in their own way also contributed to harm. In either case, discriminating analysis, based on research, is needed to determine what is useful and should be retained, and what is not.

It will be interesting to attend the ACMI conference in another 20 years. I will have been retired for nearly 10 years, but that has not stopped some of our most active ACMI members from continuing to contribute. Hopefully, I can follow their lead. While I am not naïve enough to think that we will have solved all of our problems, if the rate of achievement begun 20 years ago continues to be maintained, a great amount will have been accomplished. I will enjoy the leadership of our next generation, already very evident and competent now. I look forward to the contribution of my colleagues in nearby countries. Many are now busy raising the profile, quality and contribution of midwifery to maternity care and service delivery as they continue to improve the safety of childbearing for women and their infants. Others need our assistance and encouragement as they begin to face professional and educational challenges that we all share.

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Résumé

L'auteur examine un certain nombre de problèmes professionnels auxquels sont confrontés, en Australie et dans la région du Pacifique, sages-femmes et services de maternité, et qui viennent de ce que le métier de sage-femme est une profession essentiellement féminine, exercée dans un système de santé dominé par la médecine et les soins infirmiers. En Australie, la formation des sages-femmes a récemment été enlevée aux hôpitaux pour être confiée aux universités, et seules des infirmières ont le droit de suivre cette formation - même si les sages-femmes opérant en milieu urbain ont rarement l'occasion de dispenser des soins infirmiers. La situation est différente dans les zones rurales de l'Australie et dans les îles du Pacifique, où les infirmières-sages-femmes peuvent être les seuls agents de santé des villages, voire des villes. Pourtant, la nécessité d'un système de formation dualiste n'est pas partout admise en Australie. L'auteur plaide pour l'incorporation de la recherche dans la pratique, le recours à des matériels de qualité, fondés sur la recherche, pour guider l'apport de soins obstétricaux sûrs, axés sur la femme, et pour l'amélioration du profil et de la qualité de l'art obstétrical, et de sa contribution aux services de santé maternelle et infantile dans toute la région.

Resumen

Este ensayo explora los aspectos profesionales que enfrentan actualmente las comadronas y los servicios de maternidad de Australia y la región del Pacífico, debido a que la labor de la comadrona es primordialmente un oficio de la mujer, y al desempeño de éste en el contexto de sistemas de salud dominados por la medicina y la enfermería. En Australia, los estudios de capacitación comadrona fueron transferidos recientemente de los hospitales a las universidades, pero sólo las enfermeras tienen acceso a ellos, a pesar de que las comadronas urbanas rara vez trabajan como enfermeras a lo largo de sus carreras. La situación esdiferente en las zonas rurales de Australia y en las islas del Pacífico, donde la enfermera-comadrona es frecuentemente la única trabajadora de salud existente para toda una aldea o un pueblo. A pesar de ello, en toda Australia no se ha aceptado la necesidad de contar con un doble sistema de capacitación. Este ensayo propone la incorporación a la práctica de los resultados de las nuevas investigaciones; el uso de materiales de alta calidad basados en investigaciones, con el fin de proveer durante el parto una atención segura y centrada en la mujer. Asímismo, ropone el mejoramiento de la imagen, calidad y contribución de las comadronas a los servicios de maternidad e infantiles en toda la región.