THE AMAP REPORT
VOLUME I

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Glossary

ACMI: Australian College of Midwives Incorporated
AHWAC: Australian Health Workforce Advisory Committee
AMAP: Australian Midwifery Action Project
AMWAC: Australian Medical Workforce Advisory Committee
ANCI: Australian Nursing Council Incorporated
ARC: Australian Research Council
BMid: Australian Three-Year Bachelor of Midwifery
CFHM: Centre for Family Health and Midwifery
DEST: Department of Education, Science and Training
DHS: Department of Human Services
EFTSU: Equivalent Full Time Student Unit
EONM: Executive of Nursing and Midwifery in WHA
NHMRC: National Health and Medical Research Council
NMAP: National Midwifery Action Plan
NSW Health: New South Wales Department of Health
NUDIST: Non numerical unstructured data indexing searching and theorizing
SPIRT: Strategic Partnerships with Industry Research Training
UTS: University of Technology, Sydney
WHA: Women's Hospitals Australasia
WHO: World Health Organisation

Letter of Introduction

Dear Reader,

I have been privileged to lead the AMAP Team as we investigated the service delivery, educational policy and regulatory environments affecting midwifery in Australia. Our goal has been to provide information to assist industry partners, health departments, health services, universities and regulatory bodies to improve maternity care.

Midwives are the largest single group of health workers in the maternity care system. No comprehensive analysis of Australian midwifery policies was available at the time the research began, nor were the effects of recent changes in midwifery policies, regulation, education and service delivery well understood. Policy and planning is constrained by divisions within and between the professions of midwifery and nursing, and by inadequate communication between stakeholders involved in maternity care. Recent evidence suggests that the industry is having difficulty maintaining high quality services because of shortfalls in the number of midwives, especially in rural and remote areas, and there are concerns by employers over the standard of some graduates (NSW Health 2000). As over 250,000 instances of care are provided by Australian midwives each year (Nasser et al 2001), a national study was urgently needed to investigate the present constraints on the midwifery contribution to maternity care.

The project investigated maternity service provision, midwifery education, policy and regulation and analysed the barriers to safe and cost effective midwifery care. It also examined the problems of communication and co-ordination across these sectors. An action oriented research process facilitated the collaboration of Industry Partners, researchers, relevant organisations and the wider community in active collaboration throughout the project. This positioned the work to actively inform and support improvements in midwifery care. Important research participants included health services and agencies who provide maternity care; professional organisations for midwifery, nursing and obstetrics; educators and institutions involved with midwifery education; statutory authorities responsible for the regulation of midwives; and consumer groups. These stakeholders collaborated in the research to generate the outcomes needed to inform: maternity service policy and service provision; the education of midwives; and the workforce and the regulation of midwives within the maternity sector.

The research has provided information that will assist the professions, health departments, health services, universities and regulatory bodies to co-ordinate planning and improve their contribution to the quality of maternity care in Australia.

My role was to supervise the student candidature of Pat Brodie (PB) and Sally Tracy (ST), to coordinate investigators and to supervise the activities of employed staff and stakeholders involved. Kerreen Reiger (KR) and Karen Lane (KL) contributed related but distinct studies, Linda Saunders (LS) provided legal advice for our work on regulation and Sally Tracy and Pat Brodie undertook the bulk of the research and consultation activity. Nicky Leap began her role as an investigator from Flinders University and later was employed as a researcher on midwifery education.

For those who need detail and substance not possible to include in Volume I, I suggest you obtain Volume 2 of our report or refer to the professional doctorates of Pat Brodie, Sally Tracy and Nicky Leap. Only material that has been read and endorsed by all industry partners has been included in Volume 2. Material not readily available in published form can be extracted from the professional doctorates of Sally Tracy and Pat Brodie or obtained from the Centre or the investigator involved.

On behalf of the industry partners, investigators, employed staff and doctoral candidates I commend this report to you.

Professor Lesley Barclay

Background

In April 1997, a group of midwifery educators, practitioners and researchers met in Melbourne to share their experience of current issues affecting midwifery in Australia. An increasing level of concern was being raised about problems with standards of education, midwifery practice and the limited range of midwifery services available to women. Informally, through various networks, there was growing consensus that midwifery education and practice in Australia was falling behind standards elsewhere and that urgent evaluation and assessment was required. Directors of Midwifery Services had also shared with Professor Barclay their concerns about standards of newly graduated midwives. A plan was reached to pursue funding for a major national study about midwifery and the role of midwives in Australia. A meeting with Maternity Coalition, a maternity services advocacy group, provided the basis for consumer involvement in the study. At about the same time, the organisation known as 'Women's Hospitals Australia' (subsequently to become 'Women's Hospitals Australasia') was concerned about the calibre of midwives who were seeking employment following graduation. The resulting funding proposal brought together researchers from the fields of midwifery, nursing and sociology, along with five separate industry partners.

The Australian Midwifery Action Project (AMAP) subsequently received funding from the Commonwealth government through the Australian Research Council as part of its Strategic Partnerships with Industry Research and Training (SPIRT) program. This funding was awarded, in part, on the basis of the significant support of the project by industry partners. The project commenced in April 1999. The overall aim of the study was to conduct an analysis of the effects of recent changes in maternity care policies, midwifery regulation and educational systems as well as models of care and practice. The study was designed under SPIRT auspices to include the research training of two midwives undertaking postgraduate qualifications.

The research endeavoured to maintain a national focus through the extensive use of Internet technology, networking and structured workshops undertaken in all states and territories over the three years. Chief Investigators contributed from three states and four universities.

Terms of Reference

The contract between UTS and the Industry partners (Schedule 2) stated that a national research project entitled 'The improvement of midwifery care', would 'provide information that [would] assist Industry Partners, health departments, health services, universities and regulatory bodies to co-ordinate planning and improve the implementation of maternity care.'

The two main aims of the research project were:

- To investigate the service delivery, educational, policy and regulatory environments affecting midwifery in Australia;
- To analyse and facilitate collaboration, planning and communication across these sectors.

Two senior research officers (postgraduate research students) would undertake candidature in a doctorate at the University of Technology, Sydney, under the supervision of the principal investigator, Professor Lesley Barclay, and produce research theses around Strand I and 2 from the project data, [to] inform the final report.

Research Team and Industry Partners

The team was lead from UTS by Lesley Barclay, who was responsible for project design and oversight. Two research midwives, Pat Brodie and Sally Tracy, conducted the research on a full-time basis, along with Nicky Leap as Chief Investigator initially from Flinders University, South Australia and then, UTS, Sydney. The project was managed by Ruth Worgan.

As Chief Investigators, Karen Lane and Kerreen Reiger contributed their discrete research and, with Linda Saunders, provided support to the UTS researchers in carrying out the project.

Industry Partners were: The Australian College of Midwives Inc.; New South Wales Department of Health, Office of the Chief Nursing Officer; South Australian Department of Human Services, Nursing Branch; South Eastern Sydney Area Health Service; Women's Hospitals Australasia.

About this Report

This report is presented in two volumes in order to meet the challenge facing the research team of providing an effective report on an action oriented research project[1]. This was designed both to conduct discreet empirical studies and to inform and facilitate improvements in midwifery within maternity care. Volume I outlines the activities and methods employed by the project, the summary of research findings, a brief discussion and recommendations. Many of the publications arising from the research are presented in Volume 2.

The Australian Midwifery Action Project was, as its name implies, focused on research and action for improvement in maternity care. Therefore, we have reported research findings and activities within each section. Some 'actions' constituted empirical studies whilst others took the form of processes such as: reports, submissions, attendance at key meetings, presentations, consultancies, workshops, and responding to requests for research evidence or information.

The researchers have included a table of the various people and organisations who were contacted and consulted during the term of the project. The reader will become aware of the multiple areas of policy, education, service provision, regulation and consumer participation where the AMAP team became involved to support or inform those responsible for change.

The research project was unique in that the two full time researchers undertook the inaugural Professional Doctorate in Midwifery at the University of Technology in Sydney alongside the AMAP project. For this reason, some of the referenced research and texts referred to in Volume I will be found in the published professional doctorates of one or other of the research midwives (Sally Tracy or Pat Brodie).

The AMAP research midwives were based at the Centre for Family Health and Midwifery within the Faculty of Nursing Midwifery and Health at the University of Technology, Sydney. This provided them with an opportunity to draw on a wider body of research in addition to that specifically undertaken within the AMAP project. Where appropriate, references are made to the research work being undertaken by other midwives or affiliates of the Centre during the course of the AMAP project. The researchers are identified within the report by their initials.

[1] These have both been published on a CD-ROM for economical distribution and available from the Centre for Family Health and Midwifery, UTS.

Research Categories

This chart has been used to categorise each piece of research and help to clarify the evidence that informs the recommendations in the report[2]. The categories listed in the following chart indicate the nature of the investigations and clarify the status of the evidence informing the Recommendations.

'Categories' Chart

A	Original AMAP research and critique
B	Original research carried out in the professional doctorates of AMAP researchers
C	Research carried out by AMAP researchers in conjunction with others
D	Evidence from literature reviews carried out by AMAP researchers
E	Consensus expert opinion of the AMAP researchers derived from the project

Research Questions

The research addressed these questions:

- What are the barriers to the provision of safe, efficient and economic midwifery care within maternity services?
- What are the strategies to overcome these barriers?

The project, therefore, consisted of two concurrent and interlinked strands:

STRAND I consisted of several interrelated studies investigating state and territory differences in service provision, education, policy and regulation associated with midwifery care within maternity services.

STRAND II worked towards interaction across sectors during the research and engaged a broad range of individuals, groups and institutions in the research process.

The aims and objectives were:

- To investigate the service delivery, educational, policy and regulatory environments affecting midwifery in Australia
- To analyse and facilitate intersectoral collaboration, planning and communication across these.

[2] The Research Categories are an organizing structure and not a hierarchy of evidence

Executive Summary

This Executive Summary and Recommendations reflect the findings of the research carried out by the AMAP team that are summarised in Volume I of this report. Further detail is available in full in Volume 2 and in the Professional Doctorates and other publications of Sally Tracy, Pat Brodie and investigators.

SERVICE PROVISION

The government, the midwifery profession and education sectors must accommodate changing community and workforce needs through changes to maternity care delivery across Australia. Whilst addressing the tensions that exist between the primary health care model and the realities of midwifery services provided under acute care hospital management and funding systems, the needs of industry must also be met in relation to service provision. This means developing models of service delivery based on evidence of safety and cost effectiveness, that promote collaboration, communication and co-ordination between health care professionals and link hospital and community care.

The findings from AMAP show that many of the midwives who responded to our national surveying process believe midwives leave the maternity service disillusioned by the lack of recognition of their skills and potential role. This was also supported by the research undertaken with WHA Executives of Nursing and Midwifery. Midwives are made invisible by the over riding 'culture' of the acute services system and payment systems that create barriers to their practice. This is compounded by constraints within traditional models of service provision that prevent midwives practising across the full spectrum of care, or to the full potential of their role.

At present the focus of maternity care appears to be driven by funding models and the difficulty of providing financial support for alternative models of care, rather than the identified needs of women. A funding model that recognises the importance of community based care and continuity of midwifery care within a public health framework would address this.

WORKFORCE

An acute shortage of midwives is a global problem, not unique to Australia, but presents a crisis with the potential to compromise the quality and safety of Australia's maternity care. The need for high quality data on the midwifery labour force is pressing (AMWAC 2002 - a final draft report on the Midwifery Workforce is currently being discussed prior to its release by the Health Ministers). The capacity to draw meaningful conclusions is currently compromised because of the use of non-standardised terminology and the incompatibility of databases and data domains. It is difficult to form a national picture with published sources of data because there are differences in definition and a lack of relevant information.

EDUCATION

When considering workforce requirements and program development, providers of midwifery education must address the current and future needs of women. There are 27 post basic [nursing] midwifery courses on offer in the universities of Australia; however, there is no overall consistency in design, duration or level of award both nationally or within each separate state. Many programs appear deficient in clinical experience for students. At present there is no national monitoring system to guarantee comparability or an adequate baseline of theory, competence or award nomenclature. Standards are not compatible with international midwifery education programs, particularly in relation to the length of courses and therefore, Australian midwives have to undertake further education if they wish to enter practice overseas.

The Australian College of Midwives Inc (ACMI) recently led the development of national standards for the 3-year Bachelor of Midwifery (BMid) program. This demonstrated excellent national

professional leadership in facilitating consensus from experienced educators across the country on standards required to enter practice with regard to international compatibility. Regulatory authorities with the responsibility to establish and monitor standards for midwifery education should adopt these standards for all programs. This will require national or State and Territory jurisdictional commitments, incentives or requirements to comply with the national standards.

With the transfer of midwifery education to universities, health services reduced their responsibility for student learning as their budgets for this responsibility were removed. Increasing health industry 'ownership' of midwifery education and investment in students to achieve workforce and clinical competency requirements could re establish the balance between university education and clinical leadership. This may improve recruitment. The supernumerary status of midwifery students appears to exacerbate the separation of the educational program from industry involvement or investment in some jurisdictions. This also perpetuates economic hardships for students and a fragmented service to women.

Australia women in rural and remote areas are suffering most as a result of shortages of midwives. There are particular problems related to recruitment and retention when addressing the needs of rural Australia, especially those of Indigenous communities. Both the cultural and financial barriers to the training and education of Indigenous midwives are significant. The cost, duration and geographic location of the present midwifery training programs disproportionately disadvantage Indigenous and rural women. Many potential students, in particular those from Indigenous and/or rural and isolated backgrounds, cannot afford postgraduate study in nursing and are facing financial hardship following further education. Women in female dominated professions feel particularly disadvantaged by up-front fees where a relatively low level of employer support, combined with low incomes, pose serious equity problems.

The current system of addressing the continuing education of midwives in Australia is ad hoc and needs systemic review. This is linked to a lack of national education and regulation standards regarding recency of practice and the ongoing competency requirements for midwifery practice.

In 2002, new midwifery education programs commenced in Australia in the form of a three-year Bachelor of Midwifery (B Mid) and a four-year double degree in Nursing and Midwifery. National research is needed to investigate, monitor and evaluate the introduction of these programs and to compare and standardise outcomes with other midwifery education programs in Australia and internationally.

REGULATION

A lack of consistency and evidence of discrepancies in the standards of midwifery education and practice regulation have been identified nationally. There is an urgent need for improvement and increased national consistency within any regulatory reform that protects the consumers of services and requires educational standards to be met. This change must recognise and deal with the different characteristics of nursing and midwifery. With an increasing emphasis on the use of evidence to inform practice, policy making and the organisation of services, the midwifery profession is challenged to change and develop, in order to meet the needs of the community, governments and employers. This impacts on regulation and monitoring of the performance of practitioners and on the regulations put in place to protect the community.

CONSUMERS

Consumer participation has been at the forefront of state and federal government policies. Providers in the public sector are now required to instil mechanisms at policy, planning and service provision levels to ensure that consumers' needs are canvassed, documented and instituted in corporate policies and services. AMAP has shown that consumer participation initiatives have been instituted at the policy level but are implemented only marginally in clinical settings and relationships.

Recommendations[3]

The themes of the AMAP study – service provision, workforce, education, regulation and consumers - are reflected in the organisation of these recommendations:

SERVICE PROVISION

Recommendation 1

That an evidence-based, woman centred approach to the provision of public sector maternity care be adopted. This would involve the mainstreaming of models of continuity of midwifery care that have been demonstrated to be effective in the Australian setting.

Recommendation 2

That models of maternity care be implemented to provide high quality, safe, appropriate and cost effective care:

- To enable midwives to practise according to the full potential of their role, providing continuity of care to women across the interface of community and acute services
- To ensure that midwives practise within a framework that is supportive, collaborative and interdisciplinary.

Recommendation 3

That both Commonwealth and State governments review the funding mechanisms that govern the provision of maternity care in Australia in order to support community orientated maternity services and midwifery care as an option for women.

Recommendation 4

That midwives be authorised to order and interpret a limited range of tests and to prescribe specified drugs as part of the care of healthy women during uncomplicated pregnancy and childbirth, as already recommended by the 1998 'NHMRC Review of Services offered by Midwives'. This should be implemented immediately.

Recommendation 5

That, in order to support enhanced midwifery practice through the development of national standards, leadership and a cohesive political voice, the Australian College of Midwives Incorporated develop further strategies to increase its profile within health services.

WORKFORCE

Recommendation 6

That a national database of the midwifery workforce be developed to allow for rational planning of the future midwifery workforce.

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[3] Recommendations are repeated within the sections of this volume that generated the findings on which they are based.

Recommendation 7

That research identifying issues related to recruitment, retention, attrition and the employment profile of new midwifery graduates to be funded by the Commonwealth government.

Recommendation 8

That the current midwifery workforce shortages be addressed through national recruitment and retention strategies[4] targeted to areas of critical need. This may require collaboration and involvement by the Commonwealth government, the state and territory governments, the professions and/or industry.

Recommendation 9

That workforce development and maintenance of midwifery practice standards be identified in the overall planning and provision of safe and supportive maternity care in any setting.

EDUCATION

Recommendation 10

That the Commonwealth DEST increases its allocation of funded positions for students (EFTSU) in midwifery education programs.[5]

Recommendation 11

That dedicated funding be identified to promote collaboration between industry and universities to guarantee adequate clinical placements in hospitals, birth centres, midwifery models and community midwifery settings in order to achieve minimum clinical practice standards in midwifery education.

Recommendation 12

That the interface between universities and the health system be strengthened in midwifery education, emphasising the importance of clinical placements and the engagement and investment of clinicians and health services in the teaching and assessment of students.

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[4] Since the AMAP research was carried out the findings of the National Review of Nursing Education (Department of Education, Science and Training, 2002) have been published. We support the relevant recommendations of the Review that suggest strategies to improve recruitment and retention with the proviso that the wording of this Review be changed throughout to include midwifery [our italics below]:

Recommendation 3 – State and Territory governments should establish nursing and *midwifery* workforce forums

Recommendation 12 – Maximising education pathways

Recommendation 23 – HECS for undergraduate nursing and *midwifery*

Recommendation 24 – Clinical education funding

Recommendation 25 – Commonwealth assistance for specialty, *midwifery* and re-entry courses

Recommendation 26 – Remuneration for practice: postgraduate award course recognition

Recommendation 33 – Commonwealth funding for additional undergraduate university places 'to include direct-entry midwifery' (p.13)

[5] National Review of Nursing Education (Department of Education, Science and Training, 2002)

Recommendation 13

That the amount and nature of supernumerary content of programs be reviewed to ensure:

- Students 'belong' to a clinical workforce and benefit from becoming part of a clinical team;
- An appropriate system of funding by jurisdictional health authorities support and resources from industry enables this to happen.

Recommendation 14

That active support and incentives are funded and implemented for rural students and Aboriginal and Torres Strait Islander students to enter programs that meet their learning and cultural requirements.

Recommendation 15

That the costs for students undertaking midwifery education be subsidised in the light of workforce shortages.[6]

Recommendation 16

That the Commonwealth Government funds the evaluation of the introduction of the three-year Bachelor of Midwifery and the double degree in Nursing and Midwifery.

REGULATION

Recommendation 17

That the ACMI standards for midwifery education and practice be adopted by all regulatory authorities as the national standards for midwifery education and practice, and that the ACMI and service providers become key participants in the accreditation of all courses leading to authorisation to practise midwifery.

Recommendation 18

That the renewal of registration for midwifery practice be tied to continuing education and recency of practice.

Recommendation 19

That all industrial, legislative and regulatory frameworks give recognition to the safety and cost effectiveness of midwifery care recognising and licensing the midwife as a practitioner in her or his own right.

Recommendation 20

That the current State and Territory Nurses Regulations be strengthened to improve standards in the accreditation of midwifery education programs and national comparability through a national organisation such as a National Nursing and Midwifery Council of Australia[7].

[6] Recommendations are repeated within the sections of this volume that generated the findings on which they are based

CONSUMERS

Recommendation 21

That providers initiate coherent policies at regional, stat and national levels to encourage the participation by consumers in planning, reviewing and monitoring maternity services and that jurisdictional health authorities fund these initiatives.

Recommendation 22

That attention be directed towards philosophies and models of care that recognise the importance of placing women at the centre of decision-making about their own care.

[7] For National Nursing and Midwifery Council see: Commonwealth of Australia (2002). National Review of Nursing Education. Final Report. Our Duty of Care. Department of Science, Education and Training.

Research Approach

Given our dual goals of generating information as well as facilitating change, we have described how we conducted this research overall, and the rationale for taking a pluralist approach. The scope and diversity of the AMAP project required multiple methods and an operational research approach. This is reflected in the way the research is presented, not solely as a series of empirical studies, but rather as a series of activities that involved 'mapping' key areas of concern and consulting widely with stakeholders to develop a number of outcomes and recommendations. The stakeholders in the project consisted of Australian women, the midwifery profession, health service leaders, regulatory bodies, the academic community and related professions. The areas of investigation included maternity consumer needs, midwifery practice, maternity service provision, and midwifery workforce, regulation and education.

A variety of research and engagement strategies were used by researchers involved in the AMAP project. These reflect the shift in social science research away from traditional methods that sought to emulate natural science techniques and principles. By contrast, like many other research projects in health care, AMAP investigations drew on a combination of quantitative data collection, interpretive methodologies, and most notably, an action-orientation. In the post positivist environment of contemporary research, models of knowledge and research processes tend to be pluralist.

AMAP therefore consisted of a range of research strategies, around an action orientation towards improving the role played by midwives in the Australian maternity care system. This was an ambitious project with no comparable studies to provide a reference point. In view of the aims of the project, an eclectic range of strategies was chosen in what Denzin and Lincoln (1998) refer to as a process of constructing a 'bricolage', a 'pieced together' construction to 'provide solutions to a problem in a concrete situation'. Thus the researcher as 'bricoleur' uses the tools of his or her methodological trade, deploying whatever strategies, methods or empirical materials are at hand and not determining in advance which techniques to use.

Within a post positivist framework, however, some endeavors were situated within more conventional positivist data-gathering and analysis strategies. The education and regulation studies, data on the midwifery workforce, and on aspects of professionalisation remain within conventional data gathering and analysis strategies. While divided into three sub-projects on education, regulation and service provision, and aiming at both data collection - Strand I's 'mapping' - and the awareness raising, communication enhancing and intervention activities of Strand II, the discrete studies share some common underpinnings. These will be articulated below in terms of an action framework, in particular one influenced by feminist research practice.

While AMAP was not a conventional, neatly demarcated action project in the sense of establishing a singular intervention process, which was evaluated, theorised and fed back to the field, it is appropriately understood in the 'professional practice' action tradition (Winter 1989). Here the focus is on the study of a social situation, often by professionals, with a view to improving the quality of action within it. The professional practitioner, in this case the midwifery research staff, shaped the agenda, linking previous practice experience and theoretical analysis. Compared with either conventional social science or conventional action research, practitioner action research attempts to implement change within a professional environment (Winter 1989).

Several methodological characteristics follow from locating AMAP in this tradition that are also influenced by feminist research strategies. These include:

- **Close personal involvement of researchers in the research process**: as against positivist social or natural science, interaction is intrinsic, so researchers' distance or detachment from the 'data' is not only not to be expected but would hinder the insights of being part of the professional field under scrutiny. Indeed passion and emotion are actually necessary to the action research process. As Morton-Cooper (2000:8-9) points out 'Without active engagement and personal as well as collective commitment to its aims, action research withers and dies on the vine. [It] describes a real-world intervention in a real-life scenario and in many ways it is dramatic, contentious and fraught with

inconsistency and unpredictability'. The crucial feature is an attempt to improve practice as well as produce knowledge.

- **Critical reflexivity and cyclic nature of action research**: much recent qualitative research stresses the extent to which researchers need to be flexible and adapt research processes in the light of attention to emerging findings. For example positioning the approach, data collection and findings in relation to midwifery education in ways that simultaneously respect the work of those providing data. Something (at least partially) hidden is exposed- leading to increased academic insight, and increased politicisation and corresponding activism' (Fonow and Cook 1991). For example, the analyses of workforce and education issues have been crucial to national inquiries and the analysis of regulation is informing state and territory level reform. However no final answers are possible as the social situation continues to unfold. Conventional ideas of 'data-gathering, then analysis, then implementation' are inadequate for action research in which reflection needs to be built into the actual research process (Winter 1989:35). New forms of validity are hence also involved. The validity of research is ascertained less through a formal process than through carrying 'cultural validity' i.e. 'whether it provides a trustworthy and believable narrative of the social interactions involved in bringing it about' (Morton-Cooper 2000:85). Validation techniques nonetheless remain important. Almost every piece of work undertaken within Strand I has been subjected to conventional review process and published. We have also drawn on methodological triangulation or using a multimethod approach, which admits data from several sources. AMAP investigations took a range of directions, yet there was congruency of findings regarding the invisibility or insufficient visibility of midwifery in policymaking, workforce and state information systems, and in a selection of midwives' views about this.

- **Use of the 'situation at hand'**: much qualitative and feminist research is pragmatic, prepared to use 'already given situations' as a methodological strategy (Fonow and Cook 1999:11). The opportunities presented by government inquiries, public meetings, seminars and conferences presented the AMAP team with chances to discuss the project but also intervene in political action towards heightening consciousness of problems affecting midwifery and maternity care more widely. A problem of evaluation of impact or effect arises especially in short term. 'Consciousness-raising' is hard to measure. However, examples in the brief summary of Strand II suggest the breadth of consultation, and outcomes of this process have both been fundamental to the research and highly significant. The researchers' own experience of interaction and reflection should also be considered as integral to this evaluation.

- **Reporting action research**: Final reporting can never be 'final' in that action research is exactly that, a cycle of ongoing change (Wadsworth 1984), hence, in action research the final writing process is not the whole product as it is also the bringing together of practitioners which contributes to change. This report therefore tries to reflect and do justice to work from both Strand I and Strand II, while acknowledging the limitations in doing full justice to the work conducted in Strand II.

The operational research methods undertaken during the three years fall into three main categories. These are broadly defined as: Mapping activities – Strand I; Consultation – Strand II; Informing Developments – Strand II. The activities of the researchers are summarised in the report under these headings.

MAPPING ACTIVITIES

The mapping actions involved the initiation of a number of projects.

SERVICE PROVISION

1. **Brodie P. (2002) Addressing the barriers to midwifery: Australian midwives speaking out. *Australian Journal of Midwifery* 15 (3): 5–14.**

A national study of midwives' own perceptions of barriers to their full contribution to high quality maternity care was explored using the 'graffiti' method of data collection and a qualitative method of data analysis.

2. **Tracy S. (2002) A study of the views of WHA Executives of Nursing and Midwifery from tertiary teaching hospitals in each state of Australia.**

A modified Delphi technique was used to draw together the expertise of a sample of managers of midwifery and nursing services from managers within Women's Hospital's Australasia

3. **Several papers were prepared primarily as part of the professional doctorate of one of the research midwives (ST).**

This work involved collaboration with others outside the AMAP project; however, the research findings further enhanced and informed the AMAP project on policy issues affecting the scope of practice of Australian midwives.

The study: Roberts CL, **Tracy S**, Peat B. (2000) Rates for obstetric intervention among private and public patients in Australia: a population based descriptive study. British Medical Journal 321: 137-141, was undertaken in collaboration with the research director of the NSW Centre for Perinatal Health Services Research and a multidisciplinary team to ascertain the rates of obstetric intervention for otherwise low risk women in Australia

A further study: Roberts CL, Algert CS, Douglas I, **Tracy S** and Peat B. (2002) Trends in labour and birth interventions among low risk women in New South Wales. ANZJOG, was undertaken with this multidisciplinary group, using similar methods, to ascertain the trends of obstetric intervention in childbirth for low risk women.

A costing formula was devised by ST to assist midwifery managers to project the current costs of care for low risk women in order to evaluate the economic effect of introducing midwifery models of care within a finite health budget. The model was developed using population data. This paper: **Tracy S** and Tracy MB. (2002) Costing the cascade: Estimating the cost of increased obstetric intervention in childbirth using population data. (Accepted for publication in British Journal of Obstetrics & Gynaecology 18th October 2002) will be published shortly.

A study undertaken to compare midwifery in New Zealand and Australia in terms of the funding of midwives and public health outcomes. This paper will be found in the Professional Doctorate of ST and is being prepared for publication and will be published as: **Tracy S** and Guilliland K. (2002) Midwifery as a public health strategy: is there any evidence?

4. **Reiger K. (2002) Difficult Labour: struggles to change Australian maternity care**.

This paper will be submitted for journal publication. It outlines the complexity of state–commonwealth relations, health financing and a lack of political will to change maternity care in the face of dominant medical interests and organisational restructuring in the new market state of the 1990s.

5. Lane K. (2002) Midwifery: A profession in transition. *Australian Journal of Midwifery*, 15(2): 26-31

This study sought to understand how midwives expressed their professional practice via reference to the two major competing discourses informing midwifery: an obstetric assistant model and a professional, independent model.

6. Submissions to Senate Inquiries.[8]

Submissions to Senate Inquiries provided the AMAP project with an opportunity to carry out extensive literature reviews of both national and international evidence and materials. The process of preparing and presenting these submissions partially fulfilled the aim of engaging with policy makers and politicians on the need for reform within the maternity services. The research team were invited to give oral submissions to both Inquiries and were invited to participate at the Senate Funding Round Table in Canberra. The written and oral submission made to the Senate Inquiry into Childbirth Procedures on the 6th August 1999 drew attention to evidence that demonstrated the range and provision of antenatal care services; the variation in childbirth practices with respect to the level of interventions such as caesarean birth; the rates of episiotomy and epidural anaesthetics between public and private patients; and variations in clinical outcomes associated with intervention rates, including perinatal mortality and maternal morbidity. A written and oral submission to the Senate Inquiry into Public Hospital Funding[9] on the 22nd October 1999 addressed how maternity services may be improved, within the legislated principles of Medicare, with particular reference to: the adequacy of current funding levels; current practices of cost shifting between levels of government for medical services; and the potential impact on consumers of cost shifting practices, including charges, timeliness and quality of services. This provided a valuable forum for the examination of funding models for midwifery within the Australian health system.

WORKFORCE AND PROFESSIONAL ISSUES

7. Tracy S, Barclay L and Brodie P. (2000) Contemporary Issues in the workforce and education of Australian midwives. *Australian Health Review* 23 (4): 78-88

The study was undertaken to identify the projected workforce deficit and to identify the current student midwifery deficit from all available published data. It included a mapping exercise to construct a profile of the current midwifery workforce.

8. Data on workforce issues generated by the AMAP Education Survey

This data confirmed concerns raised in the first year of the study and provided new data regarding recruitment and retention issues. NL

9. Reiger K. (abstract) The Organisation of a Profession.

This study (in progress) investigates the growth, organisation and perceptions of the present role of the Australian Midwives College Incorporated (ACMI).

[8] These were submitted on behalf of the research team alone. Industry partners made their own submissions through their various organisations.

[9] The AMAP submission concentrated on the funding of maternity services.

MIDWIFERY EDUCATION

10. Leap N, Sheehan A, Barclay L, Tracy S and Brodie P. (2002) Mapping Midwifery Education Survey: Findings of the AMAP Education Survey. Volume 2 of AMAP Report.

A telephone survey was undertaken with course coordinators of all programs for initial authorisation to practise midwifery. This is the most comprehensive data available on midwifery education in Australia.

11. Australian College of Midwives Expert Panel

ST was invited by one of the AMAP Industry partners, the Australian College of Midwives Incorporated, to provide research support and oversight to an Expert Panel convened to contribute evidence and monitor the introduction and development of the three year Australian Bachelor of Midwifery

12. Senate Inquiry into Nursing

Senate Community Affairs References Committee (2002). ST, NL. In June 2001 The AMAP team made a submission to the Senate Inquiry into Nursing [and midwifery] in Australia. The Inquiry attracted 975 public submissions, 13 confidential submissions and oral submissions in every capital city. The AMAP submission was based on our earlier workforce paper published in the Australian Health Review in 2000 (Tracy S, Barclay L and Brodie 2000). The submission was endorsed by the Faculty of Nursing, Midwifery and Health, UTS, Sydney, the ACMI and WHA. The Inquiry set out to consider the impact of the shortage of nurses (and midwives) on the delivery of health services in Australia, the opportunities to improve education and training to meet future labour force needs, the interface between universities and the health system. It also considered strategies to retain nurses (and midwives) in the workforce and to attract nurses (and midwives) back into the profession(s) as well as making a nursing (or midwifery) career more family friendly. Strategies for improving occupational health and safety were also considered. NL also submitted a paper in response to specific questions asked by one of the Senators participating in the Inquiry.

13. National Review of Nursing Education.

The AMAP team did not formally submit to the National Review of Nursing [and Midwifery] Education (Commonwealth of Australia 2002) since two AMAP researchers (NL and LB) were commissioned to provide a review of midwifery education for this review under the auspices of the Centre for Family Health and Midwifery. However, a submission based on the one prepared for the Senate Inquiry into Nursing by AMAP was forwarded to the National Review of Nursing at the request of the review secretariat during the final stages of their analysis.

14. Leap N. (2002) Identifying the midwifery practice component of Australian midwifery education programs: results of the Australian Midwifery Action Project (AMAP) Education Survey. *Australian Journal of Midwifery* 15 (3): 15–23.

This publication is the first of a trilogy reporting on aspects of the AMAP Education Survey.

REGULATION

15. Submission to the NSW Department of Health on the Revision of the Nurses Act 1991

ST, LB and PB provided an extensive literature review of the current legislation affecting midwives in Australia, and set this within a comparison of other similar health systems and models. The submission identified that the practice of midwifery in Australia is undergoing examination. This requires us to re examine the regulatory procedures governing the education and practice of

midwifery. The review of the NSW Nurses Act 1991 has the potential to become an innovative and visionary article of legislation that could be a benchmark for changes in other Australian states and territories.

16. Brodie P and Barclay L. (2001) Contemporary Issues in Australian Midwifery Regulation. *Australian Health Review* 24 (4): 103–118

An empirical study of all Australian Nurses Acts allowed an in-depth examination and comparison of key factors in the various statutes that affect contemporary midwifery practice and education.

CONSUMER PARTICIPATION

17. Lane K. (2000) Consumers as arbiters of professional practice? What does this mean for users of maternity services? *Sociological Sites/Sights.* TASA Conference. Adelaide. Flinders University. December 6-8

This paper reviewed the public policy with reference to consumer participation in maternity services. The paper assessed specifically the shift in emphasis from 'patient' to 'consumer' both in philosophical and empirical terms. Major reports commissioned by the Department of Human Services in Victoria were evaluated with the conclusion that only the midwifery partnership model of care could provide the optimal realisation of the 'consumer collaboration' policy envisioned by the Department of Human Services, Victoria.

18. Lane K. (2000) Multiple Visions or Multiple Aversions? Consumer representation, consultation and participation in maternity issues. *The Annual Review of Health Social Sciences Volume 10 (1) p 43-52.*

This paper reports on a case study of consumer participation in rewriting the annual report of a large tertiary provider of maternity services. The study found fundamental philosophical differences between consumers, research staff and obstetric staff around significant aspects of birth including the meaning of birth, the nature of knowledge, how to measure outcomes and ethical concerns. The paper concludes that philosophical differences between consumers and practitioners may be dealt with by establishing a dialogical relationship between the woman and her carer. This will ensure that processes as well as outcomes are negotiated to the satisfaction of the woman.

19. Lane K. Consumer Participation: A Hollow Promise? (In press).

This paper summarises the findings of a survey of all providers in Australia with more than twenty maternity beds. The findings showed variations in willingness to encourage consumers to participate at the Administrative, Ward and Clinical levels between providers and within each provider. Overall, consumer participation occurred usually through inclusion on committees and special projects. Notionally, informants cited a highly democratic model (The Collaborative Model) as the ideal model for consumer participation at the clinical level. However, this was not followed up in actual practice. Managers of Maternity Units reported that the Collaborative Model was the dominant model in only a minority of Units.

20. Lane K. The Way Forward: The Win-Win Solution, or Constructing Collaboration. (In press)

This paper reports on the fourth phase of the consumer participation study. The follow-up qualitative study of models of care showed that out of a sample of twenty providers, only five managers reported that the Collaborative Model had been instituted. The findings showed that the collaboration rests on four essential preconditions, without which co-operation between all participants (medical, midwifery, management and women) can not occur.

CONSULTATION AND DATA GATHERING

Appendix 1 contains a comprehensive table of consultations and meetings to raise awareness of the AMAP project is provided in Strand II: Strategising for Change.

1. Consumer Consultations

Consumer consultations were held with various organisations and individuals. This involved informal meetings, invited presentations at conferences, research advice and regular email communication between all the major consumer organisations and the AMAP research midwives. The following groups in particular have informed and advised the AMAP project:

- Women's Electoral Lobby
- Home Birth Australia
- Maternity Coalition in all states and territories
- The NSW Health Care Complaints Commission
- Keep Birthing In The Mountains Women's Group, NSW

2. Consultation with the Women's Hospitals Australasia Executives of Nursing and Midwifery.

In addition to the modified Delphi project, informal consultation occurred with several of the Executives of Nursing and Midwifery within the WHA organisation when the midwifery researchers attended WHA meetings and during the AMAP meetings between the research team and industry partners.

The Women's Hospitals Australasia Forum As the project drew to a close in the third year, WHA organised and funded a special day for the findings and strategies to be presented and debated with a group of invited Executives of Nursing and Midwifery (EONM's) from WHA. Hosted by the Royal Hospital for Women, Sydney, this was an interactive day and included participation in the final round of the EONM's Delphi study. The implications of the results that were available from the mapping exercises into midwifery regulation and education were also presented and discussed, as was the preliminary work on costing maternity care.

3. Midwives: Midwifery Clinical Practice Development

The research midwives (PB and ST) participated in national tours and conferences that provided midwives with the opportunity to discuss evidence-based strategies for improving birth outcomes. These also provided a valuable opportunity for isolated and remote and rural midwives in all states and territories to meet with the AMAP research team and establish ongoing links through the Internet.

4. Community Organisations

Community consultations were held by arranging visits to talk informally with representatives of the:

- The NSW Human Rights and Equal Opportunities Commission;
- New South Wales Health Aboriginal Maternal and Child Health Strategy;
- Commission for Social Justice, NSW.

5. Professional Organisations

Professional consultations were held in various ways. On the occasions below members of the AMAP research team were invited to present a prepared presentation to a meeting of executive officers, or state representatives at one of the major committee meetings of the organisations concerned. Following the presentation, questions and informal consultation followed. The following organisations participated and their expertise contributed to the findings of the AMAP project:

- Australian College of Midwives Inc
- Australian Nursing Council
- Australian Nursing Federation
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
- Chief Nurses of Australia
- Royal College of Nursing
- New Zealand College of Midwives
- Nursing Council of New Zealand
- National Nursing Workforce Summit

6. Representatives of Industry

The research team and Professor Barclay undertook similar consultation processes with the following industry representatives and stakeholders:

- Women's Hospitals Australasia
- National Health Workforce Unit
- The Royal Women's Hospital, Melbourne
- National Rural Health Alliance
- Department of Human Services, Victoria
- NSW Midwifery Education Advisory Board
- National Nursing Workforce Forum
- National Nursing Workforce Summit
- National Health Workforce Unit
- Commonwealth Chief Medical Officer

7. National Conferences

There were many occasions where the research team were invited to participate in conferences, workshops or informal information sessions. This gave ample opportunity for consultation and for sharing ideas and information:

- Rural Midwives Conference, Wagga Wagga 1999
- ACMI National Conference, Hobart, 1999
- ACMI State Conference, Sydney, 1999
- National Child Health Conference, Adelaide, 1999
- Rural Health Education Network, Adelaide, 1999
- Nepean Hospital Midwives Conference, 1999
- UWS Research Forum, Sydney, 1999
- WHA, Melbourne, 1999
- ACMI, Canberra, 1999
- South Pacific Nurses Forum, Brisbane, 2000
- Remote Midwifery Conference, Kalgoorlie, WA, 2000
- Royal Women's Hospital, Brisbane, 2000
- Colac District Health Service, Victoria, 2000
- NSW Perinatal Society, 2000
- Royal Hospital For Women, Sydney, 2001
- ACMI Conference, Brisbane, 2001
- Westmead Midwifery Conference, 2001

8. The National Consultative Forum

The project culminated in a whole day national forum, held in Sydney in November 2001. Representatives from consumer associations, Members and Shadow Members from State and Federal government, Industry partners and representatives of the nursing, midwifery and medical profession were invited to attend to hear both the results and to have input into, or debate, findings with the research team. The research team presented the results of formal studies and the participants of the forum were invited to comment and contribute to the final recommendations. See Appendix 2 for a list of participants.

INFORMING DEVELOPMENTS

The following AMAP research activities will continue to inform developments in maternity service provision and the regulation and education of midwives.

1. Homer C., Brodie P and Leap N. (2001) Establishing Models of Midwifery Continuity of Care: A handbook for midwives and managers. Centre for Family Health and Midwifery, UTS ISBN 0-9579592-0-6

Researchers from the AMAP project (PB and NL) collaborated with a researcher affiliated with the Centre for Family Health and Midwifery to publish an up to date handbook on how to introduce models of midwifery care in to the Australian maternity system.

2. The Australian College of Midwives Inc.

ACMI has been able to access the AMAP team to provide the latest research evidence for submissions from the professional organisation to several recent national inquiries, and for issues such as indemnity insurance.

3. Advice to The Australian Health Workforce Advisory Committee (AHWAC) Midwifery Workforce Working Party.

AMAP has assisted this working party in its investigations into the workforce needs of Australian midwifery. This included advice and expertise on the reformation of data fields for the national databases on the medical, nursing and midwifery workforce. In particular, the AMAP Education Survey (Leap, Sheehan, Barclay, Tracy and Brodie (2002) provided unique evidence regarding the potential number of graduates entering the workforce, and estimated attrition rates of students and new graduates.

4. The Advanced Life Support in Obstetrics (ALSO) course

The ALSO course, a multidisciplinary course in responding to obstetric emergencies, was introduced into Australia by two of the team from AMAP (NL and PB) in collaboration with an obstetrician, and a health risk manager. All work carried out by ALSO Instructors and Advisory Faculty is on a voluntary basis. NL and PB have studied aspects of introducing this program, in terms of collaboration and leadership, as part of their professional doctorates.

5. The National Tours

The research midwives undertook two national tours, (PB in 2000 and ST in 2001) with well known national and international speakers. Birth International funded the tours privately meeting travel and accommodation costs. The AMAP project benefited by being able to access large and geographically diverse groups of midwives in most of major cities in Australia, including some large rural and remote centres. Approximately 2,000 midwives and consumers participated in the sessions and contributed to AMAP during these tours. Special speakers' forums were arranged as well as informal sessions with groups of women who were seeking the advice and expertise of the AMAP team. During these trips an anonymous survey was undertaken and contributed to work of PB as well as information given on how to use the AMAP website for recording a response to the research question.

6. Advice to Maternity Coalition

Research support was provided by AMAP researchers (ST and NL) on a voluntary basis to the Maternity Coalition, a coalition of consumer and advocacy groups in preparing the National Maternity Action Plan. This collaboration has reinforced a partnership between midwifery researchers and childbearing women in the Australian community. Maternity Coalition has

consulted nationally with other consumer organisations, service providers and politicians to reach consensus on the final plan that is seeking endorsement as the ‘consumer blueprint‘ for the future of maternity services in Australia.

Summary of AMAP Research Findings

SERVICE PROVISION

ADDRESSING THE BARRIERS TO MIDWIFERY - AUSTRALIAN MIDWIVES SPEAKING OUT

Pat Brodie

Category A, B

Brodie P (2002) Addressing the barriers to midwifery: Australian midwives speaking out. *Australian Journal of Midwifery* 15 (3): 4–14.

Rationale for the Study

The potential to reorganise and improve the efficiency of Australian maternity services through an increase in the utilisation and recognition of the midwife's role is demonstrated through research, policy and planning documentation (NHMRC 1996, NHMRC 1998). However, actual evidence of widespread change and reorganisation in service provision is much less evident. This study sought to give a voice to midwives by asking them to identify the barriers and current problems in the organisation of maternity care in Australia and to suggest strategies for improvement.

Objectives of the Study

The views of midwives were sought to answer the two research questions:

- What are the barriers to the provision of safe, efficient and economic midwifery care within maternity services in Australia?
- What are the strategies to overcome these barriers?

Methodology

Multiple samples and data collection methods were used to ensure that the opinions and views from a broad cross section of practising midwives from around Australia were obtained. Interactive forums to facilitate 'brainstorming' / consensus responses ('graffiti' boards) as well as the use of anonymous surveys 'graffiti' sheets (Tracy 2002, professional doctorate) placed in professional journals and a website, were all utilised as data collection tools. Interactive forums were held with groups of midwives participating in 28 separate professional conferences and seminars. These took place in every capital city and several rural / regional centres throughout Australia in 1999 and 2000.

All data was entered into the computerised software package known as Non numerical unstructured data indexing searching and theorizing (NUDIST). Five hundred and sixty three responses were received, transcribed and introduced as documents into the QSR-N5 version of NUDIST. These consisted of 236 responses from journals, 260 individual graffiti sheets, 44 website and 23 group responses. Responses were in the form of short answers, one word, one line or a list of dot points. Nodes were attached to the data as a way of abstracting and organising data with thematic groupings that reflected analytic judgements and interpretations. Through application of standard qualitative research methods themes were identified that enabled analysis of significant issues affecting the current status of midwifery.

Outcomes

A clear picture of the challenges facing Australian midwifery practice emerged from the midwives' voices data. Respondents described their role and practice as being constrained by several factors. These factors are grouped as themes related to service provision and the practice domain of midwives:

- Professional recognition
- Opportunities to practise midwifery
- Societal recognition and image
- Supply of midwives
- Stress and workload
- The 'system' of maternity care
- Midwifery education standards

The role of the midwife in Australia was seen by participants as being dominated by medicine and controlled by nursing. The system of maternity care was identified as restricting of women's choices and not evidence based, with little recognition of midwifery. There was a perception that midwifery autonomy was not recognised or supported within this system. The invisibility of midwifery within the community was identified as a significant barrier.

Midwives in this study demonstrated a clear understanding of the challenges facing service planners and managers. In particular, midwives expressed concerns with the current organisation and funding arrangements for maternity care which were seen to benefit medical practitioners, and restrict women's choices. Many identified direct funding of midwifery care within a broader public health approach as a key strategy to address these structural barriers.

Midwives reported being unable to fulfil the role for which they were educated and a subsequent loss of skills and confidence. Furthermore, shortages of midwives are having a cumulative effect on the capacity of midwives to contribute effectively and safely.

Recommendations

AMAP Recommendation 1: That an evidence-based, woman centred approach to the provision of public sector maternity care be adopted that involves the mainstreaming of models of continuity of midwifery care that have been demonstrated to be effective in the Australian setting.

AMAP Recommendation 2: That models of maternity care be implemented to provide high quality, safe, appropriate and cost-effective care:

- To enable midwives to practise according to the full potential of their role, providing continuity of care to women across the interface of community and acute services
- To ensure that midwives practise within a framework that is supportive, collaborative and interdisciplinary.

AMAP Recommendation 3: That both Commonwealth and State governments review the funding mechanisms that govern the provision of maternity care in Australia in order to support community orientated maternity services and midwifery care as an option for women.

AMAP Recommendation 4: That the recommendations of the *1998 NHMRC Review of Services offered by Midwives* which authorises midwives to order and interpret a limited range of tests and to prescribe specified drugs as part of the care of healthy women during uncomplicated pregnancy and childbirth, be implemented immediately in maternity services across Australia.

A STUDY OF THE VIEWS OF WHA EXECUTIVES OF NURSING AND MIDWIFERY FROM TERTIARY TEACHING HOSPITALS IN EACH STATE OF AUSTRALIA.

Sally Tracy

Category A

Rationale for the Study

Industry Partners supporting the AMAP project, the Executives of Nursing and Midwifery from Women's Hospital Australasia provided a rich source of expert opinion and advice regarding all the current issues affecting midwives such as service provision, workforce, education and the constraints of regulations within and between state boundaries. It was important that this resource of information and experience informed AMAP and so the study of the Executives of Nursing and Midwifery within Women's Hospitals Australasia was initiated.

Objectives of the Study

The study was designed to gather the views of a recognised expert panel of Executives of Nursing and Midwifery from Women's Hospital's Australasia (WHA), to identify the barriers to the provision of safe, efficient and economic midwifery care within maternity services in Australia, and to clarify the particular strategies to overcome these barriers.

Methodology

A modified Delphi technique was used to draw together the expertise of this small select group.

Outcomes

There were eleven Executives of Nursing and Midwifery who were identified as eligible to respond to the research questions. They were all contributors to the AMAP research project through WHA and had access to email. Eight of these managers responded. They collectively manage services affecting a large proportion of midwives from area health services in Western Australia, South Australia, Tasmania, New South Wales, Victoria and Queensland. They represent some of the largest teaching hospitals from these six Australian states and manage at least 25% of hospital-employed midwives.

The table below lists the barriers to midwifery care identified by the mangers **in their own words.**

WORKFORCE	MODELS	FUNDING	EDUCATION
There is a shortage of midwives, An ageing workforce, heavy workloads with a shrinking budget, No planning, Not enough skill mix to suit staff needs, Large vacancy rates A need for casual staff, lack of students. Midwives are leaving the service in droves and there is an ever-present threat of medic-legal action.	Midwifery models are: Not recognised, Not funded within the health service, Not supported by the medical colleagues	No funds for equipment, No funds for research, Lack of funding for women's services generally, Lack of funding for new midwifery models of care, Maternity services are missing out because of the priority towards general medicine - particularly in rural and remote areas.	Lack of students, Inconsistent education programs, The workforce needs up-skilling.

In the first round, the managers identified the **priorities for Strategies** in their own words as:

- Develop new midwifery models
- Fund the education of midwives
- Research and practice review
- Improve the consistency of education programs
- Promote and fund professional development including a focus on rural and remote issues

In the second round, the managers scored their **agreement with these priorities** in the following way (descending order of agreement):

- Address workforce issues at State and Commonwealth levels
- Improve the consistency of midwifery education
- Provide 'preceptorship' for new midwives
- Develop new Midwifery models of care
- Fund a midwifery practice review

Recommendations

This was a small select group of managers who have already shown a commitment to changing practice and reforming midwifery by committing funding to the AMAP project. Their responses showed a strong agreement around the three major issues of funding, workforce shortages and the need to implement new models of midwifery care that included a wider scope of practice and continuity of care for childbearing women. There was also a strong belief that education and professional development are key strategies for solving the current crisis in midwifery.

AMAP Recommendation 1: That an evidence-based, woman centred approach to the provision of public sector maternity care be adopted that involves the mainstreaming of models of continuity of midwifery care that have been demonstrated to be effective in the Australian setting.

AMAP Recommendation 2: That models of maternity care be implemented to provide high quality, safe, appropriate and cost effective care:

- To enable midwives to practise according to the full potential of their role, providing continuity of care to women across the interface of community and acute services
- To ensure that midwives practise within a framework that is collaborative and interdisciplinary.

AMAP Recommendation 3: That both Commonwealth and State governments review the funding mechanisms that govern the provision of maternity care in Australia in order to support community orientated maternity services and midwifery care as an option for women.

AMAP Recommendation 4: That the recommendations of the *1998 NHMRC Review of Services offered by Midwives* which authorises midwives to order and interpret a limited range of tests and to prescribe specified drugs as part of the care of healthy women during uncomplicated pregnancy and childbirth, be implemented immediately in maternity services across Australia.

INTERVENTIONS IN CHILDBIRTH

Roberts C.L, **Tracy S** and Peat B. (2000) Rates for obstetric intervention among private and public patients in Australia: Population based descriptive study. *BMJ* 321(7254): 137-141. http://bmj.com/cgi/content/abstract/321/7254/137

Roberts C.L, Algert C, Douglas I, **Tracy S** and Peat B. (2002) Trends in labour and birth interventions among low risk women in New South Wales ANZJOG 42 (2) 176-181.

Category B, C

This is published work that appears in the professional doctorate of **Sally Tracy**.

Recommendations

AMAP Recommendation 1: That an evidence-based, woman centred approach to the provision of public sector maternity care be adopted that involves the mainstreaming of models of continuity of midwifery care that have been demonstrated to be effective in the Australian setting.

AMAP Recommendation 2: That models of maternity care be implemented to provide high quality, safe, appropriate and cost effective care:

- To enable midwives to practise according to the full potential of their role, providing continuity of care to women across the interface of community and acute services
- To ensure that midwives practise within a framework that is collaborative and interdisciplinary.

COSTING OBSTETRIC INTERVENTIONS

Sally Tracy

Category B, C

This paper has been accepted for publication in the BJOG 18th October 2002. See also Sally Tracy's Professional Doctorate.

Recommendations

AMAP Recommendation 1: That an evidence-based, woman centred approach to the provision of public sector maternity care be adopted that involves the mainstreaming of models of continuity of midwifery care that have been demonstrated to be effective in the Australian setting.

AMAP Recommendation 2: That models of maternity care be implemented to provide high quality, safe, appropriate and cost effective care:

- To enable midwives to practise according to the full potential of their role, providing continuity of care to women across the interface of community and acute services
- To ensure that midwives practise within a framework that is collaborative and interdisciplinary.

AMAP Recommendation 3: That both Commonwealth and State governments review the funding mechanisms that govern the provision of maternity care in Australia in order to support community orientated maternity services and midwifery care as an option for women.

MIDWIFERY AND PUBLIC HEALTH

Sally Tracy

Category B, C

This work will be published at a later date and can be found in the professional doctorate of Sally Tracy. Further research is recommended to test the hypothesis that appears justifiable based on the work that contracting midwives to provide midwifery care across the interface of primary and acute settings may affect an improvement in some public health outcomes.

DIFFICULT LABOUR: STRUGGLES TO CHANGE AUSTRALIAN MATERNITY CARE

Kerreen Reiger

Category A, D

Rationale and Objectives

This paper sought to establish the context shaping the parameters of contemporary Australian maternity services, especially with a view to identifying changes, continuities, and barriers to reform. In the light of historical analysis of the structures of the Australian health care system, this paper addresses their implications for maternity care.

Methodology

A variety of secondary sources were drawn upon to establish the historical development of health services and their implications for the organisation of maternity care in Australia. Reports of several State and Federal investigations into the management of childbirth provided evidence of attempts to implement changes. Policy documents and telephone interviews with State health advisors responsible for maternity service provision provided contemporary data on policy-making structures and key issues for each State and territory.

Findings

The basic structure of maternity service provision emerged during the early decades of the twentieth century as part of a complex set of historical struggles. These developments have been analysed in general terms by historians of health and medicine, but the history of maternity care has been neglected. The increased role of the medical profession in managing childbirth came to be supported by the state and accepted by the public. It was entwined with commitment to maintaining doctors' private practice model and with individual or family responsibility for payment for care. Public provision was only for the poor. The political struggles over health insurance and federal-state relations, and the eventual incorporation of midwifery within nursing laid the basis for an obstetric model of care, which located childbirth in acute health settings. Attempts to change this model in the later twentieth century have used government inquiries but only succeeded in providing some modifications of, and limited alternatives to, the basic framework. Current maternity policy is fragmented and affected by recurrent organisational restructuring and inconsistent information exchange. The paper argues that there are several major explanatory factors in the mix of change and continuity in Australian maternity care. They include the complexity of state–commonwealth relations and health financing and lack of political will to change maternity care—especially in the face of dominant medical interests and organisational restructuring in new market state of the 1990s. Only by understanding the intersection of these factors can effective change strategies be formulated.

MIDWIFERY: A PROFESSION IN TRANSITION

Karen Lane

Lane K. (2002) Midwifery: A profession in transition. Australian Journal of Midwifery 15 (2): 26-31

Category A

Rationale for the Study

The study drew on a range of different theories about the nature of midwifery; primarily, from the Commonwealth Department of Human Services and Health (1996) that midwifery is a collection of skills (a static and discrete body of knowledge); or, that midwives fall neatly into several different strands (Davis-Floyd 1992). The question was how to conceptualise midwifery in Australia.

Objectives of the Study

This study sought to understand how midwives expressed their professional practice via reference to the two major competing discourses informing midwifery; an obstetric assistant model and a professional, independent model.

Methodology

Interviews were conducted with twenty-two midwives working in a range of settings – hospital, birth-centre, and in the community. Interviewees were asked to describe what they thought constituted a 'normal' birth, why intervention occurs, whether they thought it had been necessary, and the relationships between midwives, women and obstetricians.

Findings

The study showed that very few midwives fell into either the medical (obstetric assistant) model or the midwifery (professional, independent) model. Most Australian midwives could be classified 'hybrid' in the sense that their clinical practice drew variously on each of the major discourses according to contextual factors. These included age, experience and setting of practice. Of primary significance is the way midwives viewed the body – whether it was seen as a universal biological entity susceptible to pathological tendencies, or whether it was regarded as a much more elastic and contextually-sensitive organism. The study demonstrated that it is more useful to conceptualise midwifery as a discursive practice (Kent 2000). The midwife (like other health professionals) trawls through a range of discourses (or ways of understanding and knowing) about the body and childbirth in order to construct their own practice. Midwifery is thus a fluid process of subject formation which changes over time. In short, midwifery is actually a range of midwiferies, that is, there is no universally agreed upon practice of midwifery.

Conclusion

Factors which influenced midwifery subjectivity included age; experience; setting of practice (private or public hospital, birth centre or home); and, significantly, the way in which they viewed the body. 'Obstetric assistant' midwives regard intervention as inevitable when bodies fail, and they fail quite often as a matter of physiological determination. They comprise a minority faction. 'Hybrid' midwives hold contradictory views. They make up the major component of midwifery in Australia. They think much intervention is routine and unnecessary and see the importance of the social environment in the efficient working of the body. However, they switch seamlessly into an objectivist view with regard to intervention regarding the body as ultimately pathological. 'Autonomous' midwives employ a 'productivist approach' to childbirth. Every woman and every delivery is different because every woman will negotiate the discourses of childbirth in her own unique way. They argue that obstetricians intervene routinely because the medical model is an interventionist model. Obstetric knowledge and the medicalisation of childbirth have nullified traditional midwifery - to listen, observe and take their cue from women. They are a minority view. The majority of midwives grapple with both major discourses and construct their own framework

and body of knowledge, which they put to task in their daily practise, at least within the overwhelming constraints of hospital and medical protocols.

Recommendations

AMAP Recommendation 1: That an evidence-based, woman centred approach to the provision of public sector maternity care be adopted that involves the mainstreaming of models of continuity of midwifery care that have been demonstrated to be effective in the Australian setting.

AMAP Recommendation 2: That models of maternity care be implemented to provide high quality, safe, appropriate and cost effective care:

- To enable midwives to practise according to the full potential of their role, providing continuity of care to women across the interface of community and acute services
- To ensure that midwives practise within a framework that is supportive, collaborative and interdisciplinary

A SUMMARY OF THE SUBMISSIONS TO THE SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE: THE SENATE INQUIRY INTO CHILDBIRTH PROCEDURES[10], AND THE SENATE INQUIRY INTO PUBLIC HOSPITAL FUNDING.

Sally Tracy, Lesley Barclay, Pat Brodie

Category D, E

Rationale

The AMAP research team believed that in undertaking the submission to the two Senate Inquiries, we would be able to determine from both the national and international literature the perceived barriers to midwifery care, and the strategies that would effect a change in practice. The Senate Inquiry into Childbirth Procedures was initiated in July 1999, and in the following August 1999, the Senate Inquiry into Hospital Funding was established to determine how, within the legislated principles of Medicare, hospital services may be improved.

Objectives

The aim of undertaking the submissions to the Senate Inquiries was twofold.

The terms of reference of the national Inquiries provided a framework for extensive literature reviews that were important to the wider community. The Inquiries also offered the AMAP research team an opportunity to present our preliminary findings on barriers to the provision of safe, efficient and economic midwifery care within maternity services in Australia within this particular framework.

Secondly, the Senate Inquiries were platforms offering the AMAP research team the opportunity to engage with policy makers and the profession nationally to form links for future collaborative strategies. This partly addressed one of the operational aims of Strand II of the AMAP research project.

[10] The submission from the AMAP team is available from the Commonwealth Government, Submissions Volume II, No. 45

Methodology

Extensive literature reviews were undertaken addressing the terms of reference of the two Inquiries.

Outcomes

The Senate Inquiry into Childbirth Procedures received 190 written submissions[11] and heard oral submissions[12] from a further 116 individuals representing over fifty organisations in Australia. The Inquiry resulted in the publication of 'Rocking the Cradle' (Commonwealth of Australia 2000), and the following recommendations are summaries and excerpts from the final report that were relevant to the AMAP objectives:

- That the Commonwealth Government work with State governments to implement the recommendations of the National Health and Medical Research Council as they relate to continuity of care and shared care during pregnancy and birth.

- That all pregnant women in Australia be provided with a maternity record by their principal carer giving details of their health as it relates to their pregnancy and any test results or treatment, with a duplicate to be held by their principal carer.

- That the Commonwealth Government fund major tertiary hospitals to extend the provision of satellite clinics and visiting teams of obstetricians to assist women in rural and remote areas.

- The lack of non-interventionist midwifery models of care were strongly noted. The Committee recommended that the Commonwealth Government work with State governments to ensure the continuation and expansion of hospital birthing centres.

- There was a need for the Commonwealth Government to continue to fund midwives to assist at home births for women at low risk through the Public Health Outcome Funding Agreements.

- That the Commonwealth Government work with State governments to assist Aboriginal and Torres Strait Islander women who have to give birth outside their communities by funding an accompanying family member, with funding provided through their patient transfer assistance schemes.

- That the Commonwealth Government, through the Office of Aboriginal and Torres Strait Islander Health, fund culturally appropriate birthing services, either in hospitals or stand alone, in centres with large Aboriginal and Torres Strait Islander populations.

The Inquiry heard that intervention rates were higher amongst women with private health insurance, those giving birth in tertiary hospitals, and those attended by specialist obstetricians. The Inquiry also heard that these differences were not fully explained by the greater proportion of older and high-risk women in those groups. [At the time of the Inquiry there was very little research based evidence on which to make these assumptions].

It found that women perceived themselves to be disempowered in the decision making around birth, and that too many caesarean sections were being performed.

The issue of early discharge following birth, without the necessary community midwifery support was also identified as an area of deep concern.

[11] See http://www.aph.gov.au/senate/committee/history/index.htm#Community

[12] See http://www.aph.gov.au/senate/committee/history/index.htm#Community

The Senate Inquiry into Public Hospital Funding received 93 public submissions, 6,739 postcards, letters and emails from all states and territories expressing support for Medicare and the public health system. Summarised here are some of the findings of the Inquiry[13],[14] and the subsequent 'funding roundtables' that were relevant to the AMAP objectives:

The community values its public hospitals very highly, although there is evidence that our public hospitals are underfunded and suffering severe strain

Staff are being required to do more with less, and it is no coincidence that public hospitals are experiencing extreme difficulties in recruiting staff, particularly nurses.

There is extensive evidence of cost shifting with examples where the states or territories shifted costs to the Commonwealth and where the Commonwealth shifted costs to the states or territories.

The key problem that needs to be addressed is the fragmented nature of the roles and responsibilities of the Commonwealth and the State and Territory Governments in the funding and delivery of public hospital services

The option for reform of the current funding arrangements that received the most support was a 'single fund' or 'joint account' model at a statewide level. This would combine State and Federal funds across a number of programs, which are currently partially funded by both levels of Government. This would also provide flexibility to enable funds to be delivered to the most appropriate and effective forms of care. It would also give the community greater transparency to ensure that the funding commitments made by both levels of Government were kept would enable an environment in which the funding system facilitates, rather than obstructs, the provision of seamless, integrated health care.

Recommendations

AMAP Recommendation 1: That an evidence-based, woman centred approach to the provision of public sector maternity care be adopted that involves the mainstreaming of models of continuity of midwifery care that have been demonstrated to be effective in the Australian setting.

AMAP Recommendation 3: That both Commonwealth and State governments review the funding mechanisms that govern the provision of maternity care in Australia in order to support community orientated maternity services and midwifery care as an option for women.

AMAP Recommendation 4: That the recommendations of the *1998 NHMRC Review of Services offered by Midwives* which authorises midwives to order and interpret a limited range of tests and to prescribe specified drugs as part of the care of healthy women during uncomplicated pregnancy and childbirth, be implemented immediately in maternity services across Australia.

Further Reading[15]

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[13] The First Report may be accessed at www.aph.gov.au/senate_ca

[14] CHERE provided a detailed research paper for the Committee which can be accessed at http://www.aph.gov.au/senate

[15] Report on Scrutiny of Annual Reports No. 1 of 7, March 2001 (PDF Format)

Inquiry into Public Hospital Funding - 7 December 2000 (List of Submissions)

First Report - Public Hospital Funding and Options for Reform - 11 July 2000

Report on the Aged Care Amendment Bill 7 November 2000 Submissions (PDF Format)

WORKFORCE and PROFESSIONAL ISSUES

Sally Tracy, Lesley Barclay, Pat Brodie

Tracy S, Barclay L and Brodie P. (2000) Contemporary Issues in the Workforce and Education of Australian Midwives. Australian Health Review 23 (4): 78-88.

Category A, B, D, E

Rationale for the Study

The AMAP research team undertook a mapping exercise to identify the issues in the workforce and education of Australian midwives. The original issues were raised by the findings of the Australian Medical Workforce Advisory Committee (AMWAC) report, which found that no comprehensive data was available on the workforce of practising midwives in Australia (AMWAC 1998). Where data was available it demonstrated the shortage of midwives, older age group of practitioners and the lack of consistency in educational programs for midwives within states or territories and nationally.

Objective of the Study

The aim of the study was to determine the key overriding factors that influence the current crisis in the shortage of midwives and the inconsistencies and problems with midwifery education.

Method

In the first year of the project a search was made of all the available publications and data on both the workforce and curricula in midwifery.

Outcomes

The comprehensive detailing of the shortcomings of workforce data collections and education programs across Australia provided baseline information for the AMAP team to further investigate and examine. The study found that there is an urgent need to increase the number of midwives, and that the shortage of midwives is a global problem and Australia can no longer rely on migration from other countries to correct the serious shortfall. It found that there is a serious lack of culturally appropriate midwifery training at tertiary level. The study identified the need to both retain and recruit midwives through more attractive working conditions, including the introduction of midwifery models that would promote communication and co-ordination between health care professionals, linking hospital and community care. The study also identified the need to make maternity care more clearly focused in primary health care rather than hospital illness or trauma. It suggested a revision of the funding of midwives is required to reflect a primary health model where midwives practice across the interface of community and acute care setting. This would promote continuity and collaboration between providers of antenatal, birth and postnatal care and strengthen support for evidence-based models of maternity care. A public health model of care does not necessarily reward tertiary surgical care for all women in childbirth but recognises and funds the wider contribution of midwives within the health sector. The available literature suggests that a system that provides Indigenous communities with their own midwives could contribute significantly to improving perinatal health care for mothers and their infants. Such an initiative would reduce the social disruption to remote area women who are transported hundreds of miles to give birth to their infants. It also identified that a national database of the midwifery workforce is a prerequisite to careful and judicious planning of the midwifery workforce, allowing all concerned to monitor trends and predict supply.

Recommendations

AMAP Recommendation 1: That an evidence-based, woman centred approach to the provision of public sector maternity care be adopted that involves the mainstreaming of models of continuity of midwifery care that have been demonstrated to be effective in the Australian setting

AMAP Recommendation 3: That both Commonwealth and State governments review the funding mechanisms that govern the provision of maternity care in Australia in order to promote community orientated maternity services and midwifery care as an option for women.

AMAP Recommendation 6: That a national database of the midwifery workforce be developed to allow for rational planning of the future midwifery workforce.

AMAP Recommendation 7: That research identifying issues related to recruitment, retention, attrition and the employment profile of midwifery graduates should be funded by the Commonwealth government.

AMAP Recommendation 8: That the current midwifery workforce shortages be addressed through national recruitment and retention strategies targeted to areas of critical need. This may require involvement by the Commonwealth government, the state and territory governments, the professions and/or industry.

AMAP Recommendation 9: That workforce development and maintenance of midwifery practice standards be identified in the overall planning and provision of safe and supportive maternity care in any setting.

WORKFORCE ISSUES IDENTIFIED BY THE AMAP EDUCATION SURVEY

Nicky Leap

Category A

Rationale for the Study

There has been no study to identify workforce issues such as the potential number of places in courses, attrition rates, and the number of graduates from midwifery education programs who seek and obtain employment in midwifery.

Objectives of the Study

The aim of this study was to describe midwifery education across Australia, as identified by the midwifery course coordinators in each university offering a program for initial authorisation to practise midwifery. The study compared courses on a range of issues and data was collected to inform midwifery workforce planning.

Methodology

Using a structured questionnaire and undertaken primarily using telephone interviews, a survey was administered to all 27 universities offering a midwifery course leading to authorisation to practise as a midwife. An initial draft of the questionnaire was reviewed by AMAP researchers and two midwifery course coordinators (from different states) who also piloted the survey to identify any problems with the questionnaire. Experienced managers of maternity services and other AMAP industry partners made further comment through the AMAP meetings. The questionnaire was adjusted to take account of all recommendations and perceived omissions.

Following university ethics committee approval, the study commenced in May 2001 and data collection was completed in February 2002. The research was undertaken on behalf of AMAP by various researchers with different roles. Researcher A (NL) oversaw the study in consultation with the AMAP Chief Investigator (LB). Researcher B (AS) conducted the interviews, collated and coded the data from the questionnaires, and presented it in a blended, de-identified format to NL and LB for analysis.

Outcomes

The AMAP Education Survey raises serious concerns about the shortfall of midwives currently being educated for workforce requirements in terms of:

- The total number of graduates currently enrolled
- The potential number of places in courses
- The number of graduates from most the most recent courses
- Approximate attrition rates and the percentages of graduates seeking and obtaining employment.
- Summary of current enrolments (as at April 2001)
- The number of full time students enrolled: 375
- The number of part time students enrolled: 563
- (Counted as 281 FTE for university funding purposes)
- Total number of students enrolled: 938 (FT + PT)*
- Total number of FTE enrolments: 656 (375 + 281 FTE)*

  * [+ estimated 18 FT or PT students and 2 unidentified cohorts of approximately 18 FT and 32 PT respectively]

Projected annual numbers of graduates based on current enrolments

Estimations of projected annual numbers of graduates based on current enrolments is problematic given the large number of enrolled part-time students (563), who take several years to complete their studies in some cases. This may lead to a significant over-estimation of numbers graduating each year. Although the total number of enrolled students was identified as 938, if the total number of currently enrolled part-time students (563) is halved and added to the total number of currently enrolled full-time students (375) one arrives at a total figure of 656. This calculation presumes that part-time students will complete in two years, which was not the case for many. This method of calculating projected numbers of graduates based on current enrolments should therefore be treated with caution since it may lead to over estimation.

Potential places in courses

The total number of potential places identified added up to 693 FTE (allowing for the fact that 21 courses had full time and part time students, one had only full time students and three had only part time students). Approximately three-quarters of respondents reported under enrolment on courses and at least two course coordinators stated that their numbers were decreasing. The lack of clinical placement opportunities severely limits the number of places that can be offered. Students are particularly disadvantaged in the majority of courses by not being able to access clinical placements that reflect a range of contemporary maternity service developments, in particular, placements in the community and in midwifery models of care. With only a few exceptions, this situation is compounded by a lack of any system to promote collaboration between state or territory health authorities, universities and health service providers in order to ensure adequate and appropriate teaching and learning opportunities for midwifery students.

Recruitment and retention issues

Midwifery course coordinators described financial burdens on students that contribute to the recruitment and retention of students. Financial pressures are particularly acute for students in rural areas and there are few incentives to attract Aboriginal and Torres Strait Islander students

into midwifery programs. Students undertaking supernumerary placements and part time study appear to be disadvantaged both financially and by issues associated with fragmented placements and the allocation of fewer clinical practice hours when compared with students in models with a paid component.

Course coordinators highlighted difficulties experienced by students in clinical practice placements that may contribute to attrition rates, both during their education and on graduation. These included the impact of a system where lack of funding limited the 'ownership' by hospital staff of the need to provide support and supervision for students. The understaffing of areas where students were placed, stressful working environments and horizontal violence compounded these difficulties for students.

Strategies suggested by the midwifery course coordinators to improve midwifery education included systems change at the top level of administration and policy development to promote and fund organisational change and evaluation of midwifery education and the management of maternity care. Collaboration between area health services, universities and health service providers was seen as essential to devise better systems of planning and organisation.

Approximate attrition rates from courses

The total number of graduates from the most recently completed course was 550. Five respondents stated that their attrition rate from the most recent course was 0%. The others had an attrition rate of up to 30%.

Employment profile in midwifery of graduates from courses

The majority of graduates sought employment in midwifery but many ended up not being employed in midwifery. The total number of graduates identified as having gained employment in midwifery was 346 [+20] and the total number identified as not having gained midwifery employment was 114.

According to one respondent, some of those who are unable to find permanent employment in midwifery may have 'casual work' in the field. One course coordinator stated that she had 'no idea' as to whether the 57 graduates from the course sought or obtained employment. The same applied to other course coordinators in relation to 14, 11, and 10 graduates, thus the total number of graduates for whom their employment status in midwifery was not known is 92.

Summary of graduate employment profile:

Total number of graduates from last course = 572

Majority of graduates sought employment in midwifery

Total number graduates estimated to have gained employment in midwifery = 346 (+ 20 'most' of whom gained employment in midwifery) Total: 366

Total number estimated to have not gained midwifery employment: 114 (some may have 'casual work')

- Graduates for whom employment status in midwifery not known: 92.

Workforce calculations

- Depending on how projections are made for these 92 unknowns [366 plus or minus 92/572], attrition rates can be estimated to range from 28% - 37%
- If these attrition rates are applied to the 92 graduates whose midwifery employment status is unknown, an estimated potential 58 - 74 more midwives may have gained employment in midwifery. [366 + 58 = 424, 366 + 74 = 440]

- If all 92 graduates of unknown employment status in midwifery were to have gained successful employment, this would give an absolute maximum number of 458 [366 + 92] out of 572 graduates. This number is likely to be an overestimation.

Midwifery Courses offered for qualified midwives

Eight universities only offer a course for initial authorisation to practise midwifery, and no masters or other programs.

It is important to differentiate these 26 postgraduate courses for qualified midwives from the 27 courses for initial authorisation to practise midwifery. For example, a previous report prepared for the Department of Education, Training and Youth Affairs, Canberra (Ogle et al, 2001) identifies 53 postgraduate [nursing] courses in midwifery and from this figure projects 772 graduates for the year 2001. This is clearly an overestimation in terms of workforce planning and identifying the number of new midwives entering the workforce, which by conservative estimates is likely to be less than 450 per annum (see above).

In avoiding the tendency to quantify all midwifery courses as postgraduate specialist nursing courses, this survey is the first to differentiate courses providing further education for qualified midwives from courses educating nurses to become midwives. In clarifying this differentiation, this survey highlights the alarming shortfall in actual and projected numbers of new midwives entering the workforce.

Recommendations

AMAP Recommendation 6: That a national database of the midwifery workforce be developed to allow for rational planning of the future midwifery workforce.

AMAP Recommendation 7: That research identifying issues related to recruitment, retention, attrition, and the employment profile of new midwifery graduates should be funded by the Commonwealth

AMAP Recommendation 8: That the current midwifery workforce shortages be addressed through national recruitment and retention strategies targeted to areas of critical need. This may require involvement by the Commonwealth, the state and territory governments, the professions and/or industry.

AMAP Recommendation 9: That workforce development and maintenance of midwifery practice standards be identified in the overall planning and provision of safe and supportive maternity care in any setting.

AMAP Recommendation 10: That the Commonwealth DEST increases its allocation of funded positions for students (EFTSU) in midwifery education programs.

AMAP Recommendation 11: That dedicated funding be identified to promote collaboration between industry and education sectors and to guarantee adequate clinical placements in hospitals, birth centres, midwifery models and community midwifery settings in order to achieve minimum clinical practice standards in midwifery education

AMAP Recommendation 12: That the interface between universities and the health system be strengthened in midwifery education, emphasising the importance of clinical placements and the engagement and investment of clinicians and health services in the teaching and assessment of students.

AMAP Recommendation 13: That the amount and nature of supernumerary content of programs be reviewed to ensure:

- Students ‘belong’ to a clinical workforce and benefit from becoming part of a clinical team and are the basis for recruitment for that service

- An appropriate system of funding by jurisdictional health authorities enables this to happen

AMAP Recommendation 14: That active support and incentives are funded and implemented for rural students and Aboriginal and Torres Strait Islander students to enter programs that meet their learning and cultural requirements.

AMAP Recommendation 15: That the costs for students undertaking midwifery education be subsidised, because of workforce shortages.

AMAP Recommendation 16: That the Commonwealth fund the evaluation of the introduction of the three-year Bachelor of Midwifery and the double degree in Nursing and Midwifery.

THE ORGANISATION OF A PROFESSION: REBIRTHING MIDWIFERY IN AUSTRALIA

Kerreen Reiger

Category A

Rationale for the Study

To understand midwifery's place in maternity care, and barriers and strategies relating to improving that, requires placing Australian midwifery in the context of international developments often referred to as the 'resurgence' or 'rebirth' of midwifery as a distinct profession. As midwives form the largest single occupational group in maternity services, their sense of professional identity is directly relevant to service provision and to attempts to change models of care. This research explores the articulation of professional awareness in Australian midwifery through investigating the growth, organisation and perceptions of the present role of the Australian Midwives College Incorporated (ACMI).

Objectives of the Study

To examine the formation and development of a distinct professional body for midwives in Australia as a measure of heightened professional identity and political consciousness; to relate its growth and role to that of comparable organisations overseas; and to explore Australian midwives' perceptions of the College.

Methodology

The study draws on the variety of techniques associated with historical sociology, including documentary analysis, oral history, participant observation, focus groups and questionnaires. Interviews with thirteen key informants who have been involved at executive levels of the organisation have been undertaken to date, including representation from almost all states and territories. In addition, four focus groups have been held, and 45 questionnaires received. Further data collection is planned, and analysis is not yet complete. Visits to New Zealand and the UK have provided comparative information, and one to Canada is planned.

Findings

The history of the 'rebirth' of midwifery reflects the complex, State-based organisation of Australian health care, the dominance of nursing and the importance of international developments. Australian midwives were, until the late 1970s, largely subsumed within nursing organisations, geographically dispersed, and lacked any coherent political voice. State-based midwives' groups, and, from 1979, a National Midwives' Association then became more active and the emerging professional consciousness was given considerable impetus by the ICM conference held in Sydney in 1984. Incorporation of the ACMI followed and since then the College has grown in membership and become the accepted professional body shaping standards of professional

practice. It has a recognised place in health policy development, runs professional education programs and provides a significant information network. However, in spite of many achievements, it appears that the Australian College of Midwives has not yet achieved the cohesion and public profile of some of its sister organisations such as in NZ and the older, well-established Royal College of Midwives in the UK. Communication difficulties, especially in view of a federated structure, and the need to improve organisational processes have been reported but have improved in recent years. Membership remains relatively low, less than a quarter of midwives estimated to be practising, with most midwives remaining within the Australian Nursing Federation as their industrial body. From research so far, ACMI is seen as an important midwifery voice but not a strong and highly visible professional force.

Several issues have emerged from the research that are salient to understanding midwifery professional identity:

- Some lack of trust of the ACMI as a national organisation although strong allegiance to state branches.
- Concerns that the ACMI primarily represents academic midwives and does not pay sufficient attention to the issues facing rural and 'ordinary' hospital midwives.
- Recognition of the value of having a strong organisation with a high public profile to speak out on maternity care generally.
- The suggestion from several midwives, including those in three tertiary hospitals in different states, that the ACMI needs to increase its visibility within the workplace and with new graduates.

Recommendations

AMAP Recommendation 5: That, in order to support enhanced midwifery practice through the development of national standards, leadership and a cohesive political voice, the Australian College of Midwives Incorporated develop further strategies to increase its profile within health services.

MIDWIFERY EDUCATION

Nicky Leap, Athena Sheehan, Lesley Barclay, Sally Tracy, Pat Brodie

Leap N, Sheehan A, Barclay L, Tracy S and Brodie P. Mapping Midwifery Education In Australia: The AMAP Education Survey[16]

Category A

Rationale for the Study

The quality, nature or process of education of midwives has not been seriously studied in Australia for nearly two decades. During this period, programs have moved from hospital locations and teaching to universities. The consequences of this major shift in the provision of midwifery education has not been monitored or evaluated.

Serious concerns have been expressed about Australian midwifery education when international comparisons are made, particularly in relation to preparing competent, confident midwives who

16 This study is presented in its entirety in Volume 2 of this report.

are able to meet the challenges of contemporary midwifery practice and innovative changes in maternity service provision (Waldenstrom 1996, 1997, Leap 1999).

Objectives of the Study

The aim of this study was to describe midwifery education across Australia, as identified by the midwifery course coordinators in each university offering a program for initial authorisation to practise midwifery. The study compared courses on a range of issues including course demographics, prerequisites, and arrangements for theoretical and clinical practice components. In line with the AMAP research questions, it also explored the course coordinators' views of the barriers to effective midwifery education and strategies to overcome these barriers.

Methodology

Using a structured questionnaire and undertaken primarily using telephone interviews, a survey was administered to all universities offering a midwifery course leading to authorisation to practise as a midwife. An initial draft of the questionnaire was reviewed by AMAP researchers and two midwifery course coordinators (from different states) who also piloted the survey to identify any problems with the questionnaire. Experienced managers of maternity services and other AMAP industry partners made further comment through the AMAP meetings. The questionnaire was adjusted to take account of all recommendations and perceived omissions.

Following university ethics committee approval, the study commenced in May 2001 and data collection was completed in February 2002. The research was undertaken on behalf of AMAP by various researchers with different roles. Researcher A (NL) oversaw the study in consultation with the AMAP Chief Investigator (LB). Researcher B (AS) conducted the interviews, collated and coded the data from the questionnaires, and presented it in a blended, de-identified format to NL and LB for analysis.

Outcomes

All twenty-seven Australian universities offering a midwifery course leading to authorisation to practise as a midwife were represented in this study. Data regarding the double-degree (Nursing/Midwifery) course that commenced in one university in 2001 and the three-year Bachelor of Midwifery courses that started in four universities in 2002 were not included in this survey. The results of this study highlight the need to fully monitor and evaluate the introduction of these new models of midwifery education in Australia. The study highlighted inconsistencies across states and territories in terms of the design, length, award and theory and clinical practice component of courses. Students are particularly disadvantaged in the majority of courses by not being able to access clinical placements that reflect contemporary maternity service developments, in particular, placements in the community and in midwifery models of care.

There are no national standards for the accreditation of midwifery education programs in Australia (although the Australian College of Midwives has recently developed national standards for the accreditation of three year Bachelor of Midwifery programs). This situation is compounded by a lack of any system to promote collaboration between state or territory health authorities, universities and health service providers in order to ensure adequate and appropriate teaching and learning opportunities for midwifery students. Over half of the university staff involved in teaching midwifery are not also involved in supervision and assessment in clinical areas. Course coordinators highlighted particular difficulties in arranging clinical placements. This restricts the number of places they are able to offer to students.

Students undertaking supernumerary placements and part time study appear to be disadvantaged by issues associated with fragmented placements and the allocation of fewer clinical practice hours than those in models with a paid component. These issues are directly related to the financial burdens on students described by midwifery course coordinators and the fact that many continue to work as nurses throughout their education in midwifery. Financial pressures are particularly acute for students in rural areas and there are few incentives to attract Aboriginal and Torres Strait Islander students into midwifery programs.

Course coordinators highlighted difficulties experienced by students in clinical practice placements that may contribute to attrition rates, both during their education and on graduation. These included the impact of a lack of 'ownership' by hospital staff of the need to provide support and supervision for students. The understaffing of areas where students are placed, stressful working environments and horizontal violence compounded these difficulties for students.

Strategies suggested to improve midwifery education included systems change at the top level of administration and policy development to promote and fund organisational change and evaluation of midwifery education and the management of maternity care. Collaboration between area health services, universities and health service providers was seen as essential to devise better systems of planning and organisation.

Recommendations

AMAP Recommendation 10: That the Commonwealth DEST increases its allocation of funded positions for students (EFTSU) in midwifery education programs.

AMAP Recommendation 11: That dedicated funding be identified to promote collaboration between industry and education sectors and to guarantee adequate clinical placements in hospitals, birth centres, midwifery models and community midwifery settings in order to achieve minimum clinical practice standards in midwifery education

AMAP Recommendation 12: That the interface between universities and the health system be strengthened in midwifery education, emphasising the importance of clinical placements and the engagement and investment of clinicians and health services in the teaching and assessment of students.

AMAP Recommendation 13: That the amount and nature of supernumerary content of programs be reviewed to ensure:

- Students 'belong' to a clinical workforce and benefit from becoming part of a clinical team
- An appropriate system of funding by jurisdictional health authorities enables this to happen.

AMAP Recommendation 14: That active support and incentives are funded and implemented for rural students and Aboriginal and Torres Strait Islander students to enter programs that meet their learning and cultural requirements.

AMAP Recommendation 15: That the costs for students undertaking midwifery education be subsidised, because of workforce shortages.

AMAP Recommendation 16: That the Commonwealth fund the evaluation of the introduction of the three-year Bachelor of Midwifery and the double degree in Nursing and Midwifery.

AMAP Recommendation 17: That the ACMI standards for midwifery education and practice be adopted by all regulatory authorities as the national standards for midwifery education and practice, and that the ACMI become key participants in the accreditation of all courses leading to authorisation to practise midwifery.

AMAP Recommendation 18: That the renewal of registration for midwifery practice be tied to national standards for continuing education and recency of practice.

AMAP Recommendation 19: That all industrial and legislative frameworks give recognition to the safety and cost effectiveness of midwifery care recognising and licensing the midwife as a practitioner in her or his own right.

AMAP Recommendation 20: That the current State and Territory Nurses Regulations be strengthened to improve standards in the accreditation of midwifery education programs and

national comparability through a national organisation such as a 'National Nursing and Midwifery Council of Australia'.

A REPORT FROM AMAP ON THE ACMI TASKFORCE FOR THE INTRODUCTION OF THE AUSTRALIAN BACHELOR OF MIDWIFERY

Sally Tracy

Category A

One of the AMAP researchers, ST, was invited by one of the AMAP Industry partners, the Australian College of Midwives Incorporated, to participate in an Expert Panel convened to contribute evidence and monitor the introduction and development of the three year Australian Bachelor of Midwifery. The importance of developing internationally compatible standards for the accreditation of Australian midwifery education programs was highlighted by this project. Currently midwives educated in Australian programs have to undertake further education if they wish to practise overseas. The development of standards for midwifery education is particularly important given the introduction of new midwifery education programs such as the three year Bachelor of Midwifery and the double degree in Nursing and Midwifery.

Recommendations

AMAP Recommendation 16: That the Commonwealth fund the evaluation of the introduction of the three-year Bachelor of Midwifery and the double degree in Nursing and Midwifery.

AMAP Recommendation 17: That the ACMI standards for midwifery education and practice be adopted by all regulatory authorities as the national standards for midwifery education and practice, and that the ACMI and service providers become key participants in the accreditation of all courses leading to authorisation to practise midwifery.

AMAP Recommendation 20: That the current State and Territory Nurses Regulations be strengthened to improve standards in the accreditation of midwifery education programs and national comparability through a national organisation such as a 'National Nursing and Midwifery Council of Australia'.

THE SENATE INQUIRY INTO NURSING

Sally Tracy, Nicky Leap

Category A, B, D, E

Rationale for the Study

AMAP Studies investigating issues related to workforce and education found that there is not only a shortage of midwives in Australia, but that the education of midwives is also in crisis. There are a number of post basic nursing midwifery courses on offer in the universities of Australia but there is no overall consistency in design, duration or level of award both nationally or within each separate state. At present there is no national monitoring system to guarantee comparability or an adequate baseline of competence.

Objectives of the Study

The aim of the submission to the Senate Inquiry into Nursing was to join with some of the Industry partners of the AMAP project to submit a coherent and strong argument for some of the reforms that we believe are necessary. The submission to the Senate Inquiry into Nursing was endorsed by the Faculty of Nursing, Midwifery and Health, UTS, Sydney and the ACMI and the WHA.

Methodology

All available published data and literature were examined to identify where the acute problems lie. The AMAP submission summarised the workforce issues paper and where possible updated the tables and graphs[17]. NL also submitted a paper in response to specific questions asked by one of the Senators participating in the Inquiry.

Outcomes

The Senate Inquiry into Nursing (Senate Community Affairs References Committee, (2002) found several main themes affecting both nursing and the midwifery profession. With regard to workforce issues, the Inquiry cited a questionnaire undertaken by the ANF where the most strongly and commonly expressed concerns were:

- The lack of recognition of skills accompanied by poor pay rates and low morale;
- Staffing shortages, high workloads and stress associated with high workloads (p.242).
- The rural and remote workforce faced an even more desperate situation with the National Rural Health Alliance claiming that the turnover of nurses in rural and remote areas was sometimes as high as 450% (p.167).
- In regards to midwifery education, the Inquiry found that 'serious inconsistencies' (existed) across states and territories in both the education and regulation of Australian midwifery and expressed concerns about the standard of midwifery education in Australia, particularly when compared with other Western countries (p.87).

Recommendations

Recommendations from the Senate Inquiry into Nursing (pp.xvii - xxv) included the following:

- All rural and remote area health services with the assistance of State governments offer additional incentives to nursing staff through incentives to nursing staff through employment packages including accommodation assistance, additional recreation and professional development leave, and appointment and transfer expenses to encourage nurse recruitment.
- The Commonwealth provide the Australian Institute of Health and Welfare with the resources required to establish a consistent, national approach to current data collection on the nursing workforce in Australia.
- National registration be implemented for registered and enrolled nurses.

[17] The original submission to the Senate Inquiry was updated and submitted to the Commonwealth Review of Nursing Education (2002) undertaken by the Department of Education, Science and Training and Department of Health and Aged Care, Canberra, at the request of the review secretariat during the final stages of their review. This second submission included updated findings from the AMAP Education Survey and was endorsed by the Faculty of Nursing Midwifery and Health, UTS, Sydney and the ACMI.

- The Commonwealth while examining medical insurance issues also consider the issue of professional indemnity insurance for nurses, including midwives and allied health workers.

REGULATION: CONTEMPORARY ISSUES IN AUSTRALIAN MIDWIFERY

Pat Brodie, Lesley Barclay

Brodie P and Barclay L (2001) Contemporary Issues in Australian Midwifery Regulation. Australian Health Review. 24 (4): 103-118

Category A, B, D

Rationale for the Study

In the last decade the organisation and context for the provision of maternity services has changed considerably. Major shifts in government policy direction and reforms across maternity care services have occurred as a response to community demand and evidence of the safety and satisfaction with midwifery care (Homer et al. 2001; Kenny et al. 1994; Rowley et al. 1995). As a result, new models of care have emerged that require midwives to work in more flexible arrangements. New working conditions are emerging reflecting increased autonomy and self regulation of practice and standards (Department of Human Services 1999a, Department of Human Services 1999b, NHMRC 1996, NHMRC 1998, NSW Health 1989, NSW Health 2000, Victorian Department of Health 1990). Compounding this internationally and nationally there is increasing prominence of undergraduate (non-nursing) programs in midwifery. The United Kingdom (UK) now prepares the majority of midwives in comprehensive three-year and four-year programs (Fraser 2000). Other Western countries such as the Netherlands, France, Denmark, Germany and Sweden have always educated midwives through three and four-year programs. These countries report some of the best standards of practice and clinical outcomes in maternity care in the world (Campbell and McFarland 1994, McKay 1993, Tew 1990). In New Zealand, all one-year midwifery programs have now ceased. Nurses themselves who considered that their one-year program was inadequate in comparison to the three-year midwifery program initiated this action (Personal communication, Pairman 2000). With an increasing emphasis world-wide on the use of evidence to inform practice, policy making and the organisation of services, the regulation of midwifery practice and education across Australia required investigation to determine whether it meets the needs of the community, governments and employers.

The authors hypothesised that, within the current system of nursing regulation through the state and territory Boards, there is confusion about the role of the midwife with a lack of consistency that challenges the legitimacy of the current Acts and their capacity to protect the public.

Objectives of the Study

The aim of this research was to analyse the Nurses' Acts, regulations and current policies of each state and territory to determine their adequacy in regulating the education and practice of midwifery in Australia.

In line with the AMAP research questions, this research explored the barriers to effective regulation and strategies to overcome these barriers.

Two key questions were asked of the regulations:

- What are the current laws, regulations and policies, which govern midwifery practice and education and how do they compare between states or territories and internationally?

- What are the features of the current system of regulation of education, practice and competency of the midwifery profession?

Methodology

Each of the eight statutes were obtained electronically and downloaded from The Australasian Legal Information database (AustLII)[18]. These were analysed for similarities and consistency in structure, format, content and relevance. An overview of the current legislation that regulates midwifery in all states and territories was constructed from this data.

A systematic content analysis that included the search for the basic attributes and common features found in most forms of professional regulation was conducted.

Themes, contrasts, gaps and inconsistencies were highlighted and compared across each of the statutes. Diversity within these basic attributes and their relative importance to each other was analysed and reported only when this appears to have negative consequences or outcome. A comparison of midwifery regulation documents from the United Kingdom, Europe and New Zealand, as well as some of the recent published literature, was made to verify assumptions and contrast Australia with international standards of midwifery education and practice.

The authors consulted with an AMAP investigator who is a nurse-lawyer (LS), who enabled a number of inconsistencies and anomalies to be identified. This resulted in the drawing of a number of conclusions about the Acts and regulations as they currently exist including certain limitations and concerns.

Outcomes

This paper identified that the Nurses' Acts, regulations and current policies of many states and territories in Australia are seriously deficient in terms of their capacity to regulate the education and practice of midwifery. The current regulatory system that subsumes midwifery into nursing was assessed as inadequate in protecting the public appropriately and ensuring that minimum professional standards are met. In some cases minimum standards for continuing education and recency of practice are not required. This is of particular importance in Australia currently, where many maternity health care services are seeking to maximise midwives' contributions through the development of new models of care that increase midwives' autonomy and level of accountability.

Nationally a lack of consistency and evidence of discrepancies in the standards of midwifery education and practice regulation, including course accreditation standards, were identified. When these factors are considered alongside the planned development of a three-year Bachelor of Midwifery being introduced into Australia, there exists an urgent need for regulatory change. The need for appropriate national midwifery competency standards that meet consumer, employer and practitioner expectations, which can be used to guide state and territory regulations, was also identified.

The importance of a need for change in the view and legal positioning of the Australian Nursing Council and all Nurses Boards regarding the identification of midwifery as distinct from nursing was argued and substantiated along with a rationale for a national and consistent approach to midwifery regulation.

Recommendations

AMAP Recommendation 17: That the ACMI standards for midwifery education and practice be adopted by regulatory authorities as the national standards for midwifery education and practice, and that the ACMI and service providers become key participants in the accreditation of all courses leading to authorisation to practise midwifery.

AMAP Recommendation 18: That the renewal of registration for midwifery practice be tied to continuing education and recency of practice.

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[18] Australasian Legal Information database (AustLII) http://www.austlii.edu.au

AMAP Recommendation 19: That all industrial, legislative and regulatory frameworks give recognition to the safety and cost effectiveness of midwifery care recognising and licensing the midwife as a practitioner in her or his own right.

AMAP Recommendation 20: That the current State and Territory Nurses Regulations be strengthened to improve standards in the accreditation of midwifery education programs and national comparability through a national organisation such as a 'National Nursing and Midwifery Council of Australia'.

CONSUMER PARTICIPATION

Karen Lane

The study into consumer participation within maternity services comprises four inter-related phases represented by four papers. These may be found in Volume 2.

Phase One of the study is described in the paper entitled, 'Consumers as arbiters of professional practice? What does this mean for users of maternity services? (Lane K 2000). It is a study of comparative policy with special reference to maternity services under the new managerially in health care. The **rationale** was to understand the shift in emphasis in public documents from 'patient' to 'consumer' and the new prominence accorded to 'consumer empowerment' and 'consumer collaboration'. The **aim** was to assess specifically what effect this may have on the direction of maternity services. The **methodology** involved a close analysis of major reports commissioned by the Department of Human Services (DHS) in Victoria, namely The Health Services Policy Review (1999) by Duckett (proposing 'consumer empowerment' and Communication with Consumers Good Practice Guide to Providing Information (2000) by the Department of Human Services ('consumer collaboration').

The **findings** of the study revealed distinct philosophical differences between the two models of consumer participation. The DHS model ('consumer collaboration') recognised that consumer information needs to be inserted into the medical encounter so that knowledge can be created through the medical encounter itself. The Duckett report ('consumer empowerment') merely requires practitioners to act more respectfully towards consumers in providing information about disease states, waiting lists and professional performance.

The conclusion was that a midwifery partnership model of care would provide optimal operationalisation of the 'consumer collaboration' policy advocated by DHS because professional midwifery by definition centralises the mother's role in decision-making. Obstetric models by virtue of bifurcating the patient/expert relationship are less able to embrace the demand for equality in the conceptual shift from 'patient' to 'consumer'.

The second phase of the study is represented in the published paper entitled, 'Multiple visions or multiple aversions? Consumer representation, consultation and participation in maternity issues'. The **aim** of the study was to observe the implementation of 'purposeful reporting' in a provider/consumer alliance. The case study utilised a participant observer **methodology**. The author was a consumer representative on a team comprising an obstetrician, researcher, three consumer representatives and midwifery manager. The team was formed to rewrite the hospital's clinical outcome and services report in a format accessible and useful to consumers. The project was funded by the Commonwealth Department of Health and Aged Care as part of the Consumer Focus Collaboration Strategic Plan designed to improve accountability and responsiveness to consumers on the part of hospitals and professionals.

Outcomes

The study found fundamental philosophical differences between consumers, research staff employed by the hospital and the Director of Obstetric Services around several areas - the meaning of birth, the nature of knowledge, the measurement of outcomes and ethical concerns. Specifically, consumers wanted the birth to be an experience that reflected their priorities and

values; in other words, women expressed a desire to remain in control of decision-making throughout the birth. The women also prioritised their relationships with the carers. Thus, safety was regarded as a necessary but not sufficient condition in defining a successful birth. Since processes were prioritised alongside of clinical outcomes (i.e. a live birth), the women believed that satisfaction with relationships should be measured via qualitative methodologies in addition to mortality and morbidity rates and intervention rates. In ethical terms, 'informed consent' does not ensure that women's needs will automatically be incorporated at all times. An appropriate ethical framework might be called 'incrementalism'; it encapsulates the notion that decisions should be made incrementally among all parties when the necessity arises. Decisions about how to proceed are properly executed in the context of a dialogical relationship between the carer and the woman. Professional midwifery models are the 'natural' solution since they inherently recognise the importance of putting women at the centre of decision-making, they understand the importance of attending to processes rather than just outcomes and constantly refer to the woman's wishes throughout.

Phase Three of the study of consumer participation comprised a survey of all providers in Australia with more than twenty maternity beds. The **aim** was to assess the extent to which providers embraced the concept of consumer participation as reflected in policies and protocols as well as changes in procedures as a result of consumer feedback. The survey included policies at the Administrative, Ward and Clinical Levels. The **methodology** comprised a 19-point questionnaire posted to all eligible providers.

The findings showed variations in willingness to encourage consumers to participate at the Administrative, Ward and Clinical Levels between providers and within each provider. Overall, there was a medium to high level of acceptability of the concept of consumer participation mainly through inclusion on committees and special projects. Changes did occur as a result of consumer feedback although these may be described as cosmetic, rather than structural. Few providers instituted new models of care, for example. Certainly, providers were cognizant of the importance of making consumers aware of their policies and services and made special efforts to provide information through antenatal classes and encourage feedback via consumer satisfaction surveys.

Positive signs towards the need for active and on-going consumer input extended to the clinical relationship. The final question invited unit managers of midwifery units to choose which model from among three possibilities they believed was the ideal model to ensure optimal consumer participation. The models were:

Participatory: Information gathered from consumers is integrated into choices made available to women.

Collaborative: Decision-making is an ongoing process between the woman and her carer, both of whom possess special expertise in childbirth.

Consultative: Carer/provider provides information to families about available services.

The most democratic model was the Collaborative Model which was the choice of 71% of participants. The Participatory Model attracted 18% of participants while the Consultative Model was elected by only 6%.

However, when followed up via interview qualitative evidence showed that consumer participation at the clinical level was negligible. According to maternity unit managers, only five providers out of twenty had instituted the Collaborative Model in practice. A further seven hospitals followed the Participatory Model with limited opportunities for women to have their needs met and eight hospitals instituted the Collaborative Model, or a system where options are controlled by obstetricians and issued to women with minimal negotiation.

Phase four of the consumer participation project comprised a follow-up qualitative study. The **aims** were to (1) evaluate the extent to which the Collaborative Model of care was instituted in practice, and (2) investigate the necessary conditions for Collaborative models to succeed. The **methodology** involved a 15-20 minute telephone interview with twenty maternity unit managers (or approximately 10% of the original sample).

The evidence showed that 5 providers had instituted the Collaborative Model; 7 the Participatory Model; and 8 the Consultative Model. The **findings** also showed that collaboration is necessarily premised on four conditions without which co-operation between all participants (medical, midwifery, management and women) cannot be achieved:

- A policy directive to ensure that a choice of models of care are in place for women and midwives;
- Antenatal care is conducted by a midwife;
- Trust exists between medical and midwifery staff; and
- Women must insist on a partnership model of care.

Recommendations

AMAP Recommendation 21: That providers initiate coherent policies at the policy, planning and service provision levels to encourage the participation by consumers in planning, reviewing and monitoring maternity services and that jurisdictional authorities fund these initiatives.

AMAP Recommendation 22: That attention be directed towards philosophies and models of care that recognise the importance of placing women at the centre of decision-making about their own care.

STRAND II : Strategising for Change

Category A

Rationale and Objectives of Strand II

Strand II was designed to engage the participation of the relevant industry and government organizations in AMAP and to encourage further intersectoral collaboration. The process was designed to assist the AMAP team to identify limitations of current mechanisms and to facilitate the development of a national rather than a state or narrow institutional view of midwifery. It was also designed to maximize consultation between all parties and the research team to disseminate preliminary findings and to engage and inform improvements in midwives contribution to maternity care. It directly and indirectly addressed the research questions through interactive processes with midwives and key stakeholders influencing midwifery contribution to maternity care and analysing the process of building leadership and collaboration. The substantive analysis and results of this work are to be found in Pat Brodie's Professional Doctorate. Through discussion, sharing information, consultation and a process of seeking advice, researchers were able to inform and stimulate discussion and opinion around Australia over a period of three years.

Methodology

The methodology employed in this process involved formal appointments with key stakeholders, small group discussions, presentations followed by discussion, conference presentations, and contributions to related activities that were informed by our research data (e.g. contributions to the AHWAC Midwifery Workforce Working Party, and the Commonwealth National Review of Nursing Education). We also contributed to media requests for information with researchers appearing on national television, radio and commenting in the press. During the project we had at least 50 appointments, at least 20 presentations, conference presentations and discussions with key stakeholders as individuals. For example we met on an individual level with Executive Director of Rural Health Alliance and in small groups e.g. Chief Nurses of each state at a joint meeting.

Outcomes

The process of creating opportunity and engaging in a two way dialogue from which all parties learned and built collaborative understanding, not only advanced the project but appeared to contribute significantly to opinion shifts and developments of knowledge about problems midwifery has in contributing fully to Australia's maternity care. A limited number of examples are included below. For example meeting with the executive of the Australian Nursing Federation in 2001 followed individual meetings with key individual leaders nationally and in two states. The National Executive, towards the end of the project, demonstrated increased awareness and support for the Bachelor of Midwifery as **one** strategy to try to address workforce shortages. Early in the project professional leaders in nursing had little knowledge of, and based opposition to the Bachelor of Midwifery on absence of relevant information about how such programs worked in other countries and had been planned to occur in Australia. In another example a meeting with the Royal College of Obstetricians and Gynaecologists in 2001 helped to build a shared and well-informed commitment to improving the quality of midwifery and its capacity to work with medicine to optimise outcomes in Australia's maternity care. Thirdly, an independent comment of the AMAP process provided by a well known Australian consumer representative described it as a:

> *'collective effort to find answers and initiate solutions with researchers determined not to produce a weighty tome that would gather dust as so many have done in the past'. Instead they established a dynamic process producing research and useful reports that would produce the basis for change. They have been a major factor in the resurgence of energy amongst midwives in Australia, which is having far reaching effects on policy makers, educational institutions and the community (Robertson 2001).'*

A final example included here were our meetings with the Australian Nursing Council and members of Nurses Boards in a number of states and territories, raised awareness of the results

and reasons for problems in the regulation of midwives and accreditation of midwifery education in a way that publishing data in a peer reviewed journal could not hope to achieve.

The project provided opportunity and travel funding to enable a level of dialogue to occur around midwifery not previously possible through other means. The accessibility of paid researchers to government inquiries and their capacity to provide information and expert opinion has been a major contribution to others efforts in relation to maternity care and the education of health workers. A range of opportunities to consult with stakeholders was most useful in determining strategies for change.

DISCUSSION

The AMAP Initiative

All papers carried out under the AMAP Initiative may be seen as integral elements of an organic enterprise formulated in relation to Strands I and II of the original project proposal. All studies and activities throughout the past three years of the project underline barriers to the future of midwifery - the lack of a coherent approach to the role of the midwife – the invisibility of midwives in policy, planning and regulation, and problems in contemporary midwifery education offered by schools of nursing. These include the lack of symmetry between various stakeholders with regard to the role of the midwife; her sphere of practice, her skills, degree of professional autonomy and legal responsibilities forms a singular and monolithic barrier to the emergence of a fully functional midwifery profession. The future potential of midwifery as a provider of primary health care to all women, regardless of designated medical risk status, rests on the capacity of educational, regulatory and service institutions to mobilise a unified vision of midwifery practice and the requisite skills and legal framework to achieve it. This is the challenge for all stakeholders as made evident in various ways in the papers registered in Volumes II (published papers and papers in press or under review).

The Way We Were

Concerns have been expressed over two decades about midwifery practice, regulation and education in Australia in relation to international developments and issues of power (Barclay 1986, 1995, Bogossian 1998, Chamberlain 1998, Hancock 1992, 1996, Summers 1995, Waldenstrom 1996, 1997). Reiger sets her recent contribution within an historical and international context Reiger (2001) analysing the historical trajectory of midwifery in relation to the emergence of the medical profession in the late nineteenth and twentieth centuries. She then describes Australian midwifery history in the larger context of similarities and discontinuities with other Western industrial nations (for example, Canada, the US and New Zealand). The effect of the professionalisation of medicine in all of these countries was to demote midwifery from a relatively autonomous practice to a dependent arm of obstetrics and an add on to nursing. Superordinate relationships with medicine and nursing have continued not just on the basis of a contest over legitimate knowledge and skills, but over the struggle of women to achieve equivalence with men in the public sphere. It is an empirical question how much they still prevail, but their effects are realised in varying degrees in the tensions evident in all papers submitted under the AMAP project.

Reiger (2003) documents in new work the struggles of Australian midwives first, to professionalise themselves in reaction to the fact of domination and, second, to resist their own demise often via their representative professional body, ACMI. Out of these struggles and in conjunction with midwifery professional bodies in other Western countries (the International Confederation of Midwives, the International Federation of Gynaecologists and Obstetricians and the World Health Organisation), emerged the first coherent definition of the midwife. It is a definition that constructed the gold standard for those who envisioned a practice of midwifery (relatively) autonomous from other health professionals. One would imagine that this vision would be easier to achieve in Australia because it did not follow the US model of almost total capitulation of midwifery to obstetrics. However, policy decisions made by successive governments provoked a continuing contest between health practitioners for the authority to assume the primary role in maternity services. The introduction of new technologies in the post-war period, the private-fee-for-service system of remuneration for doctors (which preserved their economic and political dominance in the health system), the forced symbiosis between maternity services and hospital-based care, and the federal system of health funding (which has encouraged cost-shifting strategies between the states or territories and the Commonwealth) severely limited the ability of midwives to achieve the potential encapsulated in the ICM definition. 'Autonomous' midwifery has been possible in limited enclaves only, such as birth centres and homebirth. These sites attract and/or admit very few women.

The Way We Are Now

Inevitably, political struggles both reflect and draw upon diverse discourses about the role of the midwife. Educational developments currently waver between policies that prepare midwives for a specialist version of the nurse, an associate aide to obstetrics or a fully professional practitioner (one accountable directly to women and in equal partnership with them). The diversity of the education sector is documented in the paper by Leap, Sheehan, Barclay, Tracy and Brodie (2003) in Volume 2. An outstanding feature of this research is the lack of uniformity between a multitude of educational institutions, course designs, course requirements; divergences which belie conflicting philosophical bases around which definition of the midwife should prevail. Workforce participation trends, although approximate because of lack of coherence among providers about standardised terminology and incompatibility of databases and data, demonstrate in a broad way the contested definitions articulated earlier, as the paper by Tracy, Barclay and Brodie reveals (see Volume II). Many midwives are educated to perform one role and find themselves faced with another in the workforce. As a result, significant numbers leave the field altogether. The remainder may experience ongoing frustrations and disappointments, as the Midwifery Voices paper by Brodie reveals (see Volume II). Workforce shortages are being experienced now and will be exacerbated in the future; trends that prompt urgent attention to remedy discrepancies in operational definitions and educational preparation. Brodie and Barclay's paper 'Issues in the Regulation of Australian Midwives (2001)' on regulatory provisions (Volume II) similarly mirrors the lack of consistency between states and territories and suggests a pressing need to create uniformity at the national level. Uniform standards governing the accreditation of midwifery practice and education would protect consumers and recognise the competence of midwives to practice in settings of their choice, including the community.

There is always the larger question of how policy is driven. Reiger (2001b) foreshadows the groundswell of interest by consumers in the 1970s in changing maternity care from obstetric management models to models comprising partnerships with midwives. Tracy's work with NMAP, in the latter part of the AMAP research, supported a very effective national movement by consumers that is just coming to fruition politically as this report is written. Consumer activism also sparked a debate within ACMI regarding formal institutional representation at the executive level; a debate only recently resolved in favour of consumer involvement. Reiger and Tracy (Vol 2) follow up with papers on the current status of maternity policy at the federal and state levels. This demonstrates how the complexity of state-commonwealth relations and mode of financing health care in the new market state of the 1990s impedes the development of a political will to change maternity care. The paper by Lane (2000a) shows that participation by consumers in the planning, monitoring and operation of maternity services represents a new phase in the transition from the Keynesian welfare state to the market state. Providers have generally responded well in including consumers at the administrative and ward levels but less so at the clinical level (Lane 2002a, Volume 2). Models of care which reflexively place women at the centre of the decision-making process (such as the partnership models of midwifery) need to become mainstream options to redress consumer/professional asymmetry.

Midwives themselves are not immune from divergent definitions of their proper function. Indeed the divergences are cemented by the institutionalised division of work practices whereby midwives are typically assigned to one of three spheres – antenatal, labour or postnatal care. A contingent of midwives willingly embrace a role which confines their commitment to a set roster and specified hours. Indeed, they eschew a more expanded professional practice. Others prefer caseload practice or team midwifery which enable continuity of care/carer models for women. Reiger (2003) claims that other divisions within the Australian profession mimic those in other countries; between those advocating an elitist, professionalising route and those more amenable to a feminist, egalitarian model of partnership with women. The upshot is the institutionalisation of all of these conflicts within the professional representative body, the Australian College of Midwives formed in 1987.

It is evident that the current limited resources of the Australian College of Midwives limit the College's potential to inform and contribute sufficiently to the needs of maternity care. At present, midwives often are dependent on nursing leaders and organisations to represent their needs on midwifery issues. This has been seen as problematic in various strands of the AMAP research, particularly in relation to education and regulation.

The Way Forward

Using this knowledge of the dilemmas facing midwives in Australia, the AMAP researchers were inspired to undertake additional studies as part of their Professional Doctorates. The studies were designed to fill in significant gaps in the knowledge base of maternity care enabling policymakers to construct optimal arrangements for the future. Four papers by Tracy (2000, 2002, one accepted for publication in a medical journal and one in press) in conjunction with others outside the AMAP project reviewed: rates of obstetric intervention among private and public patients in Australia; trends in labour and birth interventions among low risk women in New South Wales; trends in obstetric interventions in childbirth for low risk women; economic costs of obstetric interventions; and the funding of midwifery as a public health strategy. Although designed to be separate from the main research questions driving the original AMAP research project, they provide valuable information informing the AMAP project.

Similarly, Brodie's case studies on leadership around clinical, organisational and system improvement have informed the recommendations of the final report for future directions. Her analysis of this collaboration has been written about in detail in her professional doctorate. Filling in the gaps around practical advice on exactly how to construct models of midwifery care for the future Homer, Brodie and Leap (2001) published a handbook for midwives and managers on how to introduce models of midwifery care into the Australian maternity system (Establishing Models of Midwifery Continuity of Care: A handbook for midwives and managers).

During the life of the project, the Commonwealth government and the Australian Parliament spearheaded key inquiries, in an effort to gather information upon which to base future decisions about the health workforce, including nursing and midwifery. These included the Senate Inquiry into Childbirth Procedures, the Senate Inquiry into Hospital Funding, the Senate Inquiry into Nursing, The Australian Health Workforce Advisory Committee Midwifery Workforce Working Party and the National Review of Nursing Education. The AMAP researchers submitted substantial papers to these forums. There were also numerous consultations with consumer, obstetric and nursing bodies around Australia (see Volume I) in an effort to progress towards a coherent vision of midwifery in Australia for the new millennium.

What is this new vision? In their various ways, the papers collected under the AMAP umbrella testify to the underlying notion that knowledge is constructed. If knowledge about the body and birth is constructed as a set of scientific facts (or that knowledge is posited without dispute i.e. positivism) then the management of birth can occur only via a set of unswerving rules administered by an expert (the doctor or the midwife) to the exclusion of the woman. If knowledge about the body and birth is constructed as the outcome of interactions between people (a social model of birth) the idea of a set of external rules imposed on individuals is fundamentally inadequate. In the social model methodology, there is no right or wrong, true objective or non-validated subjective knowledge, but merely ways of knowing or discourses. Our interpretation will be shaped, in turn, by the social forces and institutions, including language, surrounding us and our interaction with them. Partnership models of birth follow the second definition of knowledge. It is the model of the new midwifery of the future because it understands that physiological changes are an integral part of the perception by women of their social environment. If patients/ consumers/women feel that they are part of the decision-making process in an ongoing way (continuity of care and carer models) and if women have the opportunity to form supportive relationships with their carer throughout the entire maternity episode including the birth, the outcomes generally reflect lower interventions, higher levels of emotional satisfaction and equivalent safety records to positivist models of knowledge and maternity care.

The qualitative study by Lane (2003) entitled, The Way Forward: The Win-Win Solution, or Constructing Collaboration, foregrounds the shape of future models of care which harness the creativity of all participants in maternity services – women, midwives, managers and obstetricians. The study reports on interviews with twenty managers of maternity units to gauge the extent to which providers have been willing to institutionalise collaborative models of care. The findings were that collaboration rests on four indispensable preconditions without which genuine co-operation cannot proceed. The four conditions include: (1) a policy directive to ensure that a choice of models of care are in place (for women and midwives); (2) that antenatal care is

conducted by a midwife; (3) that trust is a defining characteristic of the relationship between midwives and obstetricians; and (4) that women exercise agency in decisions about their birth.

All of the studies conducted under the auspices of the AMAP initiative intrinsically recognise the need for educational, service and regulatory provisions to create coherence in their vision of the full potential of the role of the midwife in developing woman centred services that improve outcomes. In order to promote and support maternity services that respond to the identified needs of women, it is necessary to articulate the nature of collaborative relationships that foster high quality, safe, appropriate and cost effective care. The recommendations arising from the AMAP research provide a framework for this way forward.

CONCLUSION

The AMAP project set out to investigate the service delivery, educational, policy and regulatory environments affecting midwifery in Australia and to analyse and facilitate collaboration and communication across all of these sectors. It has been well demonstrated, over the life of the project, that the results are already informing the development of national and state initiatives to improve maternity services.

We have identified shortfalls in the numbers of midwives in practice and those in education programs and this data has contributed significantly to the Australian Health Workforce Advisory Committee's (2002) report, The Midwifery Workforce in Australia 2002-2012**.** Strategies have been proposed to support the recruitment and retention of midwives, for example recommendations for new models of maternity care. Service providers now have information on which to base professional development and workforce planning and to make recommendations to the university sector concerning their requirements for new graduates.

Data was collated from all tertiary institutions that provide midwifery education in Australia. Factors believed to be important in the education of midwives were analysed and future strategies articulated in order to enable midwives to meet acceptable professional standards and the demands of service providers and regulators. The AMAP research has provided information on the impact of moving education to universities in terms of the skills and knowledge of graduates. Strategies have been suggested to bring relevant jurisdictions, service providers and universities together as an urgent priority in improving the quality of midwifery education and recruitment to the profession. The AMAP research and recommendations can guide course revision and development in the interest of national and international consistency of standards.

Analysis and collation of data on the various government policies, laws, and professional regulations that impact directly on midwifery practice or midwifery education was undertaken. Currently there is no mechanism to set nationally recognised standards of education, training and practice for midwives that could be incorporated into state regulations or higher education. The research has produced data to inform recommendations on standards and strategies to assist service providers, universities and regulatory authorities to achieve their common goal of high quality midwifery services. The AMAP research has also highlighted the necessity of a national approach to achieve this goal.

The research process was designed to increase the participation of relevant industry and government organisations and to encourage further intersectoral collaboration. This process assisted the researchers to identify why current mechanisms are of limited effectiveness. There is a need for a national forum to bring together expertise that can inform national, state and territory and institutional developments. This will be critical to ensure that health and education systems maximise midwives' contribution to maternity care and the improvement of health outcomes.

The research team identified that changes, which are occurring in the health industry, midwifery education and policy sectors, are related and overlap. Many of the problems now faced by the midwifery profession reflect poor communication and a lack of co-ordination between, and sometimes within, sectors. Industry partners and stakeholders have contributed to identifying strategies to improve collaboration and consistency in their contributions to midwifery practice and maternity services. Knowledge generated by the AMAP project can inform urgent actions to promote this collaboration. Such developments will be crucial in enabling midwives to contribute to maternity services according to the full potential of their role in providing safe, satisfying maternity care for Australian women.

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APPENDIX ONE - AMAP Activities

STAKEHOLDERS AND PEAK BODIES	NAME-VENUE-MEETING	PURPOSE/FOCUS	DATE
National Rural Health Alliance	Gordon Gregory		March 1999
Chief Nurses	National Nursing Workforce Summit	AMAP presentation and discussion	September 1999
AHWAC	National Nursing Workforce Forum	AMAP representation - LB, PB	September 1999
WHA	Benchmarking meeting Adelaide	Advise re AMAP	October 1999
ACMI BMid Taskforce	Inaugural meeting – Adelaide	AMAP research - ST	December 1999
WHA	Annual conference – Melbourne	AMAP presentation and interactive	February 2000
WHA Executives of Nursing & Midwifery	Lunchtime meeting –Melbourne	LB, PB, ST workforce discussion	February 2000
Department of Human Services, Victoria	ST, PB met with Mary Draper and Wendy Dawson.	Discussion re Maternity Services Enhancement, Victoria	February 2000
Women's Electoral Lobby	Canberra - Helen Leonard	Discussion and exchange ideas	March 2000
Royal College of Nursing	Canberra – Elizabeth Percival	Discussion and exchange ideas	March 2000
NSW Midwifery Education Advisory Group	Sydney University – Professor Marie Chamberlain	AMAP presentation – ST	August 2000
NSW Nurses Registration Board	Board Meeting	AMAP presentation and discussion	October 2000
ACMI BMid Taskforce	Melbourne	ST – AMAP research reference panel	December 2000
ACMI	National Executive Meeting – Melbourne	AMAP presentation and interactive discussion	February 2001
ANCI	Federal Council – Canberra	AMAP presentation and interactive discussion	February 2001
RANCOG	National Executive meeting	AMAP presentation and interactive discussion	February 2001
Royal College of Nursing	Executive Director, Rosemary Bryant – Canberra	Follow up meeting – emerging issues	February 2001
Consumer Public Health Forum	NSW State Parliament – Sydney	Explore issues re introduction of Health care Liability Act 2001	March 2001
Chief Nurses of Australia	Board Meeting - Sydney	AMAP presentation and interactive discussion	April 2001
Australian Nurses Federation	Federal Council - Canberra	Follow up meeting and issues	May 2001
DETYA Council	Canberra	LB representing AMAP re midwifery education and BMid	May 2001
ACMI BMid Taskforce	Melbourne	ST – AMAP Research	July 2001
Federal Parliament - Canberra *	Federal Politicians: Hon Meg Lees – Leader Democrats Hon Jenny Macklin – Shadow Health Advisors to: Hon Amanda Vanstone, Hon Michael Wooldridge	ST accompanied Dr Barb Vernon, Justine Caines, Kate McMaugh, from National Maternity Coalition - interactive discussion re: maternity service reform	September 2001

INDIVIDUAL MEETINGS AND DISCUSSIONS	NAME-VENUE-MEETING	PURPOSE/FOCUS	DATE
UWS Hawkesbury Centre for Primary Health Care	Met With Prof John McDonald	Discussed development of research methods for the AMAP Project	April 1999
UWS Hawkesbury, Faculty of Health Sciences	Prof. Anne Thompson (Visiting Academic from UK) and Anna Smith Senior Lecturer	Explored International perspectives on midwifery education and workforce development	April 1999
UTS Collaboration Research Group	Met With Professor Stewart Clegg, Ian Palmer And Dr David Grant (Kings College London)	Discussion of international trends in collaboration research and practice	May 1999
Commission for Social Justice NSW	Barbara Flick – expert in Indigenous health issues	Discussion & exchange of thinking. Position & inform project	May 1999
Human Rights and Equal Opportunity Commission	Sabina Lauber – Sex Discrimination Unit	Discussion re the Pregnancy Inquiry issues paper and the role of the midwife	May 1999
Commonwealth Chief Medical Officer	Judith Whitworth & Commonwealth workforce advisors	Commonwealth Workforce Preview And AMAP Discussion	June 1999
Nursing Review	Marion Borland, Managing Editor	Discussed Midwifery issues across Australia in preparation for several articles including AMAP	July 1999
National Health Workforce Unit	Patrick Colmer	Discussion Of Health Workforce Review	September 1999
NSW Health Aboriginal Maternal & Child Health Strategy	PB & ST Met with Project Officer	Discussion And Exchange Of Ideas And Resources For AMAP And AM&CH Strategy	Feb 2000
The Royal Women's Hospital, Melbourne	Ro Hogan, Director Of Nursing	Discussion Of Midwifery Workforce Issues	Feb 2000
ACMI (Vic Branch)	Vanessa Owen And Joy Johnston	Discussion and exchange of thinking	Feb 2000
Midwifery and Maternity Provider Organisation – New Zealand	Paul Dodd - Business Manager	Discussion re: midwives data base,	June 2000
New Zealand College of Midwives	Karen Guilliland - Director	Discussion re workforce and professional indemnity issues	June 2000
Otago Polytechnic, New Zealand	Sally Pairman and Chris Hendry	Discussion re education of midwives and the MMPO organisation	June 2000
Kings College Hospital London, City University London & UKCC For Nursing, Midwifery & Health Visiting & English National Board For Nursing & Midwifery	PB met with leaders and key advisers Re Midwifery Workforce planning and Education issues in the UK and Europe	Discussion and exchange of ideas and Resources For AMAP and Midwifery Systems Research	June 2000
Oxford University, UK	ST met with Prof. Lesley Page and Prof. Jane Sandall	Discussion and ideas re midwifery research and workforce	June 2000
Homebirth Australia	Sue Cookson, National Coordinator	Discussion re national Homebirth Outcomes and Data	November 2000

New Zealand Nursing Council	ST met with Marion McLaughlin Deputy registrar, Midwifery Adviser to NZ Nursing Council	Workforce Issues facing NZ/ Australian Midwives – Workforce Data, Attrition Rates Education	June 2001
Maternity Coalition (A.C.T)*	Justine Caines	PI For Independent Midwives, ACT	August 2001
Federal Parliament – Canberra*	Senator Meg Lees	ST and LB also Maternity Coalition members - Barb Vernon and Justine Caines	September 2001
NSW Health Department, Data Collections	Lee Taylor, Information Manager, Epidemiology and Surveillance	ST and Hannah Dahlen to discuss further research on midwifery practice outcomes and in particular data on smaller maternity units	December 2001
Mayne Health	ST and LB representing AMAP	Technical advice	March 2002
AMA Indemnity Summit*	ST representing AMAP and ACMI	Participate in workshops preceding the Health ministers Summit	April 2002
WHA - Canberra	Anne Cahill - Director WHA	ST to discuss NMAP accompanied by Maternity Coalition members, Barb Vernon and Justine Caines	May 2002

ARTICLES & PAPERS	NAME-VENUE-MEETING	PURPOSE/FOCUS	DATE
Nursing Review	Invited Article to introduce AMAP	Circulation =	July 1999
The Lamp (NSW ANF)	Article to introduce AMAP	Circulation = 46,000	July 1999
ACMI Journal	Editorial to introduce AMAP	Circulation = 3,3000	April 1999
The Lamp (NSW ANF)	Article to introduce AMAP plus Graffiti Data Sheet For Midwives & Nurses	Circulation = 46,000	April 2000
Australian Nurses Journal	Article To Introduce AMAP Plus Graffiti Data Sheet For Midwives & Nurses	Circulation = 55, 026	April 2000
ACMI Journal	Graffiti Data Sheet For Midwives	Circulation = 3,300	April 2000
Queensland Nurses Journal	Article To Introduce AMAP Plus Graffiti Data Sheet For Midwives & Nurses	Circulation = 25,000	April 2000
Medical Observer	Invited debate: The right of women to give birth at home	Circulation =	May 15th 2000
RANZCOG Journal	Article To Introduce AMAP	Circulation =	June 2001
ACMI Journal	Editorial to summarise AMAP	Circulation = 3,300	June 2002
NZCOM Journal	Editorial - Sally Tracy		April 2002

ORAL PRESENTATIONS	NAME-VENUE-MEETING	PURPOSE/FOCUS	DATE
Rural Health Education Network	National Broadcast to Rural And Remote Nurses, Midwives and Doctors	Broadcast to 500 satellites PB & LB Discussed AMAP and Related Issues including collaboration and New Models of Care Explain project and inform those attending	March 1999
ACMI (Qld) Annual State Conference	Invited Conference Presentation Re AMAP – PB	196 delegates	June 1999
Wagga Wagga	Invited Rural Midwives Conf. Present Re AMAP – PB	136 delegates	July 1999
ACMI (NSW) Annual State Conference	Invited Conference Presentation Re AMAP – ST	220 delegates	August 1999
Nation Child Health Conference Adelaide	Invited Conference Presentation Re AMAP – LB		September 1999
ACMI National Biennial Conference	Conference Presentation Re AMAP – Team		September 1999
ACMI (Act Branch)	Invited Conference Presentation Re AMAP - LB		September 1999
WHA Annual Conference	Presentation re: AMAP LB		October 1999
DHS Victoria – MSES Colac	Presentation re AMAP Invited Papers, Communities, Choices & Challenges Conference, PB & NL	198 delegates	Feb 2000
ACMI (NSW) Annual State Conference	Invited Conference Presentation Re AMAP – ST	220 delegates	August 1999
Associates In Childbirth Education (ACE)	First AMAP National Speaking Tour by Invitation - PB	Speaking In Twelve Cities And Regional Centres Around Australia: >700 Midwives And Consumers Attended	March 2000
National Midwifery Conference UK	Bournemouth University England	PB, ST & NL: AMAP & related issues at International Forum	June 2000
European Perinatal Medicine Congress	Oporto, Portugal	ST presented poster and discussed AMAP with senior midwives from Scandinavia >900 delegates	June 2000
Health and Risk International Conference	Oxford University, Oxford UK	ST presented oral paper and discussed AMAP with other midwifery professors; 300 delegates	July 2000
NSW Centre for Perinatal Research	Sydney University	ST presented AMAP project outline	August 2000
South Pacific Nurses Forum (ANF)	Invited Conference Presentation re AMAP – PB	200 midwives and nurses from South Pacific Nations	October 2000
ACMI (WA): Remote Mid. Conf, Kalgoorlie	Invited Conference Presentation re AMAP – PB & ST	220 delegates	November 2000
Birth International Speaking Tour	2nd AMAP national speaking tour by invitation - ST	Speaking In Six Cities And Regional Centres Around Australia > 1000 Midwives And Consumers Attended	March 2001
Nepean Midwives Conference - Sydney	Invited speaker, presentation AMAP – ST		March 2001
Royal Hospital for Women, Sydney	Invited speaker – ST	ST - Afternoon facilitation: Issues re education rural midwives	April 2001
Royal Women's Hospital, Brisbane	Conference Presentation re AMAP – PB		

SUBMISSIONS	NAME-VENUE-MEETING	PURPOSE/FOCUS	DATE
Senate Inquiry Into Childbirth Procedures	Written Submission	Inform the Inquiry from a midwifery position	August 1999
Senate Inquiry Into Childbirth Procedures	Oral Submission	Inform the Inquiry from a midwifery position	September 1999
Senate Inquiry Into Hospital Funding	Written Submission	Inform the Inquiry from a midwifery position	October 1999
Senate Inquiry Into Hospital Funding	Invited Participant In Round Table	Inform the Inquiry from a midwifery position	November 2000
Review Of The Nurses Act NSW	Written Submission	Inform the Inquiry from a midwifery position	September 1999
AHWAC Midwifery Workforce Working Party	Written Submission	Inform the Inquiry from a midwifery position	December 2000
AHWAC Midwifery Workforce Working Party	Oral Submission – Interviews With Project Officer	Inform the Inquiry from a midwifery position	Ongoing – 2001/02
South Australian Health Commission*	LB & PB Review Of Birthing Services Across Metropolitan Adelaide	Expert technical advice	
Senate Inquiry Into Nursing Education	Submission Endorsed By ACMI, WHA & RANZCOG	Expert technical advice	July 2001
National Commonwealth DHS And DETYA Review Nursing Education*	PB Submission Of Paper Reviewing Midwifery Regulation in Australia	Expert technical advice	August 2001
National Commonwealth DHS And DETYA Review Nursing Education*	ST & NL Submission Of Paper Reviewing Midwifery Education	Expert technical advice	September 2001
National Commonwealth DHS And DETYA Review Nursing Education*	Oral submission and invited participants to round table	PB & NL attended one and half day round table of nursing researchers in Canberra Expert technical advice	October 2001
Commonwealth Health Ministers Meeting*	ST & LB Briefing paper sent to Professor Richard Smallwood	Key Issues Re Midwives Professional Indemnity Expert technical advice	July 2001
Consumers individual representations to political leaders re maternity issues*	ST attended meetings in Canberra	Informing and advising re current issues, funding and options	September 2001
National Maternity Action Plan*	ST & NL in collaboration with national Maternity Coalition	Expert Technical Advice	November 2001 – May 2002

* activities that were not necessarily endorsed by all AMAP industry partners

MEDIA ACTIVITIES	NAME-VENUE-MEETING	PURPOSE/FOCUS	DATE
The Today Program	National Television Interview – ST	Expert technical advice	4th April 2001
Life Matters ABC Radio	National Radio Interview – PB	Discussion of midwifery issues and need for collaboration and multi disciplinary maternity service development	April 2001
Life Matters ABC Radio	National Radio Interview – ST	Discussion of midwifery indemnity issues and homebirth issues	July 26th 2001
The Age National Newspaper	LB	Content for article	
The Bulletin National Magazine	ST	Contributed to article "Vagina monologues"	April 2001
Sydney Morning Herald	ST	Letter Re Midwives Access To Public Hospitals And Professional indemnity	31 July 2001
Life Matters ABC Radio	ST	Options for birth following fall of PI	September 2001
The Today Program	National Nine Network - Television Interview - PB		April 2002

APPENDIX TWO – National Consultative Forum

NAME	TITLE	ORGANISATION
Lesley Barclay	Professor, AMAP Chief Investigator	Centre for Family Health and Midwifery, UTS
Kerreen Reiger	AMAP Investigator	La Trobe University
Karen Lane	AMAP Investigator	Deakin University
Linda Saunders	AMAP Investigator	Flinders University
Nicky Leap	AMAP Investigator	Flinders University
Judith Meppem represented by Michelle Hill	Chief Nursing Officer, AMAP Industry Partner	NSW Health
Helen Gunn	Director of Nursing Services, AMAP Industry Partner	Nursing Administration SESAHS
Alana Street	Executive Officer, Industry Partner	ACMI
Ruth Worgan	AMAP Project Manager	Centre for Family Health and Midwifery, UTS
Pat Brodie	AMAP Senior Researcher	Centre for Family Health and Midwifery, UTS
Sally Tracy	AMAP Senior Researcher	Centre for Family Health and Midwifery, UTS
Athena Sheehan	AMAP Researcher	Centre for Family Health and Midwifery, UTS
Margaret Cooke	Midwifery Researcher	Centre for Family Health and Midwifery, UTS
Honourable Michael Woolridge (representative)	Minister for Health and Aged Care	House of Representatives
Marilyn Gendek	Chief Executive Officer	Australian Nursing Council Inc.
Meg Lees	Senator	Democrats
Mr Robert Wells represented by Victoria Hennig	First Assistant Secretary	Health Industry and Investigation Division, Dept. of Health & Aged Care
Jill Iliffe represented by Victoria Gilmore	Federal Secretary	Australian Nursing Federation
Professor Allan Carmichael represented by Julia Monaghan	Dean	Faculty of Health Sciences
Dr Shirley Bowen	Chief Health Officer, Executive Director	Health ACT
Professor Jill White represented by Lin Locke	Dean	Faculty of Nursing, Midwifery and Health., University of Technology, Sydney
Mary Draper represented by Wendy Dawson	Manager	Effective Unit, Quality Care & Continuity Branch
Elizabeth O'Brien		AMWAC
Mrs Patricia Heath represented by Jenny Duncan	Chair	National Nursing Education Review
Jan Dent represented by Michael Cleary	Chief Executive Officer	NSW Nurses Registration Board
Professor Judith Clare represented by Jen Byrne	Dean	Faculty of Health Sciences, School of Nursing and Midwifery, Flinders University
Melanie Vanhaaren	Director	Council of Remote Area Nurses of Australia Inc. (CRANA)
Ms Vanessa Owen	President	Australian College of Midwives (ACMI)
Dr Caroline Homer	Midwife Consultant	Practice Development
Ms Sue Kildea	Remote and Rural Research Midwife	Centre for Family Health and Midwifery

NAME	TITLE	ORGANISATION
Mr David White	Executive Director	Royal Hospital for Women
Justine Caines	Maternity Coalition	ACT
Dr Brabin	Vice President	SANDS
Jo Hunter	Co-ordinator	Homebirth Access Society
Toni Cannard	Vice President	Association for the Improvement in Maternity Services (Australia) Inc. (AIMS)
Robin Payne	President	Maternity Coalition Inc
Sue Cookson	National Coordinator	Homebirth Australia
Deborah Pratt	Acting Principal Nursing Advisor, Industry Partner	Department of Human Services SA Health

APPENDIX THREE – List of Publications in Volume 2

INTRODUCTION

TERMS OF REFERENCE

EXPLANATORY NOTE

SERVICE PROVISION

Brodie P. (2002) Addressing the Barriers to Midwifery: Australian Midwives Speaking Out. *Australian Journal Of Midwifery*.15 (3): 5-14

WORKFORCE AND PROFESSIONAL ISSUES

Tracy S, Barclay LB, Brodie P. (2000) Contemporary Issues in the Workforce and Education of Australian Midwives. *Australian Health Review* 23 (4): 78-88

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APPENDIX