Werna Naloo – 'We Us Together': the birth of a midwifery education consortium

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Aim. The metaphor of a journey will be used to describe the process covering 2 years of development of a Bachelor of Midwifery curriculum shared between a consortium of three universities in Victoria, Australia.

Background. The landscape or background against which this journey took place is described, providing a context for understanding the political and pragmatic steps necessary to achieve common vision and processes. This journey has necessitated a convergence of our thinking about what constitutes the living theory and philosophy of the new midwifery in the Australian context, and how this fits with international trends.

Process. The journey took midwife academics from one paradigm to another, forging partnerships between universities to develop an innovative undergraduate midwifery curriculum that shares academic expertise and resources. Consultation between a multitude of competing interests and voices became one of our biggest challenges, but this process itself has helped to change the very landscape in which we travel. In the end, we had to examine our baggage, and much that was excess had to be abandoned. In particular, our emphasis on language and the politics of the midwifery partnership with women became the subject of much debate and contention, and reflects the competing philosophies developing in the midwifery profession. Despite this, there were many who suggested that we had left behind too much, and others who would have us pack even more. Compromises were inevitable

if we were to proceed and set up the next stage of a journey that would open a new and challenging frontier to working with Australian childbearing women.

Keywords: midwifery, education, curriculum, consortium, partnership, language, childbearing, woman-centred

Introduction

The metaphorical journey that we will take the reader on details the process undertaken in developing a Bachelor of Midwifery curriculum within a consortium initially of five, then four, metropolitan universities. We will describe the process that took midwife academics from one paradigm to another, forging partnerships between universities and between states. The journey has necessitated a convergence of our thinking about what constitutes the living theory and philosophy of the new midwifery. Consultation between a multitude of competing interests and voices became one of our biggest challenges, and helped to change the very landscape in which we travel. Finally, we had to examine our baggage, and much that was excess had to be abandoned. Despite this there were many who suggested that we had thrown away too much, and others who would have us pack more. Compromises were inevitable if we were to proceed and set up the next stage of the journey to a new frontier of working in partnership with childbearing women.

The landscape in which this journey took place is described first, providing a context for understanding the steps necessary to achieve a common vision and processes.

What is already known on this topic

- Australia has lagged behind similar countries in the re-introduction of a direct entry midwifery education pathway.
- Reasons for this situation are varied but largely political.

What this study adds

- This paper uses the metaphor of a journey to share with readers the development of an innovative consortium style Bachelor of Midwifery education programme in Melbourne, Australia.
- A step-by-step outline is given of the experiences and process of the adoption of a partnership model of 'working together' as applied to curriculum development and delivery.

Next we describe the way in which the vision was framed, and follow this with a brief discussion about the advisors and guides we needed to plan and work towards this vision. Some of the obstacles to our journey included pragmatics such as funding and bureaucratic processes, and these are covered in some detail. Finally, we situate these more mundane matters within the fundaments of our vision, our feminist orientation to women, each other and the more politically active and aware travellers we encountered along the way. We described this as 'walking the talk' of the new midwifery.

Background or landscape

Prior to the 1960s, the preparation of midwives in Victoria, Australia, was within an adopted United Kingdom (UK) direct entry midwifery education model (Murphy-Black 1995, McCalman 1999). Since that time, legislation has required that midwives be educated in the two disciplines of nursing and midwifery, with the prerequisite entry to a 1-year postregistration midwifery programme being a nursing qualification.

The one-year postregistration model for the preparation of midwives has persisted in Australia despite changes, particularly in the last decade, in the philosophy of midwifery, nature of midwifery knowledge, expressed needs of women, models of care and role of the midwife. Spiralling health care costs, the cost in time and money to educate nurses to become midwives, and a shortage of nurses and midwives are also factors indicating a need to rethink approaches to preparing midwives for practice (Australian College of Midwives Incorporated [ACMI] (Victorian Branch) 1999). There is a body of evidence to suggest that the outcomes for women are better where midwifery is not predicated on nursing or governed by obstetrics (Tew & Damstra-Wijmenga 1991, Thompson 1991, McKay 1993, Guilliland 1999), and the findings of a number of Australian State Government commissioned reports in the 1990s (Report of the Ministerial Review of Birthing Services in Report of the Ministerial Review of Birthing Services in Victoria 1990, Health Department of Australian Capital Territory (ACT) 1994, Health Department of Western Australia 1990, National Health & Medical Research Council (NHMRC) 1996, 1998,

Senate Community Affairs References Committee 1999) clearly indicate that women want the type of care that midwives can offer. In response to government reports such as those listed above and consumer led movements, Commonwealth countries such as New Zealand (in 1990) and Canada (1994), as well as other countries in the Western world such as the United States of America (USA) (1996), have responded to the needs identified and introduced direct entry midwifery programmes. Those countries, such as Holland and the UK that retained direct entry programmes have sought to strengthen them further (Smulders 1999). In the UK, the country on which Australian midwifery is modelled, the number of direct entry or preregistration midwifery programmes has grown from $<1\%$ in 1989 to over 70% in 2000 (Leap 2000a).

World wide, midwifery is increasingly recognized as a discrete discipline, as reflected in International Confederation of Midwives (ICM) Definition of a Midwife (1990). This definition gives direction to the education and practice of midwives throughout the world.

The ACMI, the national professional body for midwives in this country, endorses the ICMs' view of midwifery as reflected in the ICM Definition. The ACMI also endorses the ICM view that the underlying philosophy and principles of contemporary midwifery knowledge and skills be grounded in a woman-centred model of care focused on the woman within a social health and wellness framework. It argues that current midwifery education programmes often fail fully to impart the essence of a woman-centred approach to care and also fail to prepare midwives adequately to work with women throughout their health care cycles [ACMI (Victorian Branch) 1999]. Leap (2000b), a recognized international expert in the field, claims that:

> …current courses are too short to prepare practitioners to meet the international definition of the role and scope of practice of the midwife and that, on qualifying, many Australian midwives…have to undergo further education if they wish to work overseas (p. 22).

In a recent paper titled Contemporary Issues in the Workforce and Education of Australian Midwives, Tracy *et al*. (2000) reported on a collection of commonly held facts and fears which exist in midwifery, namely that there is already a national shortage of practising midwives, which will worsen as an ageing midwife workforce retires. There are also concerns about the ability to retain midwives in the workplace, particularly in rural and regional areas. Tracy *et al*. claim that Australia is currently educating less than two-thirds of the projected number of required midwives, and that the current mode of education is not cost-effective, that is, a period of 5 years is needed in order for graduating students to become beginning practitioners in midwifery. These authors contend that 'the current and projected shortage of midwives could be addressed more quickly through direct entry programs', and that 'government subsidized first degree programmes are a more viable proposition than the current expensive post (nursing) graduate programs' (p. 78).

There is some evidence that newly graduated midwives in Victoria are not attracted to midwifery because of dissatisfaction with the reality of practice that is predominantly located within a medical or obstetric model of care (Gum 1999). A similar finding has been reported by the New South Wales Department of Health (2000), which highlights that one-third of the newly graduated midwives are not practising midwifery for the same reason. Conversely there is evidence that where midwifery models of care, reflecting the ICM Definition of a Midwife (1990), are the basis of practice, retention of midwives and job satisfaction are higher (Hundley *et al*. 1995.)

Early in 2000, midwifery academics from five universities in Australia came together to realize their shared vision and respond to the concerns identified. The decision was taken to adopt a collaborative approach to the process of developing a curriculum in order to pool expertise, provide support and collegiality and realize economies of scale. Thus the *Werna Naloo Bachelor of Midwifery Consortium* was conceived and formed. The Consortium was initially comprised of Australian Catholic University (AUC), Victorian Campus, Monash University, Royal Melbourne Institute of Technology University (RMIT), University of Tasmania and Victoria University. However, the University of Tasmania and RMIT have since withdrawn, with the expressed desire to return at a more opportune time. The title *Werna Naloo* was chosen because it means 'we, us, together', and the Consortium group acknowledges the kind permission given by the indigenous Ganai Elders Language Reference Group to use these words. The Consortium considers the use of these words in its title as most apt, for they depict universities, midwives and women working together or in partnership for the development and implementation of a 3 year Bachelor of Midwifery programme to be offered in Victoria from 2002.

The introduction of the Bachelor of Midwifery in Victoria will add to existing pathways for the preparation of midwives for practice. This is in keeping with the 1996 ICM Vision Statement which includes the statement that 'midwifery education be available through a variety of routes and be based on core competencies related to the needs of the country/area where the midwife is prepared'. Prospective midwives will have choice in their pathway to midwifery,

such as an undergraduate degree or, following an undergraduate degree in nursing, a postgraduate diploma in midwifery. Alternatively they may fast track into a Bachelor of Midwifery. A shared goal, regardless of the education pathway, is that all graduate midwives will be competent to practise according to the ACMI (1998) Competency Standards for Midwives, and will coexist in most midwifery practice settings. An exception would be in some rural and regional centres, where because of the small mix of health care clientele and the model of care operating, a nurse–midwife is likely to be required.

Demand for the programme is high. Without marketing, all four Consortium universities report a very high level of interest and requests for application forms to enter the Bachelor of Midwifery. Inquiries are from mature aged students, school leavers and graduates with related qualifications such as Tertiary and Further Education (TAFE) courses for childbirth educators and enrolled nurses, and university degrees in subjects such as social sciences. A large number of these potential applicants include women who have children and are not willing to undertake a Bachelor of Nursing in order to have a career in midwifery.

Framing the vision, drawing the maps

Having established that there were mutual gains to be achieved through collaboration, the next step involved framing a shared vision for the Bachelor of Midwifery. Conceptually the vision was achieved with relative ease, as each midwife academic in the group shared a common desired outcome for the future of midwifery education. To minimize barriers arising from differences across universities the decision was made to accommodate these, rather than to try to achieve a compromise within the Consortium.

The process of mapping out a curriculum involved many layers of drafting, redrafting, positioning and repositioning. Consultation with representatives from key professional midwifery stakeholders was intrinsic to transparency and the direction taken within this dynamic and continuing process. The final Bachelor of Midwifery curriculum represents a comprehensive theoretical base with a substantial women's health component, and a strong practice focus underpinned by the generic midwifery/nursing skills necessary for midwives to work in acute maternity care.

Choosing our guides: committees and reference groups

From the outset of the journey a Steering and Course Development Committee, and local and international reference groups with key stakeholder representation, were established. The assistance of the peak body representing midwifery had also to be enlisted. It has long been the position of the ACMI that a 3-year tertiary degree was the preferred option for education of midwives in Australia. The position of the College in its 1998 statement and subsequent 2000 position statement against double degrees in nursing and midwifery (ACMI National Executive Minutes) firmly endorses midwifery undergraduate education. Practical support of the position, funding and endorsement was given to a group of midwife academics drawn from each state and territory who became the Australian College of Midwives National Bachelor of Midwifery Taskforce (Owen 2000). Their brief was to develop accreditation standards for courses in midwifery, with a particular focus on undergraduate courses. Two of the founding members of the Werna Naloo Consortium were on the Taskforce, which has enabled an informed approach to development of the curriculum.

Planning the journey: navigating obstacles

Funding

To avoid the diversion of funding from nurse education or postgraduate midwifery education programmes, an application to the Department of Education, Training and Youth Affairs (DETYA), via the ACMI National Bachelor of Midwifery Taskforce, was made in an attempt to secure pilot funding for the Consortium programme. As part of the application, funding was sought to assist with the development of flexible learning material specifically designed for subjects that will be taken by all Consortium students, and for a research project to evaluate all stages of the programme as well as cross-comparison of outcomes with the existing graduate diploma in midwifery. As this submission was unsuccessful, Consortium partners have fully funded the development. It is expected, however, that ongoing DETYA monies will be forthcoming for future intakes of students through the same process as for nursing and other courses.

Scouting the territory

As course development progressed, Consortium representatives engaged in gathering support for the Bachelor of Midwifery in the wider allied health community. Support was sought from future potential employers, nursing organizations, midwifery professional bodies and obstetricians. This process has been undertaken through dialogue and invitation for comment on course documentation within schools and faculties of each university and the associated practice agencies supporting existing midwifery courses.

Dealing with nay-sayers

The experience has been that substantial hearsay pre-empting the nature and objectives of the course existed and was responsible for creating generalized misunderstandings in the broader nursing, midwifery and medical communities. Such misunderstandings included the perceived threat to the future of graduate midwifery courses, and subsequent devaluing of midwives from a nursing background. There was also a belief that the Bachelor of Midwifery sought to prepare a new variety of midwife not suited to working in mainstream maternity services. The Consortium recognized the need to address these issues in a transparent and cohesive manner. The misunderstandings were mitigated by including a variety of individuals representing key organizations on the course steering committees for each university to ensure participation across metropolitan regions and the dissemination of course documentation necessary to clarify issues.

Co-travellers: changing from 'a race' to 'we, us, together'

The change from competing in the midwifery education marketplace to working together co-operatively was a positive individual and group experience reinforcing a sense of sisterhood. Motivated by the need to shape the future of midwifery education through collaboration in a climate of course rationalization, we were able to create a new and exciting course reflecting the philosophy of the new midwifery. However, organizational requirements had to be addressed in order for the Consortium to move into the next phase of developing subject materials for shared delivery. These requirements included the signing of a Memorandum of Understanding, formalizing the intention of each university to work together. This receded the development of a binding agreement outlining the responsibility of each university in developing and delivering the course.

Whilst most of this article has so far focused on the journey, we now turn to the motivations and spirit in which we undertook the journey. Our vision and philosophy for progress has always been informed by the concepts of women-centredness inherent in historical definitions of midwifery. We now take a theoretical turn in embedding our endeavour in the literature.

Walking the talk: feminist principles with women

All Consortium members worked from a feminist philosophy. They shared a common goal to develop a model of midwifery education that would place the contemporary woman at the centre of maternity care, as distinct from her usual role as a marginalized spectator in her birthing experience (Coslett 1994).

Dissatisfaction with traditional medicine that has appropriated women's birthing experiences by mystifying medical information, using exclusionary terminology, controlling the process of childbirth, and fostering dependency on doctors and obstetricians motivated the Consortium to develop a radically different model of midwifery education. The Consortium members', efforts to deconstruct the illness model of maternity care and produce a new paradigm for midwifery education were among the most significant factors under consideration by the Consortium.

An overview of current midwifery programmes in Australia highlights the problematic nature of the relationship between nursing and midwifery in its current form. While midwifery education in Australia has undergone changes in both its pedagogy and institutional location since the late 1980s, difficulties remain with the gap between the real and the ideal. In the past, midwifery education was based on a colonial model of nurse–midwifery hospital-based training with emphasis on technical skills. With the transfer of midwifery education to universities in the late 1980s it remained embedded as a shortened postgraduate course within a nursing context.

Nursing and midwifery education programmes traditionally reflected a medical model, where knowledge remained in the control of professionals and emphasis was on illness (Darbyshire 1994). This model and emphasis is and always was problematic for midwifery. For many years there has been frustration with and critique of traditional midwifery education for its alignment with androcentric, misogynistic discourses of childbearing. Although changes have occurred and the orientation has shifted to more woman-friendly approaches to education, it became evident that there was a need for a 3-year Bachelor of Midwifery programme that would allow time for assimilation and integration of complex and diverse epistemologies and practice experiences.

More and more women from non-nursing backgrounds were approaching midwifery academics inquiring about becoming a midwife, and stating that they had no desire to become a nurse. This nursing-midwifery dichotomy reinforced for Consortium members that the current approach to midwifery education marginalized and excluded groups of women who were passionate about wanting to be a midwife but who did not want to become a nurse in order to achieve their preferred career choice.

The Consortium was very conscious of the need for further evolution to a more inclusive and woman-centred model of midwifery education. For this to be realized, firm agreement was undertaken by Consortium members to break with traditional nursing and midwifery nomenclature, terminology

and language. From the outset, emphasis was given to an inclusive model of curriculum development that would be firmly located in the woman's centrality to the birthing experience and the midwife as partner. This was reflected through the terminology of the Consortium title (Werna Naloo – 'We Us Together'), subject titles (With Woman), and by subject content development (giving space to women's birth stories, developing a partnerships with pregnant women).

Another of the major challenges facing the Consortium was presenting the new midwifery curriculum to the internal accreditation processes within each university. Consortium members were conscious of the knowledge hierarchies within academic institutions, which are hegemonic (Cook & Fonow 1990) and based on a traditional androcentric models that exclude knowledge that is considered other or deviant, such as the more woman-friendly terminology used in the Werna Naloo Bachelor of Midwifery curriculum.

While the course was initially conceptualized using theoretical frameworks such as feminist perspectives on health, the internal accreditation process saw colleagues arguing about the problematic nature of these frameworks. Concerns were raised about the nonmedical terminology, centrality of the woman, and perceived lack of acute care nursing skills. Despite these criticisms, most colleagues saw the course in its entirety as a worthwhile, creative and innovative piece of work.

A practical application of feminist politics in action in curriculum development will be demonstrated next.

Year	*Semester*	*Individual University*	*Consortium*
1	1	Bioscience 1 Sociology/Psychology Practice 1	With childbearing woman
	2	Bioscience 2 Making practice connections	The childbearing journey; Politics of maternity services
2	3	Practice allegiances Ethics/Law	With woman: rethinking pain; Unpacking midwifery knowledge;
	4	Towards a midwife self Research in health care	Women's health: sociopolitical context Midwives working with diversity
3	5	Navigating childbearing obstacles Women's health practice	Childbearing obstacles; Woman's health: women's business
	6	Working with babies *Elective/Independent Learning unit*	Babies needing extra care; Hanging up a shingle

Figure 1 Overview of course structure showing individual and Consortium delivered subjects (shaded subjects taken with nursing students).

A word on language as politics

The philosophical and action orientation of the profession of midwifery is 'with woman', which means that the midwifery profession seeks empowerment of women. One of the ways that women have been disempowered in the past is through the use of language that is incomprehensible or promotes understandings of their body and/or baby which are contrary to theirs. Such language alienates them from participation in decision-making about their passage to motherhood, and thus is misogynist. Examples are abundant and such language is well critiqued in the literature (Oakley 1984, Koutroulis 1990, Bastian 1992, Hamner 1993, Freda 1995, Kitzinger 1998). In spite of this critique, courses in midwifery continue to use such language, the alternative of finding a new lexicon seemingly being too difficult a task.

In an attempt to address this issue, the Werna Naloo Bachelor of Midwifery programme endeavours to use the language women use. For example, instead of the term 'fetus' the word 'baby' is used, and the terms 'born' and 'unborn' will qualify the baby's status. The woman is always to be called a woman, and demeaning or pathologising terms such as girl, patient, client will not be used. She is not referred to in terms of a body part, and where possible the terms 'normal' and 'abnormal' are not used. Women and their babies will not be categorized in terms of the functioning of their reproductive organs, nor will they be referred to as 'case studies' or similar. Pathological conditions will be designated using the recognized Diagnosis Related Group (DRG) terms. Where medical language conflicts with women's understanding of the same terms, students will be encouraged to use the women's terms. Understandably midwifery students will learn the accepted language of the professions of maternity care, but they will not do so without a critique of how that language operates. Students in practice will be encouraged to adopt the linguistic style of individual women during their encounters.

The titles of the subjects (see Figure 1) in the Bachelor of Midwifery programme stimulated much discussion. We attempted, through the use of metaphor, to orientate the subject matter to the 'business' of midwifery – being with women in childbearing. Women's and midwives' understandings of their relationships (Guilliland & Pairman 1995, David 2000) inform the choice of these metaphors. The principal metaphor employed is that of a shared journey through time and experience, in which both the woman (and her close circle) and midwife form a professional partnership. This partnership will form the basis for mutual learning and goal-setting, and negotiation with others in the birthing milieu. The intent is for empowerment of women and midwives through this orientation.

Despite what we see as a curriculum designed to meet the needs of childbearing women and prospective students, there have been many dissenting voices in the field. For example, one university's course approval committee requested a complete rewrite of the curriculum in 'medical language' so that they could be sure that there was 'nothing missing'. It seems that such a panel of educated men and women were unable to read 'women's language'. As expected there was always comment on content – either too much or too little emphasis on science, social science, women's health, paediatrics and so on. However, there seemed little concern or comment about the needs of women. Rather, one comment received seemed to sum up a general disease in saying 'This course is too women-focused'.

The dissonance that came with compromise at times seemed too hard to tolerate. Inevitably, some subjects in the programme were to be shared with other disciplines, such as biomedical science, psychology and sociology, and, of course, nursing. This sharing has had two effects: the cost-efficiencies that come with critical mass in high-resource subjects, and the quieting of the voices which suggested that the level of expertise in midwifery would not be sufficient to ensure 'quality' in these areas. It is also fair to say that the politics of demarcation and 'turf' had to be attended to, and sharing was an effective way of doing that.

In trying to please our faculty colleagues in order to have our course approved, it seemed that we were in danger of alienating those we most wanted to work with – the women.

Interested women

Part of the groundswell contributing to a climate of change in midwifery practice and educational preparation were the voices of interested women, both individual and as part of special interest groups. Special interest groups in Victoria, Australia included The Maternity Coalition Incorporated, 'an umbrella organization for midwives, mothers and other individuals interested in birth writes, rites and rights', and choices for childbirth.

Women who wanted to be midwives, as well as mothers seeking alternative ways of giving birth, wanted to be part of the process of curriculum development. This was initially accommodated by inviting representative women to an information day, and later by asking consumer representatives to be part of the curriculum development committees of the four Consortium universities. While ongoing consultation and negotiation were seen as a desirable goal when devising a course aimed at, among other things, meeting the needs of interested women, there were difficulties. Following initial consultation, much discussion was needed before Consortium members had a clear idea of the structure of the course.

The process, predominantly through the curriculum development committee consumer representatives, became one of negotiation, sharing and compromise. It would be true to say that not everyone was completely satisfied; however, Consortium members were increasingly aware of the fact that politically the time was right. While some compromises had to be made in relation to the requirements of each university, the curriculum had, in essence, remained true to the philosophy driving the development of a Bachelor of Midwifery programme. Consortium members were also committed to the notion of the curriculum as a work in progress. That means a curriculum that is dynamic and will remain open in future years to contributions from everyone with an investment in seeing quality midwives working well with women and other stakeholders in maternity care.

The next stage of the journey

One of the most challenging questions being asked of the Consortium is how educational quality will be safeguarded in a Consortium arrangement with subject/s responsibility delegated to another university. We have worked closely as a group developing subject outlines and this responsibility will need to be extended to providing feedback and support for subject material development delegated to individual universities. We must be able to demonstrate a quality product that is not delineated by which university developed and delivers subject content.

Our next task is to ensure that midwives already working in the field recognize that they remain not only valued practitioners of midwifery, and will not be 'second class' midwives, but that they are also central to assisting Bachelor of Midwifery students to learn. Finally, our biggest challenge is to reassure the practice sites that these graduates will be valuable assets to the maternity services workforce, even if they are not nurses before becoming midwives. This lies at the heart of the need for Bachelor of Midwifery graduates to be able to find employment in midwifery. Given the critical state of workforce numbers in this country described above, perhaps in the end pragmatics will have the final say. Women *need* midwives. We believe our midwives will work with women to fill that need.

Conclusion

In this abbreviated travelogue we have attempted to describe our journey towards a new midwifery through a terrain of doubt, conflict and hope. The sustaining principles of women-centredness, feminist consensus and academic collegiality have assisted us to keep to our path. Through it all we

have maintained a vision of being truly with women as academics and as midwives, and have carried this through by choosing our co-travellers well. What we hope to have achieved through sharing our story is to encourage others to consider a similar path, and to create an awareness of the pitfalls, potholes and possibilities along the way.

The Werna Naloo Bachelor of Midwifery Curriculum was accredited by the Nurses Board of Victoria, Australia, and courses began in March 2002. A further postcard is planned at the next milestone when we see our first graduates in 2004.

References

Australian College of Midwives Incorporated (ACMI) (1998/2000) *Philosophy and Position Statements*. ACMI, Melbourne.

ACMI (Victorian Branch) (1999) *Reforming Midwifery. A Discussion Paper on the Introduction of Bachelor of Midwifery Programs into Victoria*. ACMI, Melbourne.

Barclay L. (1995) The education of midwives in Australia: current trends and future directions. In *Issues in Midwifery* (Murphy-Black T. ed.), Churchill Livingstone, Edinburgh.

Bastian H. (1992) Confined, managed and delivered: the language of obstetrics. *British Journal of Obstetrics and Gynaecology*. **February 99**, 92–93.

Cook J.A. & Fonow M.M. (1990) Knowledge and women's interests: issues of epistemology and methodology. In feminist sociological research. In *Feminist Research Methods: Exemplary Readings in the Social Sciences* (McCarl Nielsen J. eds), West View Press, London.

Coslett T. (1994) *Women Writing Childbirth: Modern Discourses of Motherhood*. Manchester University Press, Manchester.

Darbyshire P. (1994) Understanding the life of illness: learning through the art of Frida Kalo. *Advanced Nursing Science* **17**, 51–59.

David P.M. (2000) *Look who's talking. Women and midwives speak partnership*. Unpublished Masters Thesis. University of Tasmania, Launceston.

Freda M.C. (1995) Arrest, trial and failure. *Journal of Obstetric and Neonatal Nursing* **June**, 393–394.

Fullerton J.T., Shah M.A., Holmes G., Roe V. & Campau N. (1998) Direct entry midwifery educational evaluation of program innovations. *Journal of Nurse Midwifery* **43**, 102–105.

Guilliland K. (1999) Managing change in midwifery practice. The New Zealand experience. Ace graphics [online]. http://www.acegraphics.com.au/resource/papers/guilliland0.1htr.

Guilliland K. & Pairman S. (1995) *The Midwifery Partnership: A Model for Practice*. Monograph Series 95/1. Victoria University of Wellington, Wellington.

Gum L. (1999) *Factors which affect the career decisions of new graduate midwives in Victoria*. Unpublished Masters Thesis. RMIT University, Melbourne.

Health Department of Australian Capital Territory (ACT) (1994) *ACT Maternity Services Review*. Australian Government Printer Service (AGPS), Canberra.

Health Department of Western Australia (1990) *Report of the Ministerial Task Force to Review Obstetric, Neonatal and Gynaecological Services in Western Australia*. Government Printers, Perth.

Hewison A. (1993) The language of labour: an examination of the discourses of childbirth. *Midwifery* **9**, 225–234.

Hundley V.A., Cruikshank F.M., Milne J.M., Lang G.D., Turner M., Blyth D., Glazener C.M.A. & Mollison E. (1995) Satisfaction and continuity of care: staff views in a midwife managed delivery unit. *Midwifery* **11**, 163–173.

Kitzinger S. (1998) Shiela Kitzinger's letter from Europe: obstetric metaphors and marketing. March. *Birth* **26**, 55–57.

Koutroulis G. (1990) The orifice revisited: women in gynaecological texts. *Community Health Studies* **14**, 73–84.

Leap N. (2000a) *Charting New Waters in Midwifery Education. Paper Presented at the New South Wales*. Midwives Association. Annual State Conference Midwifery Creating a Sea Change. Sydney.

Leap N. (2000b) ACMI Bachelor of Midwifery Education Task Force – Report. *Australian College of Midwives Journal* **13**, 22 & 23.

McCalman J. (1999) *Sex and Suffering. Women's Health and A Women's Hospital*. Melbourne University Press, Melbourne.

McKay S. (1993) Models of Midwifery Care: Denmark, Sweden and the Netherlands. *Journal of Nurse Midwifery* **38**, 114–119.

Murphy-Black T. (ed.) (1995) *Issues in Midwifery*. Churchill Livingstone, London.

National Health & Medical Research Council (NHMRC) (1996) *Options for Effective Care in Childbirth*. AGPS, Canberra.

New South Wales Department of Health (2000) *Survey of New Midwifery Graduates*. NSWHD, Sydney.

NHMRC (1998) *Review of Services Offered by Midwives*. AGPS, Canberra.

Oakley A. (1984) Doctor knows best. In *Health and Disease: A Reader* (Black N., Boswell D., Gray A., Murphy S. & Popay J. eds) Open University Press, Cork.

Owen V. (2000) ACMI Bachelor of Midwifery Education Project. *Australian College of Midwives Journal* **13**, 22–23.

Report of the Ministerial Review of Birthing Services in Victoria (1990) *Having A Baby in Victoria*. Department of Human Services, Melbourne.

Senate Community Affairs References Committee (1999) *Rocking the Cradle. A Report Into Childbirth Procedures*. Senate Printing Unit, Canberra.

Smulders B. (1999) *The Place of Birth: The Dutch Midwifery System*. Ace Graphics, Sydney [Online]. http://www.acegraphics.com.au

Tew M. & Damstra-Wijmenga S. (1991) Safest birth attendants: recent Dutch evidence. *Midwifery* **7**, 55–63.

Thompson A. (1991) The midwife's contribution to the health of women and children. *Midwifery* **7**, 53–54.

Tracy S., Barclay L. & Brodie P. (2000) Contemporary issues in the workforce and education of Australian midwives. *Australian Health Review* **23**, 78–88.