Starting Life as a Midwife

An International Review of Transition from Student to Practitioner

Michelle Gray
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Introduction

A midwife is a person who supports a woman during parturition. The title midwife is not gender specific to women as midwives. The traditional meaning originated historically from Middle English; the prefix 'mid' means with, and the term 'wife' relates to the woman. Thus midwife means 'with woman'. Midwifery is one of the oldest practices, with the first recordings of lay midwives providing support to women documented in France in the fifteenth century (Connerton 2018). Today, midwifery is recognised as a profession that makes a considerable international contribution to the reduction in maternal and neonatal morbidity and mortality rates (International Confederation of Midwives (ICM) 2017a).

The skills and capabilities of a midwife have been recognised internationally by the International Confederation of Midwives (ICM), World Health Organization (WHO), United Nations (UN) and European Union (EU). The contemporary role of a midwife is defined by the ICM as:

> A midwife is a person who, having been regularly admitted to a midwifery education programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.
>
> The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.
>
> The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.
>
> A midwife may practise in any setting including the home, community, hospitals, clinics or health units. (ICM 2005)

Globally, midwives share this ICM international definition and practice standards; however, international context influences how this definition is applied to midwifery practice within each country.

The International Confederation of Midwives (ICM) has 132 association member organisations in 113 countries (ICM 2017b). Countries not currently members of the ICM seek membership by demonstrating three key characteristics that demonstrate themselves as a midwifery profession: **recognised specific midwifery education, regulation of practice standards and a professional association** (Day-Stirk and Fauveau 2012). These key characteristics form the three pillars that represent the ICM essential components of professionalism.

The first pillar, recognised specific midwifery education, is guided by the ICM Global Standards for Midwifery Education 2010 (ICM 2013). The Essential Competencies for Basic Midwifery Practice (2010) are used by member states to benchmark curriculum content. The education standards were developed during 2009–2010 using a Delphi survey approach to establish consensus between countries and establish a minimum level of competence as the outcome to direct the core content for any midwifery programme (ICM 2013). Internationally, midwifery students become registered as a midwife after the completion of a programme of study; this may be a direct entry or a post-nursing registration programme. The ICM stipulates minimum time periods for each; direct entry programmes must last a minimum of 3 years, and the post-nursing registration programme lasts for a minimum of 18 months. These education standards provide a minimum acceptable standard; therefore, in practice the scope of midwifery practice varies across continents and between countries, meaning the expectations placed on new midwives at the point of initial registration and subsequent registration renewal vary globally.

Disparity exists in the initial registration standards of new midwives between international countries, and the transition of new graduates to practice is significantly different between countries (Gray et al. 2016a), meaning that qualifications are not directly transferable between comparable westernised countries (Bourgeault et al. 2011). The diversity of global preparation for practice means that midwives in different countries graduate with various levels of autonomy and are prepared for initial registration with variations of the ICM scope of practice.

Regulation of healthcare professional practice is governed by legislation and is enacted by each country to protect the public from those who attempt to provide healthcare services inappropriately (International Confederation of Midwives (ICM) 2011, p.1). In 2002 the ICM adopted a position statement titled ‘Framework for midwifery legislation and regulation’. This position statement defined midwifery legislation and regulation as follows: ‘Midwifery regulation is the set of criteria and processes arising from the legislation that identifies who is a midwife is … The scope of practice is those activities which midwives are educated, competent and authorised to perform … In some countries midwifery practice is regulated through midwifery legislation whilst in others regulation is through nursing legislation …’ (ICM 2011, p.1). Consequently, the scope of midwifery practice is determined by the needs of the country.

The profession of midwifery in developed countries is a product of the economic and political structure of a country and the influence of the professional association bodies and health institutions (Evetts 2003). The third pillar of the ICM sees the importance of member association as a supportive professional network that

represents the interests of the profession and visibly advocates for the midwifery identity through working with governments on policies around standards of care and practice (ICM 2017c).

Midwifery regulation is influenced by the country of practice, as location dictates the scope of midwifery practice activities; for example, rural and remote regions where medical practitioners are scarce means that the scope of the midwife is greater than a midwife in a suburban hospital. In developed countries where midwifery regulation and education standards are established, the legalities of recognition and issues of maintaining or developing autonomy as a separate profession to nursing prevail. For example, in some countries, such as Hong Kong, midwifery as a profession is still not yet recognised or established as a separate profession to nursing (Chap. 6).

The three pillars are recognised as the foundational characteristics of a professional albeit globally each country will enact these foundational elements differently. The initial education of midwives and their transition to practice and ongoing regulation of practice are influenced by the country of origin. Despite the ICM international standards for midwifery education, the outcomes of initial preparation for practice programmes leading to registration have different registration standards and expectations of the new graduate midwife. In countries such as New Zealand and Canada, the new midwife can work in private practice from initial registration, whilst in countries such as the United Kingdom and Australia, new midwives are required to complete a period of practice before being permitted to work autonomously. Differences in legislation, regulation and preparation for practice have been reported even within the same country, as was evident in Australia before national registration occurred (Gray et al. 2016b; Chap. 1: Australia). Such discrepancies impact on the ability of new practitioners to move between countries (Bourgeault et al. 2011); for example, Australian midwives moving to the UK would need to complete a period of time to acquire community practice experience to gain registration with the Nursing and Midwifery Council (Nursing and Midwifery Council 2007).

This book has been prepared to provide readers with the context of midwifery in many international countries. Each chapter has been written by an author knowledgeable and able to inform the reader of the context of midwifery education, practice and regulation in the designated country. This book presents a selection of countries within which midwifery is practiced and midwifery students are prepared for practice. The content will inform the reader of the details of the context within which new midwives in each country transition into qualified practice. Each chapter will describe the legislation of the country, the initial entry to practice education programme/s and regulatory landscape in which midwifery students complete a recognised programme of study and new midwives transition to professional practice as midwives. An outline of how a midwife is educated and gains registration will be explained with details about how transition to qualified practice is organised in each country. Education within each country determines the scope of midwifery practice of all new midwives at point of registration and registration renewal. Starting life as a new midwife will differ depending on the country of graduation.

Regulatory, legislative and educational preparation shapes not only the profession but the maternity services within these countries and the practices of individual midwives. The following countries are included in this book: Australia, Brazil, Belgium, Canada, Ethiopia, Germany, Hong Kong, Iran, Jamaica, New Zealand, the Netherlands and the United Kingdom. Each chapter will provide reflective narratives from new midwives on their lived experience of their first year of practice.

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‘Birth of a Midwife: The Transitional Journey from Student to Practitioner’

1

Allison Cummins and Michelle Gray

Abstract

Australia has a mixed private and public health service. The majority of childbearing women will access maternity services through the public health system. The majority of midwives will work as part of the public health system. Most births occur in hospitals attended by a midwife, less than a third of all births occur in a private hospital with an obstetrician, a small proportion occur in a birth centre and <1% occur at home with a privately practising midwife. Midwives are employed to work on a roster in a public or private hospital. Some will work in small group practices providing care to a caseload of women known as midwifery-led continuity of care, usually in the hospital or birth centre setting. An even smaller proportion will provide homebirth as part of the public system or as a privately practising midwife in their own business. Pathways to becoming a midwife include a direct entry undergraduate degree, a direct entry double degree in nursing and midwifery and a postgraduate degree designed for registered nurses. Midwifery is regulated by the Nursing and Midwifery Board of Australia, and all midwives need to be registered with the Australian Health Practitioners Regulation Authority. Newly graduated midwives have traditionally completed a transition to practice program that involves working for a specified period of time in each area of the maternity service. More recently new graduate midwives have been employed directly into midwifery-led continuity of care models. This chapter will provide an overview of the transitional journey from midwifery student to newly graduated midwife in the Australian context.

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1.1 The Australian Midwifery Context

Australia includes a main continent and many islands. The main jurisdictions are divided into eight states and territories: Queensland, New South Wales, Victoria, South Australia, Western Australia, Northern Territory, Tasmania and Australian Capital Territory.

1.1.1 Population

The current population of Australia is 24,524,987 on September 24, 2017, based on the latest United Nations estimates. Australia is home to an equivalent 0.32% of the total world population, with a population density of three people per km^2. The total land area is 7,682,300 km^2 (2,966,151 sq. miles). Despite the large expanse of land, 90.0% of the population live in urban (21,996,082 people in 2017) areas around the edge of the continent. The median age in Australia is 37.5 years (Worldometers 2017) meaning a large reproductive potential. In 2015 according to the Australian Bureau of Statistics, 305,377 babies were born in Australia (ABS population 2017). The infant mortality rate (IMR) in 2015 was the lowest on record at 3.2 infant deaths per 1000 live births. Ten years ago in 2005, the IMR was 4.9 deaths per 1000 live births (Australian Bureau of Statistics 2015). The maternal mortality rate in Australia in 2012–2014 was 6.8 deaths per 100,000 women giving birth, which is among the lowest rates in the world (Australian Institute of Health and Welfare 2017a).

1.2 Australian Political Structure

Australia has a two-tiered government system called the federal and state governments. The federal government is led by a democratically elected prime minister. The federal government is responsible for the national issues such as defence, commerce, currency, trade, air travel, pensions and most social services. The federal government provides funding to the state and territories for many social services including health and education. State and territory governments are led by a democratically elected premier. Each state and territory have designated jurisdictions governed more locally. These local governments are led by a democratically elected mayor and a council who are responsible for local issues such as refuge disposal, pathways and libraries. Terms of office for the prime minister, premiers and mayors are 3 years.

Healthcare is funded by the federal and state governments, and the funding is for a 3-year term in accordance with the elected governments' time in office. The

universal health scheme Medicare is funded by the federal government. Medicare covers all publicly funded medical costs, a percentage of private doctors' fees, optometry and some other medical services but not dental services. The Australian public can also purchase private health insurance that covers additional health expenses that the universal health scheme does not cover. Private healthcare companies sell private healthcare and charge individuals who decide which services they would like to choose.

1.3 Maternity Services Within the Health Service Structure

Australia has a dichotomy of public and private healthcare. Most births (97%) occur in hospitals (73% public and 27% private hospitals) and a small proportion in birth centres (1.8%) and less than 1% give birth at home (Australian Institute of Health and Welfare 2017).

All residents of the Australian population who have access to Medicare are able to use public health services including maternity services at no cost. Around 30% of women choose to use their private health insurance to pay for an obstetrician to lead their care in pregnancy and give birth in a private hospital (Commonwealth of Australia 2009).

As there is limited access to publicly funded homebirth services, women can contract a privately practising midwife to provide care including homebirth (Catling et al. 2014). The cost of this care is covered in part (antenatal and postnatal) by Medicare. Private health insurance has limited to no cover for any private midwifery services. Consequently women wishing to have a homebirth with a privately practising midwife need to fund the care themselves.

The majority of midwives in Australia work within a public- or private-funded hospital. As discussed only a small percentage of midwives provide private care for a woman who employs them for the duration of their childbearing experience usually up to 6 weeks after the birth. Midwives in Australia need to be registered with Australian Health Practitioners Regulation Authority (AHPRA) to practise within a public or private hospital/health setting and require an annotation on the national register to practise as a private practitioner.

1.4 Australian Legislation and Regulation of Midwifery

In Australia all health practitioner practice is governed by legislation (Health Practitioner Regulation National Law Act 2009, Act No. 45 of 2009). The introduction of a national regulatory agency (AHPRA) in 2010 unified the regulation of health professionals under one national board. Fourteen separate health profession boards exist; 1 for each professional body (AHPRA 2011). Each profession has its own national board to govern the initial registration, registration renewal and practice of practitioners. All nurses and midwives are registered with the Australian Health Practitioner Registration Agency (AHPRA 2017) and governed by the same

board: the Nursing and Midwifery Board of Australia (NMBA). The Nursing and Midwifery Board of Australia (NMBA) has the functions of

> registering nursing and midwifery practitioners and students, developing standards, codes and guidelines for the nursing and midwifery profession, handling notifications, complaints, investigations and disciplinary hearings, assessing overseas trained practitioners who wish to practice in Australia and approving accreditation standards and accredited courses of study (NMBA 2015).

Nurses and midwives are registered on separate registers once they have successfully completed a recognised program leading to registration. Each health profession determines the minimum competency standards of practice to be demonstrated for initial registration. In nursing and midwifery, the Australian Nursing and Midwifery Accreditation Council (ANMAC) set the minimum standards to be achieved for initial registration (ANMAC 2014), and the annual registration renewal standards are governed by AHPRA and NMBA (NMBA 2014). Ongoing practice requires practitioners abide by regulatory standards of professional practice. The standards are outlined by the following documents: Code of Professional Conduct for Midwives in Australia (NMBA 2018a), Code of Ethics for Midwives in Australia (NMBA 2018b), *A Midwife's Guide to Professional Boundaries* (NMBA 2010) and the National Competency Standards for the Midwife (NMBA 2006). In 2018, several new updates from reviews mean changes will be made to the existing standards for midwifery practice—from March 1, 2018, there will be a new code of conduct for midwives, and the International Confederation of Midwives (ICM) Code of Ethics (ICM 2008) will replace the current NMBA document. Furthermore, the current National Competency Standards for the Midwife will be replaced by the Midwifery Practice Standards. A date for this change has not been released at this time but is expected in 2018.

The regulation of healthcare practitioners commences when students begin their midwifery education. Under national law all students enrolled in a program approved by AHPRA are entered on the national register. In 2011 the NMBA started to record nursing and midwifery students' details when they commenced training. In 2017 there were 3985 registered midwifery students (Australian Health Practitioner Regulation Agency 2017a). Universities are responsible for sending the NMBA a list of new and continuing students each year (AHPRA Newsletter 2011). Students at university have a criminal history check and a working with children check completed prior to going out on clinical placements and also need an International English Language Test (ELT) result of 7 overall to be registered once they have graduated. There are no fees for student registration, and the register is not publicly available. Anyone with a complaint about a student's conduct must contact the university in the first instance (Australian Health Practitioner Regulation Agency 2018).

1.5 Pathways to Becoming a Midwife

In Australia there are a number of pathways to becoming a midwife. Prospective midwives can complete a direct entry Bachelor of Midwifery program, a double degree in nursing and midwifery or a postgraduate degree in midwifery designed for

registered nurses. All these programs produce graduates who are eligible for registration as a midwife in Australia. Entry to the register as a qualified practitioner requires the completion of a recognised program accredited by the ANMAC (Australian Nursing and Midwifery Accreditation Council 2014). The standards of education programs in Australia are controlled by ANMAC. This national council is made up of nursing and midwifery leaders who establish the benchmarks which programs of study must meet before being able to deliver a curriculum (ANMAC 2014; Australian Government 2014).

Midwifery education programs are provided at a tertiary education level in every state and territory in Australia. Entry to such a program is through state- and territory-based central administration offices where applicants submit an online application demonstrating they meet the requirements of the university they are applying to (University Admissions Centre UAC 2017). Each university sets its own entry requirements which can involve a score awarded from the student's overall position in their peer group based on their exam results from high school. Mature-aged students wishing for a career change or who wish to re-enter the workforce after a long period of absence have a different score awarded based on their education and employment history. Some universities request mature-aged students to complete and pass an entry test or study a preparation for tertiary education pathway which awards a grade at the end of study, which is then used to apply for a place in a degree program.

Traditionally in Australia individuals wishing to become midwives had to gain registration as a nurse first, as midwifery education only existed as a postgraduate nursing qualification. Therefore, Australians who wished to become midwives were expected to complete an undergraduate nursing degree first and then work as a nurse before applying for admission to a hospital and/or university-based post-nursing program in midwifery, usually requiring an additional year of study. Once the midwifery education was completed, nurses were awarded an endorsement or placed on two registers, one for their nursing and one for midwifery depending on the state or territory registration requirements (NNNET 2006). Graduates were then qualified to practise in either profession although you could not register as a midwife without a previous nursing registration. The introduction of the Bachelor of Midwifery programs in 2000 enabled non-nurses to become midwives (Brodie and Barclay 2001).

The Bachelor of Midwifery was introduced in 2002 in Australia after a long collaborative process. The Australian Midwifery Action Project (AMAP) identified the need for radical reforms to midwifery education and regulation in Australia in line with international midwifery education programs and registration standards (Brodie and Barclay 2001; Gray and Smith 2017). The AMAP identified the invisibility of midwifery in Australia, and the group consulted widely with consumer organisations and leaders in maternity services to provide evidence that would influence government agencies, policymakers and professional organisations (Brodie and Barclay 2001). Currently only a limited number of universities offer the program (Australian Health Practitioner Regulation Agency 2017b). Due to the limited

number of places, the course has a high demand, and entry to the program is competitive with applicant numbers far greater than places in the course.

Routes for registered nurses, wishing to become qualified as registered midwives, are offered at undergraduate and postgraduate levels of study. All lead to an entry on the midwifery register. A registered nurse's route to midwifery registration is shorter as the nurse is given credit for prior learning and clinical practice experience. The shortened program varies from university to university but usually lasts 1–2 years. Students wishing to gain qualifications as both a nurse and a midwife on separate registers can opt to study these professions simultaneously in programs designed as a dual bachelor degree that usually takes 4 years.

1.6 Initial Registration as a Midwife

Initial registration to become a registered midwife in Australia requires that midwifery students have a transcript from the university that verifies they have completed a program of study accredited by ANMAC (AHPRA Newsletter 2011). The new graduate completes an online Graduates Application for single registration and sends their transcript from the university to the National Nurses and Midwives Registration Board (NMBA) with a registration fee and proof of identity such as verified birth and marriage certificates (AHPRA 2011). The application process can commence 4–6 weeks before the student has completed their degree in order for all the correct paperwork to be processed by the NMBA (AHPRA Newsletter 2011). This promotes a timely registration once the student's transcript is complete.

It is difficult to know exactly the numbers of graduating midwifery students within Australia. The AHPRA annual report data shows there was an increase in registered midwife registrations between 2015 and 2016 Report and 2016–2017 Report. We can assume that the increases are initial registrations of midwives. In 2017 there were 1843 new midwifery registrants (Australian Health Practitioner Regulation Agency 2017a).

Snapshot of the number of registered midwives in Australia (Data reported in AHPRA annual reports)

2015–2016 AHPRA report	2016/2017 AHPRA report	
RM 4122	RM 6624	Increase 12.2%

Once registered, the midwife can then practise anywhere in Australia due to nationally agreed standards for the learning outcomes from accredited midwifery programs (Australian Nursing and Midwifery Accreditation Council 2014). A new midwife working at level five full time (37.5 h per week) can expect to be paid around $2579.40 for each fortnight and approximately $67,295 per annum. Additional allowances are paid for night duty, working weekends and public holidays. In addition, health service staff are afforded allowances of sick pay, professional development allowances and a pension schemes. Australian midwives can apply for a position in any state or territory and cross borders from where they

originally completed their midwifery degree. Furthermore, they can consider applying for recognition of their qualification in other countries.

An agreement between the Australian and New Zealand national governments in 1992 led to a signed agreement of mutual recognition (Australian Government. Mutual Recognition Act 1992), which enables reciprocal practitioners' agreements between these countries that persist to this day. Nurses and midwives applying for registration in other countries such as the United Kingdom must complete additional education or bridging courses to meet the requirements of that country.

In Australia newly qualified midwives are called new graduates, and they are unable to transition directly into private midwifery practice. The regulatory authority requires a midwife in Australia to have the equivalent of 3-year full-time experience in the full scope of practice before having the option of applying for an endorsement on the register as a Medicare-eligible midwife (Nursing and Midwifery Board of Australia 2017). Recognition in the form of an endorsement/annotation on the national register, of one's ability to practise as a private practice midwife, is granted once the midwife has completed a Midwifery Practice Review process provided by the ACM (Australian College of Midwives 2017). There are three components to the MPR process. Midwives undertaking MPR need to reflect on their practice by writing a synopsis about their knowledge, skills and experience in providing care to women through pregnancy, birth and the postnatal period. The synopsis also needs to demonstrate how the midwife has kept her practice evidence based and current including a learning plan or goal setting for the future. The midwife undertaking MPR then has a meeting with a consumer and an eligible midwife to discuss the midwife's synopsis, reflection on practice and professional development plan. Feedback from the reviewers includes when the midwife will be required to undertake another review, and this is usually after 3 years (Australian College of Midwives 2017). New graduate midwives are unable to apply for an annotation on the register for eligibility until they have completed 3 years of full-time practice; however, a few new graduate midwives have been mentored into Midwifery Group Practice models providing continuity of care (Clements et al. 2012, 2013). The overwhelming majority of new graduate midwives will be employed into a new graduate program designed to support their transition from student to registered midwife.

1.7 Traditional New Graduate Program

Programs designed to ease new midwives into practice are called 'transition to practice program' or 'new graduate program'. In Australia, each state and territory organises their own program that normally lasts for 6–12 months and is a paid position funded by the government (ACT Government ACT Health 2017; Government of Western Australia Department of Health 2017; Northern Territory Government Department of Health 2017; Nursing and Midwifery Office 2017; Queensland Health Clinical Excellence Division 2017; South Australian (SA) Health 2017; Victoria State Government 2017). The support and funding available vary; however,

the programs are remarkably similar with funding allocated to a health service, and then each hospital establishes the number of graduate positions and contractual hours based on the amount of funding available and the number of new graduates.

The process of application for a new graduate position is through a centralised application process through the health department in each state or territory. For example, in New South Wales the application process opens in June and closes in July. The prospective graduate needs to apply online addressing all job criteria and then attend an interview in August for employment to commence in the following February. To be eligible to apply for a graduate position, certain criteria are outlined in each state and territory. Eligibility includes having completed the student's first university undergraduate nursing or midwifery course within the past 2 years, being eligible to apply for registration as a midwife in Australia, meeting the requirements for documentation and identity checks and not having worked as registered nurse or midwife for more than 6 months, full-time equivalent (Nursing and Midwifery Office 2017; Queensland Health Clinical Excellence Division 2017). New graduate program positions are competitive with demand outstripping available positions. The reason for the decline in positions for both nurses and midwives is complex and mostly related to a decline in funding available to most health services (Tuckett et al. 2017). Successful applicants usually begin their program early in the first year after completing their studies.

The new graduate midwife will work in one area of midwifery for a set period of time before rotating to another area. For example, a new graduate midwife is employed on a 12-month contract, and during this period the new graduate will work in the postnatal ward for 3 months then the birthing unit for 6 months and then the antenatal clinic for 3 months. The new graduate programs offer the new graduates support through consolidated study days where they can consolidate knowledge and skills with a facilitator and their peers (Nursing and Midwifery Office 2017).

These types of transition support programs were first established for nurses when the education for nurses moved from the hospital apprenticeship style of learning to the tertiary sector (Evans et al. 2008). Midwifery has traditionally been seen as and treated as a specialty of nursing; thus research into new nursing graduates is relatable to new midwifery graduates. The strengths of the graduate programs are the availability of support for the new graduates through preceptors, clinical nurse educators, study days and peer support. However, it has been reported that the new graduate nurses did not have access to these support mechanisms due to inadequate staffing, and often they were in charge of wards before they were ready (Evans et al. 2008). There is also inconsistency in the length of time of the programs with calls for adequate staffing levels and access to preceptors to improve the programs (Levett-Jones and Firzgerald 2005). More recently a review of the literature found that new graduate programs were successful in retaining nurses; however, the other measured variables were all so different that it was hard to draw conclusions other than offering 'precepting' or mentoring (Rush et al. 2015). The review concluded that healthy work environments that have collegial respectful work relationships decrease reality shock and foster acceptance (Rush et al. 2015). On the contrary many new graduates experience a lack of acceptance and respect with experienced

nurses being insensitive to their needs to develop soft skills such as time management (Rush et al. 2015). Midwifery transitions to practice programs have evolved with similar strengths and weaknesses.

The experiences of new graduate midwives transition to professional practice programs have been reported in a small number of studies. One qualitative study identified the core components of the transition to professional practice program as being placed in one area for 8–16 weeks, having some supernumerary time and having study days and access to a clinical educator (Clements et al. 2012). The problems encountered were related to staffing issues where the new graduate midwives were not offered enough supernumerary time, their rotations were too quick or they were moved to work on another ward leading to feelings of isolation and not being part of the team (Clements et al. 2012). New graduate midwives have reported feeling like they are 'sinking' when working in often understaffed wards with little support from educators (Fenwick et al. 2012). In this study a metaphor of a pond was used, and the new graduate midwives described support from experienced midwives as a 'life raft' (Fenwick et al. 2012). Although these studies were limited to one area health service in one state, they provide insights into what is important to new graduate midwives.

It has been proposed that new graduate midwives who transition directly into midwifery-led continuity of care models will be well supported through the relationship with the small group of midwives they work alongside (Clements et al. 2013; Cummins et al. 2015).

1.8 New Graduate Midwives Working in Midwifery-Led Continuity of Care Models

Midwifery-led continuity of care is defined as care provided to women through pregnancy, birth and the early parenting period by one midwife or a small group of midwives. This model of care is the gold standard of care (Sandall et al. 2016) resulting in less obstetric intervention, less babies born prematurely and higher satisfaction for the woman, all at reduced cost to the health service (McLachlan et al. 2013; Tracy et al. 2013). These findings have led to government recommendations for midwifery-led continuity of care to be expanded throughout Australia. Through this process new graduate midwives have had the opportunity to be employed into the models at the time of graduation (Cummins et al. 2016a).

With the expansion of midwifery models of care, midwives who wish to provide continuity of care are needed to staff the models. Staffing the models has been the main driver to employ new graduate midwives in midwifery-led continuity of care models (Cummins et al. 2016a). The midwifery workforce in Australia is a highly feminised workforce with staff turnover often due to maternity leave (Hartz et al. 2012). This leads to opportunities for new graduates to move into the models during their transitional year.

New graduate midwives report being well prepared to work in midwifery-led continuity of care models through their degree, consolidating skills and knowledge

better when they know the woman and feel supported through the relationship with the small group of midwives they work alongside. As midwifery students need to complete a minimum of ten continuity of care experiences as part of their degree, they are prepared to work in continuity models at the time of graduation (Cummins et al. 2015; Gray et al. 2016). The small group of midwives build trusting relationship with the new graduates and provide support as they are usually available to the new graduates by phone or text at any time of day or night (Cummins et al. 2015). This support is not available in the traditional transition to practice program and demonstrates the benefit of new graduates transitioning straight into continuity of care models. The relationship of trust extends to collaborating with their obstetric colleagues with the new graduates' stating it is easier to discuss a woman's care with an obstetrician when they know the woman (Cummins et al. 2015). The Australian standards for midwifery practice dictate that midwives need to work in collaboration with their obstetric colleagues and other health professionals (Nursing and Midwifery Board of Australia 2006). Evidence-based guidelines have been developed that aid midwives with consultation and referral and enhance collaboration (Australian College of Midwives 2013). Despite these recorded benefits for new graduate midwives and staffing maternity services, there has been resistance to employing new graduates directly into continuity of care models (Cummins et al. 2016a).

In many organisations midwives who wish to work in midwifery-led continuity of care models are required to have at least 12 months experience in midwifery or have completed the transition to professional practice program. This is frustrating for new graduate midwives who feel prepared to work in continuity of care by the nature of their degree. Visionary leaders have been able to manage the myths (Cummins et al. 2016a) that new graduate midwives are not prepared to work in midwifery-led continuity of care and employ them into the models.

A conceptual model has been developed that enables new graduate midwives to work in midwifery-led continuity of care. The model outlines the essential components as building trusting relationships through continuity, providing support including mentoring, preparing students to work in continuity, providing and accessing collaborative team meetings and finally having an approachable manager or clinical support midwife available to support the new graduate (Cummins et al. 2017). The responsibilities for meeting these essential elements are required by both the new graduate and the manager who employs them. Managers who currently employ new graduate midwives provide a longer orientation period and an initial reduced caseload as well as mentors and organise reflective team meetings. This is recommended for all managers who wish to employ new graduate midwives into midwifery-led continuity of care models. New graduates need to seek out continuity of care experiences as students and at the time of graduation. Once in a continuity model, they need to develop professional boundaries, engage in reflective team meetings and seek out a mentor (Cummins et al. 2017). Although this study only had a small number of participants, the sample was drawn from five states and territories in Australia and represented the views of probably half of all new graduates working in midwifery-led continuity of care.

The number of midwives working in midwifery-led continuity of care models remains small as it is estimated that less than 10% of women currently have access to this model of care (Dawson et al. 2016). With government recommendations to expand the models of care (Australian Health Minister's Advisory Council 2016), new graduate midwives will be considered to transition directly into midwifery-led continuity of care models, and they should be supported through well-designed programs such as mentoring.

1.9 Mentorship and Support: Benefits, Challenges, Innovations, Exemplars

Mentoring involves support from a more experienced practitioner (mentor) to a less experienced practitioner (mentee) through a professional relationship. Mentoring traditionally focused on improving job-related skills and career advancement in hierarchical organisation (Eby 1997, 2011). Mentoring has been adopted in many professions including business, nursing and more recently in midwifery.

In the profession of business, the aim of mentoring is to advance the strategic directions of the company (Fajana and Gbajumo-Sheriff 2011). These aims are not dissimilar to the goal of mentoring from within midwifery-led continuity of care models. The midwives who work in midwifery-led continuity of care want to preserve the model for the women as they see it as the best care available. Mentoring new graduates into the midwifery continuity model is seen as protecting the model from being disbanded particularly in times of staff shortages and funding cuts (Cummins et al. 2015). The aims are congruent with those of business to advance the strategic direction and availability of midwifery-led continuity of care models.

In nursing mentoring was originally recommended to assist new graduate nurses to assimilate into the organisation through socialisation and an introduction to the culture of the hospital. It has been proposed nurses would leave the profession if they had not assimilated smoothly by 12 months (Beecroft et al. 2006). As both nursing and midwifery are mostly practised in a hospital setting, there is a need to socialise new graduate midwives, and mentoring has a role to play in retaining staff.

The benefits of mentoring can be summarised as socialisation into the organisation, career advancement and providing an opportunity for role modelling and teaching driven by what the mentee needs to know. Mentoring has been found to increase retention rates of new graduate midwives due to a high level of support (Dixon et al. 2015; McKenna 2003). Although the benefits seem to be far reaching, there are some challenges to providing effective mentorship in midwifery practice.

One of the challenges is the increased workload that the mentor undertakes when they agree to mentoring. Both the business and nursing models recommend training for the mentors and allocated time for the mentors and mentees to meet (Beecroft et al. 2006; Fajana and Gbajumo-Sheriff 2011). Most midwives do not have any formal training in how to provide clinical teaching, and it is difficult to find time to provide mentoring when you are not working alongside the mentee. Mentoring is an emotionally and physically time-consuming activity, and the commitment to

mentoring may go unrecognised as part of the overall workload (McKenna 2003). Innovative mentoring practices have been described to address some of these challenges.

Group mentoring is one innovative way to provide mentoring to new graduate midwives. Group mentoring has been described as a group of four experienced midwives who voluntary provide professional support to a group of four new graduate midwives. The aim is to meet the mentees needs and nurture their professional confidence (Lennox et al. 2012). These findings came from a mixed-method longitudinal study over a 12-month period. The mentors were available 24 h a day, and regular meetings between the mentors and mentees occurred (Lennox et al. 2012). The mentees in this study were referred to as competent novices, and their needs were about relationship building together with technical aspects that led to their growing confidence as new practitioners (Lennox et al. 2012). The study was set in New Zealand where formalised mentoring is funded and available to new graduate midwives, and the new graduates in this study transitioned directly into the role of lead maternity carer (Lennox et al. 2012) similar to the Australian privately practising midwives. The group mentoring model was adapted at a time of staff shortages and a lack of available mentors despite their formalised model of transition. The innovative nature of this mentoring model could be adapted in the Australian setting where there is a lack of formal mentoring programs or funding for mentoring. Both new graduate midwives and mentors need to be cognisant of the voluntary and time-consuming nature of this type of mentoring; however, sharing the load could be one solution to offering support to the transitional midwives.

Currently most mentoring that occurs in midwifery practice in Australia is informal with new graduate midwives finding their own mentors and mentors being generous with their time, knowledge and skills (Cummins et al. 2016b). It would be ideal to see some of the funds allocated to the transitional support program redirected to providing more formalised mentoring programs for new graduate midwives.

1.10 The Lived Experience of Newly Qualified Midwives in Their First Year as Registrants

1.10.1 Written by Beth Ryan Graduated in May 2017

The jump from student to registered midwife is as exciting as it is scary and something no amount of study can prepare you for because at some point you just have to put the text book down, hold onto everything you've learnt and take a leap of faith. I treasure the countless conversations, tutorials, lectures and simulation workshops I attended over 3 years of my midwifery degree.

Having secured a transition to professional practice position at the same hospital I had my university placement meant I eagerly awaited my contract to start. There was a point in third year where I suddenly felt ready. In no way did I think I knew everything, or even felt confident in what I did know, but I knew I had outgrown my

learning capacity as a midwifery student and needed to stretch my legs a little bit. When I started my new grad role a few months later, my previous confidence had wavered, and I felt myself bumbling through my first few shifts, nervous (terrified) that I would make a detrimental mistake. I suppose the enormity of my new role hit me in a way it hadn't previously. My new colleagues were asking me to sign medication charts, check CTG traces and hold the drug keys, and my name was on the staff whiteboard with a number of beds allocated to me and all I kept thinking was, who, me?? Despite my excitement the first few weeks on the job made me feel like an imposter.

I distinctly remember the first time I was supporting a woman in labour under my new 'midwife' title: she had been labouring in the bath for the majority of her labour, and before long she began actively pushing. It wasn't until over an hour had gone by without any external signs of baby's arrival that I thought to myself 'Oh! I need to do something, I'm a *midwife*, I'm HER midwife, and this labour is stalling…' I had been patiently waiting by the bath, monitoring foetal hearts, softly encouraging her to breathe, all the things I got so great at as a student, but I hadn't thought to change her position or encourage mobility to help her baby descend. The doctors had begun to enquire why this baby was taking so long. Realising this, I zipped out of the room and returned with a birth stool. Half an hour later, much to my relief, she welcomed a little boy. I reflected on everything that night, kind of kicking myself wondering why I had been waiting for a 'real' midwife to come in and gently tell me what to do—just as they did when I was a student. That feeling of glancing over my shoulder waiting for advice still occurs occasionally, but as the year draws to an end, I can also feel myself becoming more assertive, more decisive and more confident, and it's a reassuring feeling.

One of the greatest challenges and simultaneously my biggest triumph of my grad year has been working in a continuity of care model. After a few months rotating through various ward areas, a position came up within the group practice. I had been eyeing off the expression of interest in the tearoom, but dismissed the idea, convincing myself that continuity midwives needed years of experience to thrive in such an autonomous role. It wasn't until an educator encouraged myself and a few other less experienced midwives to give it a go. I submitted an application and was shocked to receive a job offer, and a few weeks later I transitioned into a group practice role as a new graduate. Just as I needed to find my feet when commencing on the wards a few months prior, I was again stumbling through on-call shifts, learning a new way of working and pushing my newly found decision-making abilities to the limit.

It has been 6 months since commencing my role in MGP, and I can feel myself relaxing into the model, worrying less about doing the wrong thing and enjoying the significant benefits of working with women with whom I've built a solid rapport. The last few weeks have been particularly special, as the December/January babies being born are with women whose booking I attended and who I know well through providing continuity of care. Regardless of the mode of birth, it is so evident that support, informed choice and advocacy for their decisions are what make women walk away, happy and confident.

Without a doubt, support has also been imperative to my success in this new role. I received two full weeks of orientation and for the first 3 months took on a reduced caseload of two women per month. Additionally, the support of my close-knit team and extended core hospital staff has made me feel comfortable to ask questions and seek guidance when needed.

Something I have found really challenging as a new grad both on the ward and MGP environments is navigating a healthcare system under significant stress due to understaffing. As a junior midwife, I know the sentiment of support is real, but on shifts where each midwife including the incharge is stretched to their professional limits due to high workloads, accessing support can be tricky. I have found that communication is key and that if you need help, you absolutely have to articulate that clearly because it is easy to fade into the background on a busy labour ward if you don't raise your hand. This is not always easy, but something I am getting better at as I become more assertive and because I value safe practice for myself and women more than anything else.

I am excited to move into my second year as a registered midwife and allow the knowledge gained this year to compound with experience. Ultimately when the time is right I would love the opportunity to enjoy midwifery in another country or a developing setting as I feel lucky to have a set of transferable skills that I enjoy using so much and want to get the most out of this wonderful career as I possibly can.

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Belgium (Wallonia and Flanders)

2

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Abstract

This chapter presents the principles of the midwifery curricula and the transition of midwifery students to qualified midwives working in Wallonia (the French-speaking part of Belgium) and Flanders (Dutch-speaking part of Belgium).

It highlights the legal, educational and practical regulations in respect of the profession including the 4-year curricula (in Wallonia) and 3-year curricula (in Flanders), current direct entry education and the fact that currently 99% female students are on programme. In total, more than 50% of the 262 graduated French midwives in 2014 have a non-Belgian secondary school diploma (according to 2014 data). In 2014, a total of 1697 were registered in the midwifery program in Flanders. A total of 364 (21.4%) Flemish and 220 (12.9%) Dutch students just finished their secondary level, and 493 (29%) had the Dutch nationality. Self-registration for 'visa' (license to practise midwifery in Belgium) and accreditation is automatically online whenever graduated from an official midwifery school in Belgium. Most of the Belgian midwives work as salaried midwives in hospital settings and midwives under 30 years old work on an almost full-time job equivalence.

There is currently a lack of evidence on new midwifery practitioners' (NMPs) transition to practise in Wallonia and Flanders. It is recommended that research

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is conducted in order to further understand the different issues linked to this area of practise.

Keywords
Midwifery regulation · Midwifery practise · Wallonia · Flanders · Belgium

2.1 The Legislation Related to Regulation of Midwifery in Belgium

Welcome to Belgium, a small and pleasant European country of about 11.35 million inhabitants!

Belgium is a kingdom, and has a complex democratic political system.

The country is divided into three parts having its own language: Dutch in the north—the most densely populated region, French in the south (from the woodlands) and German in the eastern side of the country. In the capital Brussels, most Belgians speak French and/or Dutch.

Belgium is also divided into two main different administrative levels each with its own parliament and government. These are:

- Territory level: Wallonia region, Flanders region and Brussels-Capital region
- Community level with regard to the spoken language: French and Dutch and German communities

According to Statbel.fgov.be (2019) in 1st January 2017:

The Flanders region has about 6.516.011 people.
The Brussels region has about 1.191.604 people.
The Wallonia region has about 3.614.473 people, including German community.

The German community in Belgium is small (about 76920 people in 2017). They have their own parliament for specific matter such as culture, education, family, etc., and they have some university colleges, particularly for accounting education and nursing. There is currently no midwifery school in this German part of Belgium, so we won't write more about this region.

2.1.1 Overview of the Demographics of the Population in Belgium and Links to Midwifery

In 2014 in Belgium, there were 2,521,451 women with 15–49 years of childbearing age (Benahmed et al. 2016, p. 21) with a fertility rate of 1.74 (births per woman) and the mean maternal age for the first child being 28.5 years old, but 28.9 years old in Flanders (Devlieger et al. 2017), 28.3 years old in Wallonia and 30.0 years old in Brussels (Leroy et al. 2018a, b). There were 64,323 deliveries in Flanders in 2016 (Devlieger et al. 2017), 34,808 in Wallonia and 23,414 in Brussels region (Leroy et al.

2017). The caesarean section rate is 20.2% of all births for Belgium (2012) (Benahmed et al. 2016, p. 69) and in 2016 caesarean rate is 20.9% of the births in Flanders, 20.2% of the births in Brussels and 21.5% of the births in Wallonia (Leroy et al. 2018a, b).

About 11,633 midwives have a license to practise in Belgium (Cellule Planification des professions de soins de santé 2018, p. 16). There are on average for 2014: ten births per midwife in Brussels, 13 in Flanders and 22 in Wallonia (Cellule Planification des professions de soins de santé 2018, p. 71), and the number of midwives professionally active in health care sectors as of 31st December 2014 per 1000 women in childbearing age (15–49) for the three regions are (Cellule Planification des professions de soins de santé 2018, p. 68):

– Brussels: 36.75 midwives per women,
– Flanders: 30.89 midwives per women,
– Wallonia: 19.27 midwives per women.

Figure 2.1 presents the repartition of the midwives related to the childbearing age women in Belgium (Cellule Planification des professions de soins de santé 2018,

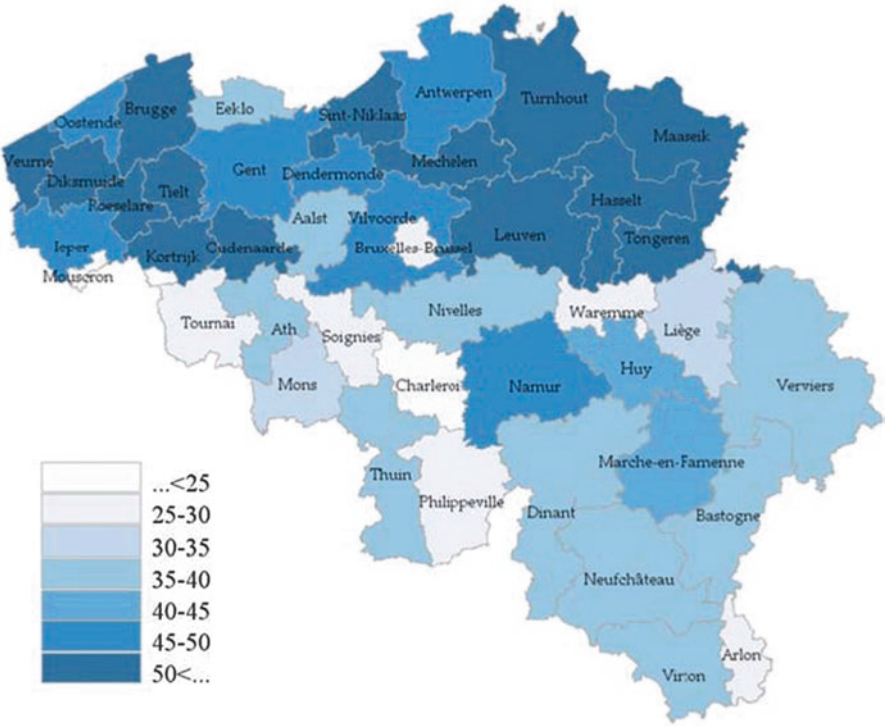


Fig. 2.1 Geographical distribution in Belgium of all midwives licensed to practise (LTP) per 10,000 women in childbearing age (15–45 years) related to the district of the place of residence (31/12/2014). *Licensed to Practise (LTP)*: includes all the midwives authorised to work as a midwife. This excludes all the midwives with a 'superior' graduation level (doctors, dentist and pharmacologist) as they are expected to work at that 'superior' level (Cellule Planification des professions de soins de santé 2018, p. 20)

Carte 6, p. 63). Obviously, there are more midwives per childbearing age women in the north of the country (Dutch speaking) than in the south. This can easily be related to the population density: about 6,516,000 are living in the north region Flanders, whilst 3,614,500 are living in the south region Wallonia (including 76,900 from the German-speaking region) and 1,191,600 people live in the region Brussels (STATBEL (2018)).

Unlike other countries (for example, the UK and the Netherlands), midwives in Belgium have no legal support through health assistants in the form of Nursery Nurses, Nursing Assistants/Auxiliary Nurses, Healthcare Assistants or any other form of support worker (Benahmed et al. 2016, p. 68).

According to Benahmed et al. (2016, p. 72), there have been two major changes that have occurred in midwifery in Belgium during the last 20 years.

The first major change is towards more autonomy. From 1995 to 2005, there has been a progressive separation between both nursing and midwifery curricula, until now they are completely separate. However, both professions' curricula may be delivered to students within the same schools. From 1993 (in Flanders) and 2006 (in Wallonia) midwives are considered as autonomous health care professionals with a medical responsibility and without medical supervision. This has been a very positive thing for the recognition of the profession (KB 78, 2006). Flanders separated midwifery curricula from nursing curricula in 1993.

The second major change concerns the evolution of post-partum care in Belgium towards a shorter stay in maternity wards and developing more home/community mother-and-baby care services. Belgian midwives have committed themselves to further lead midwifery care in low-risk pregnancies and post-partum care, which may be a typical trend for midwives already practising in other European countries, but it is a new concept for Belgium and its related healthcare.

And, officials intend to reduce care expenses, becoming too heavy for the social security system of health: shortening stays in hospital after births, and other hospital stays, is said helping to reducing social security costs and is encouraged.

The fact that this practise is relatively new partly explains the lack of available information about the evolution of midwifery workforce in Belgium. The SPF (Service Public Fédéral) has undertaken a data analysis of years 2004–2014 to anticipate the needs of midwives in Belgium within the next few years to 2039, regarding births and women's care (Cellule Planification des professions de soins de santé 2018). Analysis and projections are ongoing and will soon be published.

2.1.2 General Midwifery Regulation in Belgium

Our midwife Belgian colleague Embo (Embo and Valcke 2016) says:

> Belgium is a small country with a complex administration. The latter influences midwifery practise and education.
>
> There is one federal Minister of Social Affairs and Health who is responsible for all Belgian qualified midwives in terms of legislation and budget and there are two Ministers of Higher Education, one in Flanders (the northern Dutch-speaking region) and one in

Wallonia (the southern French-speaking region), responsible for midwifery education in their regions.

These ministers are bound by the European Directives, federal legislation and professional standards but they are autonomous as to how education is being organised.

This written piece concerns the midwifery curricula of the territory region of Belgium: Wallonia and Flanders. Some figures and information come from the French community level (Communauté française) and/or from Belgium to enhance understanding and provide context.

The regulation of midwifery curricula in Belgium (Wallonia and Flanders) is organised by three policy levels (Benahmed et al. 2016):

- *From European Union*: Directive 2013/55/EU of the European parliament and of the council of 20 November 2013 amending Directive 2005/36/EC on the recognition of professional qualifications and Regulation (EU) No 1024/2012 on administrative cooperation through the Internal Market Information System ('the IMI Regulation').
- Direct entry midwifery programmes ensure that students complete a minimum of 4600 h theoretical and practical work. Of this, there must be a minimum 1533 h (one-third) of clinical practise hours. Admission to the programme is possible if the student has achieved a minimum of 12 years of secondary education prior to entering the professional training. Equally, entry to the preregistration midwifery training is possible after completion of a prior nursing curriculum (and including 3600 h minimum, 2 years).
- *From Belgian federal legislation level*:
- Graduation is regulated by AR n°78 du 10/11/1967 related to health care professions, modified by law 13/12/2006 (echography and perineal re-education for midwives) and by law 10/05/2015 (transposition of the EU directives).
- Before 1980, the title 'accoucheuse' was a nurse specialisation and there was no legislative framework.
- *From the Belgian community legislation level*:
- Since 2007, the legal title now is 'sage-femme' in French and 'vroedvrouw' in Dutch—midwife—in order to be in harmony with international denomination and the International Confederation of Midwifes (ICM). According to the Belgian professional framework of the midwife (2016), the midwife is, as in all the world, 'the first choice health professional for childbearing women'; the definition of a midwife is the one of the ICM.

2.1.3 General Midwifery Regulation in French Community (Wallonia)

The 'ARES' (Académie de recherche et d'Enseignement Supérieur) is the community level's official higher authority for Wallonia. It guarantees the mission of public service for general interest of higher education, supports education establishments

and insures their global coordination in their missions of education, research and service to the community.

The provision of midwifery curricula in the Wallonia region is provided within nine midwifery university colleges, and nine, divided into 12 campuses, in the Flanders region, all of which are hosted within nursing schools. The main characteristics of the midwifery curricula are that it is a direct entry, 3- or 4-year program provided at bachelor level (Fédération Wallonie-Bruxelles 2016). This is a short-type bachelor, meaning a professional bachelor of 180 or 240 European credits (ECTs) leading directly to a bachelor graduation, whilst a long-type bachelor is organised in two parts, the first one of 180 ECTS leading to a bachelor graduation before entering the second part of the curricula leading to a 120 credits professionalising master degree.

Access to the midwifery curricula is possible to all who have successfully passed the secondary school certificate (after min. 12 years study), has a physical vocational certificate and an extract of clean police record (dating <3 months). There is no entrance selection. Nevertheless, most of midwifery schools are not able to accept all the candidates due of lack of appropriate available clinical placements. This is a problem for the profession, as the quality of the placements (number of deliveries and midwives per shift, number of students per shift, workloads of the midwives supporting continuous professional competence development of students, etc.) could affect the quality of the curricula. According to (Embo and Valcke 2016), 'Worldwide, workplace learning plays a crucial role in midwifery education. Midwifery workplaces continue to be critical learning environments in which knowledge, skills and attitudes are acquired within a real-life professional context.'

This informal limitation in Wallonia and Flanders is well known by the officials but for now, nothing yet is done to address this—see Sect. 2.1.3 for further explanation (Benahmed et al. 2016, p. 48). So, each French school applies its own specific criteria for the admission and choosing its candidates: for example, first arrived, first admitted or analyse the candidate's file, but this may vary. In Flanders, no limitation is allowed.

The midwifery workgroup involved in the SPF (Service Public Fédéral) data analysis of the potential needs for a midwifery workforce in Belgium (see Sect. 2.1.5) within the following 25 years will soon give advice to address this concern.

In 2016, the SPF (Service Public Fédéral) ordered a data analysis of a 10-year period for the years 2004–2014 in order to anticipate the potential needs for a midwifery workforce in Belgium within the following 25 years. This concern is developed in Sect. 2.1.4.

2.1.4 Regulation and Evolution of Foreign Midwifery Students in 2009–2014 in Belgium (French and Dutch Community)

From academic years 2006–2007 to 2011–2012, the government of the French community introduced an official regulation for foreign students applying to enter midwifery studies and other paramedical or medical studies. It is the 'Non-resident

Decret' (Décret régulant le nombre d'étudiants dans certains cursus de premier cycle de l'enseignement supérieur 2006). Midwifery schools were expected to accept up to 30% of foreign students calculated by reference of the number of previous academic year first-in-year 1 students. Due to decision of the Constitutional Court, this Decret was legally abrogated for midwifery studies (and some others) since years 2011–2012 (Direction générale de l'Enseignement non obligatoire et de la Recherche scientifique 2011, *Circulaire n° 3606*). The EU states indeed the free movement of studying and working persons inside the European Union. From that moment, midwifery schools in Wallonia once again had the opportunity to self-regulate the access of their foreign students. This varies relating to the number of Belgian candidates, which may vary itself depending on the general knowledge and interest, or news, about midwifery, as developed further in this chapter.

Table 2.1 presents the evolution of graduation in Belgium (Benahmed et al. 2016, p. 59) regarding the place of the midwives' secondary education.

In the years 2009–2014, the number of new graduated midwives in the 'communauté française' (French community) having a secondary certificate from abroad was more important than those coming from Wallonia. No study was undertaken to explain this, but an explanation may be due to the lack of information or interest of the Wallonia public at large regarding what midwifery is. As with other nations, the public may be confused with differences between midwives and nurses. This may be compounded by the fact that until 2005 in Wallonia and 1993 in Flanders both nursing and midwifery were sharing the same education and training curricula, with midwifery then being a nursing specialisation. Often, nursing and midwifery students were of the same university college, wearing the same hospital gowns, thus making differentiation across programmes almost impossible to determine. This trend and interest shown by the public is changing due to more awareness towards midwives and the midwifery profession attributable to, but not exclusively, some well-known television series such as 'Baby Boom' and 'Call the midwife'.

Table 2.1 Place of secondary education per graduating midwife

Academic year	Graduated midwives with Belgian secondary school certificate from within the Flanders community	Graduated midwives with secondary school certificate outside of the Flanders community	Graduated midwives in the French community with Belgian secondary school certificate	Graduated midwives in French community with secondary school certificate from the EU and non-EU	Total number of graduated midwives in Belgium
2009/2010	256	98	102	171	627
2010/2011	266	74	133	145	618
2011/2012	349	88	116	155	708
2012/2013	311	87	142	163	703
2013/2014	298	80	113	149	640

The last few years, employment of the (new) midwives has also been a subject of interest in some newspapers on a recurring basis, as a certain amount of professions are legally declared to be 'lacking of workers' which is not the case of midwifery, but of (specialised) nurses. This opened some debates and interest about nurses and midwives.

In an attempt to raise awareness of the midwifery profession, the professional midwifery association 'Union Professionnelle des Sages-Femmes Belges' (UPSFB) developed a free leaflet for the public, presenting what a midwife in Wallonia is and does. This is entitled 'Entre de bonnes mains, celles de votre sage-femme' which means 'In good hands, those of your midwife'. Union Professionnelle des Sages-femmes Belges. Entre de bonnes mains, celles de votre sage-femme. n.d.-b. The UPSFB also developed a powerful website outlining definitions and practises related to midwifery care provision, which may also positively contribute to a better public accessibility of contemporary and correct information and understanding of midwives. This also happened in Flanders. The Flemish professional organisation of midwives (VBOV) has set up some profiling campaigns both in the written as well as on social media.

All Wallonia midwifery schools accept Belgian and non-Belgian students according to the EU legislation about free moving from one estate to another. Most of the foreign students come from the EU, with the majority arriving from France (Benahmed et al. 2016, p. 57). This could be because France is Belgium's closest neighbour, and we share the same language. Moreover, access to midwifery studies in France is robustly regulated (entrance examination for all candidates and few candidates accepted because they are not allowed to take more than what is fixed by law). Midwifery students coming from France recognise the high-quality level of the midwifery education, even if it is different from France. They use to say Wallonia curricula emphasise more relational and empowering aspects of the profession than in France.

Since 2010, the non-Belgian students in both the midwifery curricula of the Flanders and Wallonia region represent about 30% of the total of the midwifery students 'cohort' (Benahmed et al. 2016, p. 60).

Typically, 99% of the midwifery students in French community are female, and this figure has remained stable for several years (Benahmed et al. 2016, p. 50). It seems that midwifery in Wallonia is indeed dedicated to women, and mostly seen as a woman's job. A male-midwife in Wallonia is called 'homme sage-femme' and so is decided in France in 1982 by Académie française (Belhasse 2009) and in Flanders 'vroedvrouw'. Even if men are accepted and welcome, they may not feel encouraged. The French term 'sage-femme' is strongly feminine, and we always say 'she' when we talk about midwives. The free UPSFB leaflet presenting what does a midwife in Wallonia 'Entre de bonnes mains, celles de votre sage-femme' (Union Professionnelle des Sages-femmes Belges. Entre de bonnes mains, celles de votre sage-femme. n.d.-b.) speaks it only to the feminine: 'she' and 'her'. Historically in Belgium (and in our neighbouring countries), midwives were exclusively women, dedicated to help mothers, babies and families, and a part of the group were nuns. In comparison, nursing in Belgium has only a few more male nurses than in midwifery: 108,810 women and 17,663 men (6%) were economically active on 31/12/2009 (Cellule Planification des professions de soins de santé 2014).

A maximum of 1% of non-union candidate's students in the official university colleges of Belgium are fundable by decree. This leads the university colleges to limit non-union students' access and strictly respect this strain (CIRÉ n.d.).

The graduation rate (interpreted as the relationship between number of graduated midwives after 4 years of study and number of first-year students) for the years 2009–2014 in the 'communauté française' (French community) was 65, 0% (±9, 5), which is a rather good figure. In comparison, it is 54.2% (±4.5) for the whole of Belgium where midwifery training is a minimum of 3 years in the Dutch community and a minimum of 4 years in the French community. Nevertheless, it appears that the French figures are in strong diminution for those years, which could mean that less students are finally graduating after entering the curricula (Benahmed et al. 2016, p. 56). There is no research or evidence yet to explain this. The SPF work about next year's midwifery workforce will maybe help understanding this evolution. In the Wallonia university colleges, the average success rate of the students registered in the bachelor level (180 credits) for the first year is 39%: 31% are men and 45% are women (year 2013–2013). It is a little less in university (36%) (Académie de Recherche et d'Enseignement Supérieur n.d. Statistiques). The graduation rate is not available for university colleges or universities.

2.1.5 Evolution of Midwifery Practise Among Young Midwives in the French Community (2004–2014) and Its Opportunities

Registered midwives historically had the legal opportunity to work as a qualified nurse, under the same conditions and care services as nurses. The legislation changed in 2014. Newly graduated midwives after 1st October 2018 will be legally allowed to perform nursing services and delegated medical procedures, but only in obstetric, fertility, gynaecology and neonatology care units (Loi du 10 avril 2014 portant des dispositions diverses en matière de santé (2014)). This is a positive thing, as it is protecting midwifery profession. It is also legally acceptable for a graduated midwife to continue to graduate as a nurse, or vice versa. However, the workload of that mixed curricula becomes heavier, and very few newly graduated students are actually being able to complete it.

In 2016, the SPF (Service Public Fédéral) ordered a data analysis of a 10-year period for the years 2004–2014 in order to anticipate the potential needs for a midwifery workforce in Belgium within the following 25 years. This 2018 report is now available online (Cellule Planification des professions de soins de santé 2018), and it concerns the three regions of Belgium: Flanders, Wallonia and Germany. Analysis of this report and projections for future workforce planning are required in order to advise policymakers in developing future workforce. It is expected that these statistics will help reviewers to understand recent midwifery work conditions for new midwifery practitioners (NMPs) in Belgium in order to make advancements to ensure that maternity services are fit for the future.

The different types of practise identified and considered within the report (Cellule Planification des professions de soins de santé 2018, p. 12) are:

- *Licensed to Practise (LTP)*: includes all the midwives authorised to work as a midwife. This excludes all the midwife having a 'superior' graduation level (doctors, dentist and pharmacologist) as they are expected to work at that 'superior' level.
- *Professionally Active (PA)*: includes all working midwives, who are performing a certain activity within the LTP group, and including any midwife working as independent for at least 0.1 FTE (full-time equivalent).
- *Practising (PR)*: includes all midwives practising in health care services (according to their nomenclature, having at least two midwifery or nursing services during the year).

Table 2.2 presents the professionally active midwives in Belgium.

In 2014, 11,633 midwives were licensed to practise (LTP) in Belgium, with 75% of them ($n = 8671$) being professionally active (PA) (p. 16). In Wallonia, 4107 midwives have an LTP, among them 69% ($n = 2824$) are PA. Of them, 81, 69% ($n = 1405$) are working exclusively as salaried midwives, and interesting 596 of them are <35 years old. Only, 6.86% of them ($n = 118$) are totally independent midwives, meaning that they are not salaried at all (Cellule Planification des professions de soins de santé 2018, Table 6, p. 27).

Based upon the statistical data recorded at that point in time, it is not known if the flow of incoming new midwives is enough to substitute the retiring midwives, nor if retiring midwives are staying instead of retiring. Regarding the number of births per midwife in Wallonia (Sect. 2.1.1), this workforce could be appropriate, but regarding the increasing workload among hospital wards and in the community, midwives perceive that there is a lack of midwives, especially as they wish to plan 'one women, one midwife' for better care. The SPF (Service Public Fédéral) is continuing with the data analysis for the years 2004–2014 to forecast the needs for the future midwives workforce in Belgium (Cellule Planification des professions de soins de santé 2018); however, these projections have not been presented yet.

This will be a sensitive issue for midwives, families and policymakers: recommendations of the SPF will direct the decisions for the midwifery regulation and workforce in Belgium for the next 25 years.

There are a number of midwives with both nursing and midwifery diplomas. Among midwives having a midwifery diploma in Belgium ($n = 11{,}642$), 59.15% ($n = 6886$) have a midwifery diploma only and 34.21% ($n = 3983$) are dual trained, with the majority of them completing their nursing diploma first.

Table 2.3 presents the activity sectors for midwives in Wallonia and Flanders.

The main activity sector is located within hospital wards (85.02%, $n = 1362$) (Cellule Planification des professions de soins de santé 2018, Table 7a, p. 30). Other sectors include public sector within administration departments (6.12%, $n = 98$) or social services and nurseries (1.50%, $n = 24$). Education is difficult to evaluate for PA midwives living in Wallonia because the main employer (Ministry of Education)

Table 2.2 Distribution of the professionally active midwives (PA) related to their region of activity and their professional status (31/12/2014)

		PA		Age			Communauté		Domicile			
Région d'activité	Statut professionnel	*N*	*%N*	.. < 35	35 < 50	50 < ..	FL	FR	RF	RW	RBC	N-Bel
Région flamande		4133	82.63	2018	1324	791	3810	323	4054	22	13	44
		403	8.06	118	190	95	375	28	399	1	0	3
		466	9.32	139	155	172	437	29	466	0	0	0
		5002	*100.00*	*2275*	*1669*	*1058*	*4622*	*380*	*4919*	*23*	*13*	*47*
Région wallonne	Salarié exclusif	1405	81.69	596	507	302	189	1216	57	1264	6	78
	Statut combiné	197	11.45	59	94	44	14	183	0	195	1	1
	Indépendant exclusif	118	6.86	18	48	52	8	110	0	118	0	0
		1720	*100.00*	*673*	*649*	*398*	*211*	*1509*	*57*	*1577*	*7*	*79*
Région Bruxelles-Capitale	Salarié exclusif	1676	86.04	720	590	366	894	782	898	324	431	23
	Statut combiné	234	12.01	84	93	57	106	128	100	69	64	1
	Indépendant exclusif	38	1.95	19	15	4	13	25	0	0	38	0
		1948	*100.00*	*823*	*698*	*427*	*1013*	*935*	*998*	*393*	*533*	*24*
Etranger and inconnu	Indépendant exclusif	1	100.00	0	0	1	1	0	0	0	0	1
		1	*100.00*	*0*	*0*	*1*	*1*	*0*	*0*	*0*	*0*	*1*
Total	Salarié exclusif	7214	83.20	3334	2421	1459	4893	2321	5009	1610	450	145
	Statut combiné	834	9.62	261	377	196	495	339	499	265	65	5
	Indépendant exclusif	623	7.18	176	218	229	459	164	466	118	38	1
		8671	*100.00*	*3771*	*3016*	*1884*	*5847*	*2824*	*5974*	*1993*	*553*	*151*

Professionally Active (PA): includes all working midwives, who are performing a certain activity within the LTP group, and including any midwife working as independent for at least 0.1 FTE (full-time equivalent)
Région d'activité: region of activity
Région flamande: the Flemish region
Région wallonne: the Wallonia region
Région Bruxelles-Capitale: the Brussels-Capital region
Etranger & inconnu: the foreign and unknown
Statut professionnel: professional status
Salarié exclusif: exclusively salaried
Statut combiné: combined status (means both salaried and independent)
Indépendant exclusif: exclusively independent

Table 2.3 Distribution of the professionally active midwives (PA) related to ONSS and ONSSAPL, and related to region of activity, community and for Belgium (31/12/2014)

	ONSS+											
	Région d'activité						Communauté					
	RF		RW		RBC		FL		FR		Total	
Secteur d'activité	*N*	*%N*	*N*	*%N*	*N*	*%N*	*N*	*%N*	*N*	*%N*	*N*	*%N*
Soins de santé	*4028*	*88.80*	*1434*	*89.51*	*1011*	*52.93*	*4310*	*79.99*	*2163*	*81.32*	*6473*	*80.43*
Hôpital	3499	77.14	1362	85.02	957	50.10	3786	70.27	2032	76.39	5818	72.29
MR(S)	158	3.48	27	1.69	25	1.31	153	2.84	57	2.14	210	2.61
Activités infirmiers hors hôpital	245	5.40	30	1.87	9	0.47	239	4.44	45	1.69	284	3.53
Activités sages-femmes hors hôpital	7	0.15	0	0	0	0	7	0.13	0	0.00	7	0.09
Autres secteurs de santé	139	3.06	19	1.19	26	1.36	145	2.69	39	1.47	184	2.29
Action sociale	*115*	*2.54*	*24*	*1.50*	*46*	*2.41*	*141*	*2.62*	*44*	*1.65*	*185*	*2.30*
Action sociale avec hébergement	25	0.55	5	0.31	6	0.31	28	0.52	8	0.30	36	0.45
Action sociale sans hébergement	61	1.34	10	0.62	34	1.78	82	1.52	23	0.86	105	1.30
Crèches	30	0.66	10	0.62	7	0.37	32	0.59	15	0.56	47	0.58
Enseignement	*55*	*1.21*	*18*	*1.12*	*579*	*30.31*	*433*	*8.04*	*219*	*8.23*	*652*	*8.10*
Sécurité sociale + CPAS	*223*	*4.92*	*17*	*1.06*	*17*	*0.89*	*229*	*4.25*	*28*	*1.05*	*257*	*3.19*
CPAS	216	4.76	17	1.06	9	0.47	214	3.97	28	1.05	242	3.01
Mutualités	7	0.15	0	0	4	0.21	11	0.20	0	0.00	11	0.14
Autres	0	0	0	0	4	0.21	4	0.07	0	0.00	4	0.05
Secteur public	*17*	*0.37*	*98*	*6.12*	*241*	*12.62*	*174*	*3.23*	*182*	*6.84*	*356*	*4.42*
Administration publique de la santé, de la formation, de la culture et des autres services sociaux	0	0	87	5.43	205	10.73	142	2.64	150	5.64	292	3.63
Autres secteurs publics	17	0.37	11	0.69	36	1.88	32	0.59	32	1.20	64	0.80
Autres secteurs (hors santé)	*154*	*3.40*	*31*	*1.94*	*83*	*4.35*	*188*	*3.49*	*80*	*3.01*	*268*	*3.33*
Total	*4536*	*100.00*	*1602*	*100.00*	*1910*	*100.00*	*5388*	*100.00*	*2660*	*100.00*	*8048*	*100.00*

Professionally Active (PA): includes all working midwives, who are performing a certain activity within the LTP group, and including any midwife working as independent for at least 0.1 FTE (full-time equivalent)
Secteur d'activité: business sector
Région d'activité: region of activity
Communauté: community
ONSSAPL (Office National de Sécurité Sociale des Administrations Provinciales et Locales): National Office for Social Security of the Local and Provincial Administration
ONSS (Office National de Sécurité Sociale): National Office for Social Security
Soins de santé: health care
Action sociale: social work
Enseignement: education
Sécurité sociale + CPAS: social security + public centres for social help
Secteur public: public sector
Autres secteurs (hors santé): other sectors (non-health sectors)

is based in the Brussels region, and the figures are then located in Brussels even if they work in Wallonia.

Table 2.4 presents the distribution and professional status for midwives.

In Wallonia, among the 617 midwives <35 years old, 545 are exclusively salaried and 15 exclusively independent. The others ($n = 57$) have a combined status (Cellule Planification des professions de soins de santé 2018, Table 10, p. 38).

Table 2.5 presents the age of midwives related to full-time equivalents.

Currently, 450 of these midwives are under 30 years old and those working in the Wallonia region have almost full-time jobs (0.9 full-time equivalent) (Cellule Planification des professions de soins de santé 2018, Table 7b, p. 32).

Table 2.6 presents the age of the professionally active midwives related to the region of activity.

Approximately, 7% of the professionally active (PA) midwives in Wallonia are <25 years old, and about 19% are between 25 and 29 years old. This last group is the most important of the working midwives in Wallonia (Cellule Planification des professions de soins de santé 2018, Fig. 1, p. 29). An explanation could be that a certain amount of the young newly graduated midwives choose to go on studying within master levels, or any complementary graduation (inter-university diploma, for example), and their entry in the working group is therefore delayed.

Table 2.7 presents the different category activities of midwives related to their age.

Among the 1133 midwives in the 'French community' who are under 30 years old with a license to practise (LTP), 67.7% of them ($n = 767$) are professionally active in health care sector (PR) (Cellule Planification des professions de soins de santé 2018, Table 9, p. 37). Within this category, it is difficult to accurately evaluate specific work in mother-and-child health care services, because of the double graduate nursing–midwifery.

2.2 A Brief Outline of the Education Leading to Registration as a Midwife in Belgium

2.2.1 In the Wallonia Region

The ARES' (Académie de Recherche et d'Enseignement Supérieur 2015) recommendations for the research academy for higher education are that the curricula have to include 240 European credits, distributed as follows within the 4 years (Fig. 2.2):

The integrated and internetwork framework for Bachelor in Midwifery presents eight training competencies, written according to ARES competencies (Groupe inter réseaux des enseignantes sages-femmes 2015). These are as follows:

- *First competence*: To commit herself into training, and building her professional identity

Table 2.4 Distribution of the professionally active midwives practising in health care services (PR) related to region of activity and professional status (31/12/2014)

		PR		Age			Communauté		Domicile			
Région d'activité	Statut professionnel	*N*	*%N*	.. < 35	35 < 50	50 < ..	FL	FR	RF	RW	RBC	N-Bel
Région flamande	Salarié exclusif	3672	84.96	1861	1148	663	3379	293	3612	16	7	37
	Statut combiné	379	8.77	113	177	89	352	27	376	0	0	3
	Indépendant exclusif	271	6.27	116	78	77	248	23	271	0	0	0
		4322	*100.00*	*2090*	*1403*	*829*	*3979*	*343*	*4259*	*16*	*7*	*40*
Région wallonne	Salarié exclusif	1272	82.49	545	454	273	175	1097	51	1140	6	75
	Statut combiné	192	12.45	57	94	41	14	178	0	190	1	1
	Indépendant exclusif	78	5.06	15	36	27	5	73	0	78	0	0
		1542	*100.00*	*617*	*584*	*341*	*194*	*1348*	*51*	*1408*	*7*	*76*
Région Bruxelles-Capitale	Salarié exclusif	893	80.52	438	251	204	367	526	349	173	358	13
	Statut combiné	192	17.31	77	72	43	76	116	69	59	63	1
	Indépendant exclusif	24	2.16	14	9	1	11	13	0	0	24	0
		1109	*100.00*	*529*	*332*	*248*	*454*	*655*	*418*	*232*	*445*	*14*
Total	Salarié exclusif	5837	83.71	2844	1853	1140	3921	1916	4012	1329	371	125
	Statut combiné	763	10.94	247	343	173	442	321	445	249	64	5
	Indépendant exclusif	373	5.35	145	123	105	264	109	271	78	24	0
		6973	*100.00*	*3236*	*2319*	*1418*	*4627*	*2346*	*4728*	*1656*	*459*	*130*

Practising (PR): includes all midwives practising in health care services (according to their nomenclature, having at least two midwifery or nursing services during the year)
Région d'activité: region of activity
Région flamande: the Flemish region
Région wallonne: the Wallonia region
Région Bruxelles-Capitale: the Brussels-Capital region
Statut professionnel: professional status
Salarié exclusif: exclusively salaried
Statut combiné: combined status (means both salaried and independent)
Indépendant exclusif: exclusively independent

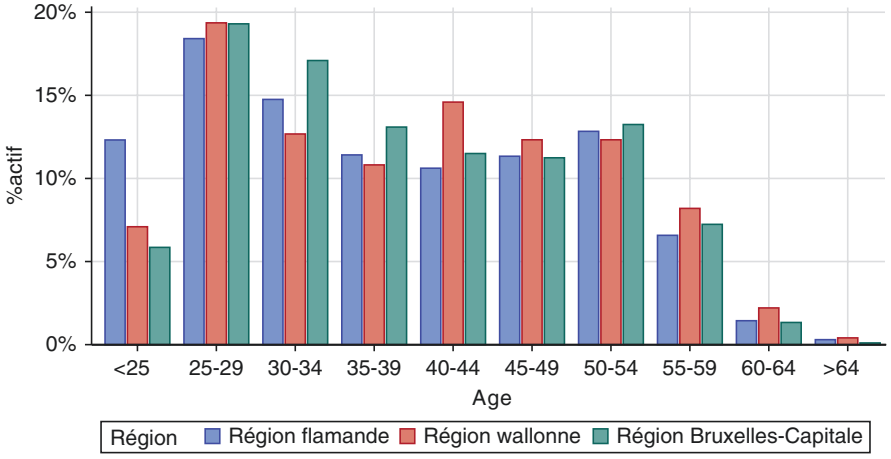
Table 2.5 Distribution of the professionally active midwives (PA) related to ONSS and ONSSAPL, and to full-time equivalents, related to region of activity, age and business sector (31/12/2014)

		ONSS+													
		Santé		Aide		Enseign.		CPAS+		Public		Autre(hors santé)		Total	
Région d'activité	Age	*N*	ETP Moy.	*N*	ETP Moy.	*N*	ETP Moy.	*N*	ETP Moy.	*N*	ETP Moy.	*N*	ETP Moy.	*N*	ETP Moy.
Région flamande	.. < 30	1347	091	25	0.86	23	0.47	34	0.92	2	0.75	49	0.51	1458	0.90
	30 < 40	1067	076	40	0.71	14	0.57	47	0.83	3	0.68	38	0.72	1198	0.77
	40 < 50	867	074	27	0.68	6	0.62	66	0.73	4	0.81	32	0.69	994	0.74
	50 < 60	709	071	22	0.77	11	0.45	74	0.73	7	0.67	33	0.66	841	0.72
	60 < ...	38	065	1	1.00	1	0.08	2	1.00	1	1.00	2	0.15	45	0.65
	Tot	4028	079	115	0.75	55	0.50	223	0.78	17	0.73	154	0.63	4536	0.79
Région wallonne	.. < 30	405	091	2	0.65	3	0.69	1	1.00	34	0.93	6	0.48	450	0.90
	30 < 40	344	076	7	0.66	6	0.27	3	0.53	19	0.69	9	0.80	381	0.76
	40 < 50	375	076	9	0.66	5	0.22	6	0.75	32	0.80	5	0.41	425	0.76
	50 < 60	283	075	6	0.49	4	0.52	6	0.80	13	0.78	10	0.78	317	0.76
	60 < ..	27	077	0	0	0	0	1	1.00	0	0	1	0.85	29	0.78
	Tot	1434	080	24	0.62	18	0.38	17	0.76	98	0.82	31	0.67	1602	0.80
Région Bruxelles-Capitale	.. < 30	331	091	4	0.39	63	0.71	0	0	66	0.86	35	0.18	479	0.86
	30 < 40	267	075	16	0.79	174	0.67	6	0.96	111	0.75	20	0.51	576	0.74
	40 < 50	185	075	13	0.82	194	0.72	6	0.96	40	0.77	7	0.41	432	0.76
	50 < 60	210	075	13	0.73	143	0.64	4	0.85	22	0.74	19	0.55	395	0.73
	60 < ..	18	086	0	0	5	0.42	1	1.00	2	0.64	2	0.14	28	0.72
	Tot	1011	081	46	0.75	579	0.68	17	0.94	241	0.78	83	0.36	1910	0.77

Région d'activité	Age	ONSS+													
		Santé		Aide		Enseign.		CPAS+		Public		Autre(hors santé)		Total	
		N	ETP Moy.	*N*	ETP Moy.	*N*	ETP Moy.	*N*	ETP Moy.	*N*	ETP Moy.	*N*	ETP Moy.	*N*	ETP Moy.
Total	.. < 30	2083	091	31	0.79	89	0.65	35	0.92	102	0.88	90	0.38	2387	0.89
	30 < 40	1678	076	63	0.72	194	0.65	56	0.83	133	0.74	67	0.67	2155	0.76
	40 < 50	1427	075	49	0.71	205	0.70	78	0.75	76	0.78	44	0.61	1851	0.75
	50 < 60	1202	073	41	0.72	158	0.63	84	0.74	42	0.74	62	0.65	1553	0.73
	60 < ..	83	074	1	1.00	6	0.36	4	1.00	3	0.76	5	0.29	102	0.71
	Tot	6473	080	185	0.73	652	0.66	257	0.79	356	0.79	268	0.55	8048	0.79

Professionally Active (PA): includes all working midwives, who are performing a certain activity within the LTP group, and including any midwife working as independent for at least 0.1 FTE (full-time equivalent)
Région d'activité: region of activity
Région flamande: the Flemish region
Région wallonne: the Wallonia region
Région Bruxelles-Capitale: the Brussels-Capital region
Secteur d'activité: business sector
Santé: health
Aide: help
Enseignement: education
CPAS: public centres for social help
Public: public
Autre (hors santé): others (non-health sectors)
Equivalents temps-plein: full-time equivalents
ETP moy.: full-time equivalents average

Table 2.6 Proportion of the professionally active midwives (PA) related to age and to activity region, (31/12/2014)



Professionally Active (PA): includes all working midwives, who are performing a certain activity within the LTP group, and including any midwife working as independent for at least 0.1 FTE (full-time equivalent)
Région flamande: the Flemish region
Région wallonne: the Wallonia region
Région Bruxelles-Capitale: the Brussels-Capital region

- *Learning outcomes*:
  - Actively take part to develop her learning
  - Take part to mentorship by peers
  - Develop her professional identity
- *Second competence*: To make allowance for deontology, ethics, laws and rules
- *Learning outcomes*:
  - Respect legislation, laws, rules and deontology that are specific to midwifery
  - Perform ethical approach
- *Third competence*: To take part in management of human resources, equipment and administration
- *Learning outcomes*:
  - Plan her duty regarding situation and organisational imperative
  - Collaborate with different multidisciplinary members of the team
  - Take part to quality process
- *Fourth competence*: To realise clinical approach (diagnosis and intervention/support strategies) during preconceptional time, prenatal, perinatal and postnatal time
- *Learning outcomes*:
  - Search for relevant information sources
  - Take part in the diagnosis
  - Decide what intervention and support to set related to the diagnosis
  - Evaluate and adjust

Table 2.7 Repartition of the midwives (LTP-PA-PA) related to the community and age (31/12/2014)

		LTP	PA		PR	
Communauté	Age	*N*	*n*	*%n*	*n*	*%n*
Communauté flamande	.. < 30	1936	1599	82.6	1412	72.9
	30 < 40	1873	1656	88.4	1279	68.3
	40 < 50	1486	1325	89.2	1000	67.3
	50 < 60	1429	1166	81.6	879	61.5
	60 < 70	418	97	23.2	56	13.4
	70 < ..	384	4	1.0	1	0.3
		7526	*5847*	*77.7*	*4627*	*61.5*
Communauté française	.. < 30	1133	883	77.9	767	67.7
	30 < 40	821	645	78.6	545	66.4
	40 < 50	830	679	81.8	552	66.5
	50 < 60	753	557	74.0	437	58.0
	60 < 70	243	57	23.5	45	18.5
	70 < ..	327	3	0.9	–	–
		4107	*2824*	*68.8*	*2346*	*57.1*
Total	.. < 30	3069	2482	80.9	2179	71.0
	30 < 40	2694	2301	85.4	1824	67.7
	40 < 50	2316	2004	86.5	1552	67.0
	50 < 60	2182	1723	79.0	1316	60.3
	60 < 70	661	154	23.3	101	15.3
	70 < ..	711	7	1.0	1	0.1
		11633	*8671*	*74.5*	*6973*	*59.9*

Licensed to Practise (LTP): includes all the midwives authorised to work as a midwife. This excludes all the midwife having a 'superior' graduation level (doctors, dentist and pharmacologist) as they are expected to work at that 'superior' level
Professionally Active (PA): includes all working midwives, who are performing a certain activity within the LTP group, and including any midwife working as independent for at least 0.1 FTE (full-time equivalent)
Practising (PR): includes all midwives practising in health care services (according to their nomenclature, having at least two midwifery or nursing services during the year)
Région flamande: the Flemish region
Région wallonne: the Wallonia region
Région Bruxelles-Capitale: the Brussels-Capital region

- *Fifth competence*: To perform health care deliveries during preconceptional time, prenatal, perinatal and postnatal time
- *Learning outcomes*:
  - Prepare and realise the health care deliveries using appropriate resources
  - Ensure follow-up of the services
- *Sixth competence*: To ensure professional communication towards clients and professional staff
- *Learning outcomes*:
  - Pass on verbal or written information
  - Use techniques of communication appropriated to the context
  - Develop help-relationship

Programme minimum Sage-Femme/*Minimum midwifery program*	**240 crédits (ECTS)**
Sciences Fondamentales et biomédicales/ *Basic and biomedical sciences*	42
Sciences humaines et sociales/ *Human and social sciences*	15
Sciences professionnelles / *Professional sciences*	45
Activités d'intégration professionnelle/ *Professional integration* or *clinical placements*	75
Recherche appliquée /*Applied research*	15
TOTAL commun	192
Liberté PO/ *Choice of the university college*	48
TOTAL Général	**240**

Fig. 2.2 Distribution of the European credits within the current curricula

- *Seventh competence*: To carry out collective and individual health promotion and education approaches
- *Learning outcomes*:
  - Identify needs, resources and expectations in health of the target audience
  - Plan educative and psycho-affective interventions
  - Realise the interventions
  - Evaluate and adjust the process or the intervention
- *Eighth competence*: to conceptualise a scientific-research process in midwifery
- *Learning outcomes:*
  - Develop a reflective thinking on her practise and improving it by evidence-based
  - Establish her practise on evidence-based

The competencies framework (Groupe inter réseaux des enseignantes sages-femmes. (2015). *Référentiel de compétences intégré inter réseaux en Bachelier Sage-femme*) identifies nine professional fields for midwifery training, which may be achieved either in or out of hospital settings, including training in simulation centres:

1. General adult care
2. Mental care and psychiatry
3. Preconceptional and prenatal health
4. Birth
5. Postnatal health
6. Health promotion
7. Care in high-risk pregnancies
8. Care in neonatology
9. Care in mourning, including termination of pregnancy and palliative care

The clinical placement training in these highlighted different professional fields may help midwifery students in their transition to practise. This is because the midwifery students are gradually exposed to the expectations required for the role of an NMP in order to gain confidence in the realities of what is like as an NMP. According to Gray et al. (2016), this could help 'the transition to the model of practise'. In

addition, it seems that more and more working placements (hospitals) ask to their NMP to be polyvalent and to regularly change their place of work to different wards, such as post-partum, neonatology, high-risk pregnancies, delivery and prenatal consultation. This flexibility may be anticipated through various clinical placements, as proposed during the curricula and reflects the realities once qualified.

It is also legally required by the EU that the midwifery student fulfils a specified number of births with attendance of an experienced midwife or obstetrician, and an amount of different practical gestures of care before graduation. The gestures have to be identified and signed in a special list evidencing achievement. Since 1987, in order for midwifery students to meet requirements for midwifery qualification and registration, they are required to perform (Di Zenzo 2012): 100 prenatal consultation, 40 high-risk pregnancies care, 40 deliveries and 100 post-partum examination. Omission of this legal aspect could lead to refuse the graduation and ultimately access to midwifery status.

2.2.2 In the Flanders Region

The competence framework in Flanders is based on:

- The European directives,
- The International Confederation of Midwives (ICM) Essential Competencies for Basic Midwifery Practice (2010, amended 2013),
- The relevant Belgian professional legislation and professional competencies (2015),
- And, the existing education programs (2008).

The competencies or learning outcomes:

1. Physiology, care and guidance
2. Risk detection and risk selection
3. Pathology, care and guidance
4. Psychosocial context
5. Ethics and legislation
6. Health educator
7. Collaboration and communication
8. Coaching
9. Personal and professional development
10. Evidence-based care
11. Quality and care

In Flanders, we have one professional profile combined with one educational profile. There are different curricula in the nine educational programs spreaded around twelve campuses. They all have 180 ECTS, about ½ clinical education (in school/at the workplace) and the obliged 3 ECTS: pharmacology (new legislation prescription).

2.3 The Regulation Related to Initial and Ongoing Registration in Belgium

Once all programme requirements have been met, for the newly qualified midwife there is no required national or regional examination before entering the midwifery registration in Belgium. Any graduated midwife is required to self-register prior to working clinically as a midwife in order to receive a visa and accreditation provided by the Public Health Services (SPF Santé Publique). Both are automatically provided if the NMPs' graduated from an official Belgian midwifery school. If not, an online procedure is available for midwives to apply. There is a special request for midwifery accreditation for prescribing drugs (SPF Santé Publique, Sécurité de la chaîne alimentaire et Environnement). The legal drugs list for prescribing midwives is newly updated and available online (SPF Santé publique, Sécurité de la chaîne alimentaire et Environnement. Formulaire de demande d'habilitation pour prescrire certains médicaments de façon autonome pour les sages-femmes. n.d.). This accreditation is mandatory if the midwife intends to work as an independent midwife, and is often sought by employers if he/she is salaried. Before 2014, this accreditation was optional in the curricula, and registered midwives had access to post-training certification in prescribing drugs. It is now legally included in the curricula and compulsory to any student midwife. The post-training certification in prescribing drugs is still available for older midwives.

Having a professional insurance is optional if the midwife is salaried and mandatory if working as an independent midwife. Independent midwives have to request a personal identity number for agreement and regulation. The midwives use specific and personal certificates of care and prescription pads, and have to join a mutual insurance company.

All midwives are legally required to undergo 75-h post-training development per 5 years as a regulation after graduation. Previously, the content of these development activities needed to be approved and were monitored by the Federal Council for Midwives (SPF Circulaire du 15 mars 2010, publié le 05 mai 2010) but it has recently been cancelled (Arrêté royal modifiant l'arrêté royal du 1er février 1991 relatif à l'exercice de la profession de sage-femme 2018). The midwife has the opportunity to choose and self-pay for training opportunities. Employers also encourage training and may organise, and or offer to pay for the midwife to attend. If the midwife does not satisfy this condition, she will receive a notice to ensure that she completes it. If she still does not satisfy the requirements after 1 year following the notice, her professional qualification could be removed, meaning that she is unable to continue practising as a midwife.

There are three midwifery professional associations, two in Wallonia and another in Flanders. All three of them are together in an umbrella organisation: the Belgian Midwives Association (BMA), which is the national midwifery association, linked in European Midwives Association (EMA).

– 'Association francophone des sage-femmes catholiques' (AFSFC) or 'French-speaking Association of catholic midwives'

– 'Union Professionnelle des sages-femmes belges' (UPSFB) or 'Professional Union of Belgian Midwives'
– 'Vlaamse Beroepsorganisatie van Vroedvrouwen' (VBOV) or 'Flemish professional organisation of Midwives'

In Wallonia, membership is optional and 39% of the 2824 midwives PA in Wallonia are members. Reasons could be a lack of information about the associations, or the fees (60–70 euros per year for a qualified midwife, less for midwifery students and retired midwives), or still the lack of interest. The associations work to develop, highlight and uphold all aspects of midwifery within official health, social and education authorities, by all the other healthcare professionals, and the general public; they support, protect and represent all midwives. They organise midwifery congresses, events, trainings, they hold a website, and they develop new education tools. All midwives committed in the associations are working for free with a view to enhancing the knowledge and understanding of quality health care provision of midwives and services to improve the nation's health outcomes ultimately. As good practise, the associations are both regularly asked to meet the future new midwives during the curricula and to share them about the practise, the midwifery representation and all concerns of a future NMP. The midwifery schools encourage students to attend congresses and events of the associations, and to develop through them their sense of community.

2.4 The Transition of New Midwives After Registration as a Midwife in Wallonia: Discussion

There is currently no research or evidence about transition to practise in Wallonia for new midwives. Even if researchers suggest that 'clinical practise experiences influence where the future midwifery practitioner will choose to work after graduation' (McCall et al. (2009) in Gray et al. 2016), there seems to be a concern in Wallonia about employment. A certain amount of the NMPs have no choice in where they will work and apply to many hospitals before securing a salaried job, sometimes in wards they didn't intend to work. Midwifery is not considered as a business in shortage (as specialised nurses) in Belgium, and for several years it has been observed that new midwives cannot easily locate a job according to their qualifications or preferred area of interest, such as part-time jobs, wards out of mother-and-baby care (e.g. surgery rooms), hospital settings far from home or simply take part in the midwifery recruitment reserve. However, once the Cellule Planification des professions de soins de santé (2018) has completed their forecast for the future of the midwifery work force, there may be a culture of new thinking related to the employment opportunities, but this would not be a quick action on behalf of the regulatory bodies of government. In the same way, it seems that some NMP's choice is to become independent earlier than planned, because of employment difficulties and this may be the option available to them.

On consideration of these points, one can question if there are too many newly graduated midwives in Belgium and whether there needs to be a reduction in the numbers of training places available. Conversely, it could be postulated that there may not be enough midwives to perform appropriate healthcare services to mothers, babies and families. As highlighted earlier, there is a consideration that there is a problem with retiring-aged midwives staying along in the job past their expected date of retirement. All of these major considerations about midwifery employment are to be solved through the current SPF analysis of the data collected for the years 2004–2014. Different scenarios of the evolution of the midwifery workforce should emerge, and the commission will give advice to the Minister of Health. However, a significant level of concern is already emerging from the data and current discussions, and will have influence on the ultimate decisions made. These include:

- Midwifery curricula are different between Flanders (3 years) and Wallonia (4 years); this is not coherent.
- Midwifery schools have to preserve the quality of the curricula within national and international regulation, but there is no regulation about the number of incoming students.
- Hospital settings are the principal workplace for midwives; her/his autonomy needs to be reinforced within those settings, including fertility wards, gynaecology and neonatology.
- Midwives give global care to women and families, and that means they are concerned by mental health and well-being. This requires time which is difficult to evaluate especially in situations of vulnerability.
- Midwives are more and more needed in first-line care services and in the community, e.g. due to shorter maternity stay and needs of sparing public money.
- Midwives ask for more 'one-to-one care' for women (and families).

2.4.1 About Becoming a Salaried Midwife

As already written, the most common employment status in Wallonia for NMPs is an employee contract within a health service (mainly hospital wards), as is the case for all Belgian midwives (Cellule Planification des professions de soins de santé 2018). The NMPs work almost full-time jobs (0.9 full-time equivalent). This could be interesting in case of NMP wishing to undergo other studies, e.g. at Master level, and wishing to still earn a living, but this could be difficult for others who need a full-time job to be able live, such as those with families. It seems that they are also frequently offered temporary contracts. Furthermore, a temporally contract could be a barrier to sign for a personal loan which may have long-term consequences for the individual midwife.

In other midwifery age groups in Wallonia and Belgium, the full-time equivalent is decreasing as the age is increasing: 0.76 full-time equivalent for 30–40 years, 0.75 full-time equivalent for 40–50 years, 0.73 full-time equivalent for 50–60 years and 0.74 full-time equivalent for >60 years (Cellule Planification des professions de

soins de santé 2018). This is probably by choice as the workload is increasing and stressful, but there is no evidence to support this concept.

It is common place for the NMPs to tell their experiences of working and covering the whole scope of midwifery practise within one hospital's wards. The benefits of doing so mean that NMPs gain autonomous practise more quickly and become a 'polyvalent' midwife who will meet the holistic needs of the women they provide care for. Therefore, the NMPs are asked to change the ward they work on after a number of months, and experience a variation of shift patterns to ensure that they have appropriate skills for future practise to support women and their families. In Belgium, mothers and children services are mainly hospital based and physician led, but new services offer midwifery-led continuity of care models, e.g. in prenatal wards, home-based post-partum services and birth centres inside hospital. Nevertheless, it seems that transition to practise within those traditional health care institutions are more 'with the institution' rather than 'with women' for the NMPs, but there currently is no evidence to support this from either perspective.

There is currently no knowledge of any institutional programs dedicated to support new midwives in their transition from student to qualified practise, or mentors dedicated to consolidate skills and knowledge required for NMPs. Transition to practise processes are likely to vary within each hospital dependent upon their individualised processes and support programmes.

With this in mind, it is probable that each hospital varies in the supervision and evaluation they offer for each NMP. It makes sense that there should be at least a mid-year and first-year evaluation for the NMPs following preceptorship and reflective principles, or a ward-evaluation before moving to other areas, focusing on individual planned goals and learning needs. These ideally will be based on their own individualised professional clinical competence, including professional development in terms of decision-making, collaborative working relationships, gaining management experience, enhancing effective care processes, etc. Whilst this is a plausible consideration for the future, research is required to address this gap in practise and add to the evidence base.

2.4.2 About Becoming an Independent Midwife

NMPs in Wallonia are transitioned to practise as soon as they are employed, or become independent midwives. This moment may be delayed, due to a shortage of employment opportunities for midwives in Wallonia, or because some NMPs choose to continue with their studying (e.g. Master Degree). For those NMPs who work in a midwifery-led unit or find themselves in an independent place of work within a birthing house, mentorship appears to be more present and better organised. We call it 'compagnonnage' which means (young) peer midwife-to-(experienced) peer midwife mentorship, within a dimension of sharing reflexivity allowing professional development (Donnay and Charlier 2008, Castiaux 2010). The terminologies infer a nurturing support from more experienced NMPs to the up and coming new workforce.

The UPSFB professional association highly recommends this mentoring practise for the new midwives to support births outside hospital wards (in birthing centres or midwifery-led birthing houses or at home) in their 'Charter for births at home and in birthing houses'. Union Professionnelle des Sages-femmes Belges. Charte de la naissance à domicile et en maison de naissance. n.d.-a.:

> Commencer sa pratique de l'accompagnement global par une période de *compagnonnage* en travaillant en « binôme » avec une sage-femme expérimentée dans ce domaine afin d'acquérir l'expérience nécessaire à une pratique autonome responsable.—Faciliter la transmission et le partage de ses connaissances » (UPSFB, Charte de la naissance à domicile et en maison de naissance). The English interpretation is: « To begin her/his working practise of global follow-up—of the mothers—with a time of *compagnonnage/mentorship* 'peer-working' with a field-experienced midwife, in order to gain the necessary experience for an autonomous and responsible practise—to facilitate the transmission and the sharing of knowledge.

The new independent midwife (working within birthing houses) is expected to sign up this Charter before her professional details are put on the UPSFB website. This is a kind of protection for mothers and families, and for the professional association hosting the website, and a quality control for all. This is not required for salaried midwives because they are supposed to adhere in their own hospital's chart or protocol of care.

2.4.3 About 'Mentorship' During Midwifery Studies and After

The French term 'compagnonnage' is used in Wallonia midwifery as a professional specific term very early in the curricula. The first competence of the Integrated and Internetwork Framework for the Bachelor in Midwifery (Groupe inter réseaux des enseignantes sages-femmes. (2015). *Référentiel de compétences intégré inter réseaux en Bachelier Sage-femme*) is to commit herself into training, building her professional identity to present it in this way: 'Contribuer au compagnonnage par les pairs'. This includes professional qualities of respect and empathy, assertiveness and responsibility but also critical analysis and security. Similar terms may be used in English, within learning experiences for care practitioners (nurses or midwives), e.g. 'Mentorship' as Anderson and Shannon (1988) described it in Ashwin et al. (2015) 'mentorship as a nurturing process which involves an experienced and more skilled person who acts as role model and who teaches, encourages and counsels another less skilled and less experienced person so that the latter is able to develop professionally'. Ashwin (Ashwin et al. 2015) also mentioned 'preceptorship' and 'midwifery preceptor' in the same spirit. 'Companionship' as by Simkin and Ancheta (2009) describes in Ntombana et al (2014) 'the accompaniment and continuous support offered to woman in labour. Such support is provided through talking, keeping the woman company and rubbing her back during each contraction in the first stage of labour'. This aspect is highly important in following and supporting women in labour, but it does not include the peer-to-peer aspects we previously developed. In all Flemish educational programs also mentorship is a mandatory item. As written

in the learning outcome 'coaching' 'the midwifery student coaches fellow students from their own and other disciplines to ensure quality care'.

Considering the evidence presented, the best translation of 'compagnonnage' in French could be 'mentorship' in English. Midwifery students are then familiar with this concept, and it is encouraged within each and every clinical block placement. During their curricula, all the midwifery students in Belgium experience professional work in the clinical placements and receive mentorship on behalf on the midwives of the team. Besides, in each ward hosting midwifery students, it is expected that there are 'referent' midwives nominated by the officials of the hospital to assist and support the students in building skills and knowledge to promote the growth of self-confidence. Indeed: 'Importantly, accepting students at the workplace means that the team members collaboratively feel responsible to observe students, to guide reflective activities and to give feedback on performances. Only a small number of motivated supervisors should take the responsibility for guiding the continuous process of competency development'(Embo and Valcke (2016)). Again, there is no evidence base to support these concepts other than custom and practise.

A professional profile around supporting nursing students in clinical placements was recently built collaboratively between four Wallonia nursing schools (Dury et al. 2016). The role of the 'nurse referent' was determined as follows:

Établir une relation pédagogique efficiente/to establish a collaborative paedagogical relationship
Faciliter les apprentissages/to facilitate learning
Créer un contexte de soin propice aux apprentissages/to create a care context favourable to learning
Fonder sa pratique sur des preuves/to work with evidence-based
Évaluer et responsabiliser/to evaluate and empower
Évaluer la qualité de la formation pratique/to evaluate quality of practical training
Exercer un leadership/to perform leadership

It appears that the 'referent midwife' could have a similar role to the 'referent nurse', for supporting the midwifery students. In addition, the Professional Profile of the Belgian Midwives (Conseil Fédéral des Sages-Femmes 2016) is very clear about mentorship whereby the midwife is a coach/mentor for her colleagues and midwifery students.

> Compétence 10: Coach
> Coacher et accompagner les collègues et les étudiants de sa propre discipline ainsi que d'autres disciplines, en vue de garantir des soins de haute qualité.
>
> – Elle remplit le rôle de mentor pour les collègues et les étudiants;
> – Elle donne un feed-back oral et/ou écrit aux collègues et aux étudiants en vue de garantir des soins de qualité;
> – Elle est un modèle pour les collègues, les étudiants et les professionnels des soins de santé d'autres disciplines.

Means: To coach/mentor and accompany colleagues and disciplinary and other students, in order to guarantee a high-quality level of care.

- -She/he is a mentor for her/his colleagues and students;
- -She/he gives an oral/written feedback to colleagues and students in order to guarantee high-quality level of care.
- -She/he is a role model for colleagues, students and healthcare professionals of other disciplines.

Nevertheless, it seems that not all the midwives of the teams/shifts intend to be a 'mentor' or a 'referent' or a 'preceptor' of the midwifery students. This can result in less commitment of the midwives towards the students. This withdrawal from mentorship in midwifery could lead the midwifery students into less active commitment in their own setting of goals (Spencer, 2010, cited by Embo and Valcke 2016): 'Midwifery workplaces continue to be critical learning environments in which knowledge, skills and attitudes are acquired within a real-life professional context. To benefit from workplace learning, learners must take an active part in their own education by setting goals and monitor their progress towards these goals.'

Unfortunately, we have no evidence about how the midwifery students feel when they go for training in areas where the midwives are less supportive. A recent study of Mestdagh et al. (2018) stated that midwifery students perceive less support from midwives who don't have the tendency to behave proactive on the working floor.

A high turnover of students could be one explanation for how midwives embrace the support and education of the next generation of midwives. Clinical placements in midwifery vary in length, lasting from 2 to 6 weeks or more, depending on the school and the availability of placements. Whilst there are national and international recommendations for a required amount of hours in clinical placement, there is no national or regional recommendation for duration of block placement, and hence there is a lack of peer-mentoring program system. All Belgian schools of midwifery face a significant number of students, whilst current birth rates are low. This leads to a saturation of students in clinical placements and a necessity to frequently change programmed activities to ensure that all of the students have the similar opportunities to learn. To address this current trend, students are encouraged to consider mobility abroad; however, this does not alleviate the problem. This is an area in need of review as evidence suggests that "short periods of 1–2-week block placements do not enable nursing students enough time to settle into the clinical setting, which influences their experience of 'belongingness'. Clinical staff are also less likely to feel a sense of ownership of the process of block placement, resulting in inadequate time being allocated to meet students' needs" (Birks et al. 2017). Furthermore, Gray et al. (2016) suggest 'that completion of an intensive, formal, final year placement for graduates may be beneficial to assist with transition to qualified practise with guidance and support from a preceptor'.

Further research is required to understand how Belgian midwives perform their 'mentorship' or 'referent' role with the midwifery students and the NMPs, as described by their professional profile. In addition, research is required to elicit what it is that the NMPs need in Belgium in order to begin under optimum conditions her/his new midwifery work.

2.4.4 About 'Mentorship' During Midwifery Studies and After (Flanders)

In Flanders, a shared educational program was built to educate midwives in their role as a professional mentor for midwifery students. The concepts taught in this course are:

- Regulations on higher education and the place of clinical education in the program
- Evidence-based practise
- Relational intelligence
- Learning styles
- Reflection
- Systematic student guidance
- Time management
- Liability of the mentor
- Mentorship and coaching
- Place and role of the mentor in the team

2.5 Reflective Experience by a New Midwife in Her First Year of Practise: Pauline GALLOY, New Midwifery Practitioner of Wallonia

Pauline graduated as a midwife in June 2017. She succeeded with 76% pass rate overall. She applied for work in several Wallonia hospitals. During her last days of clinical placements in July 2017, she had a positive one-to-one contact with the chief-midwife of the delivery rooms. She has been engaged as salaried since 1st of August in a general private hospital after a positive job interview. The mother-and-child area includes birth rooms (1640 deliveries in 2017), two post-partum wards (hosting stable high-risk pregnancies) and a neonatology ward for standard/stable premature babies. When Pauline was hired, there were no full-time jobs or long-term contracts available. According to Pauline, the officials seem to prefer having more NMPs in order to have more choice about when the time will come to propose permanent contracts. So, Pauline and seven other NMPs were hired in approximately summer 2017 with fixed-term contracts and part-time jobs. They typically are required to work 1 week-end in two, and 3–4 night shifts per month.

The NMPs were informed that they would have to be polyvalent midwives, as it is the official's choice to meet the service delivery requirements. Therefore, Pauline had a ward-change plan from 01/08/2017 to 31/12/2017, then from 01/01/2018 till 31/03/2018, and last from 01/04/2018 until 01/09/2018. Her first role was an 80% time job (during the first 5 months) and then a 75% full-time equivalent job (since 01/01/2018). Here is her ward planning:

- Begin with neonatology: 2 months;

- Then, standard post-partum ward (without emergency unit without high-care pregnancy): 4 months;
- For the moment, post-partum ward including high-risk pregnancies: 2 months;
- Furthermore, delivery ward: at least 2 months;
- Later: home post-partum to be organised.

No NMPs started working in the delivery rooms as it was planned for later, only if they appear to be competent in working in those areas. It seems that only experienced midwives have the opportunity to remain in the same ward if they wish. Most of them do not change wards anymore choosing to remain in one place and hence becoming the expert and consistent 'face' of that particular area. There were eight NMPs to be engaged; four remain in the mother-and-child wards and have short-term contracts; three did not have their contracts renewed after few months and have since left the place of employment, and one had been invited to work within the surgery ward (recovering room) or to leave the organisation. She chose to stay in the recovering room.

The NMPs all received information that there would be an evaluation of their practise in relation to specific objectives after month 1, month 3 and month 6. They were aware that this evaluation was to be conducted by the chief-ward, using specific documents to assess knowledge, skills and behaviours. For Pauline, there was no prior evaluation until now. The only form of assessment was conducted by her colleagues at the end of her neonatology ward job, and this was a rather informal process.

Would It Be Nice to Have an Evaluation?

I think yes but I'm conscious that the workload of my chief-midwife is high and I know perfectly well that I would be evaluated if it was necessary, if my work was not appropriate. That is why I don't feel frustrated about it. However, as beginner, I think I still have more to learn and to improve. That's the reason why I made a habit of regularly asking my colleagues if I do well. It allows me to progress through their advices and to show them I'm committed.

I also heard about new evaluation plans for all the midwives, according to quality management, but I still have to receive further information about it.

How Were your First Days in Each New Ward?

The very first day in the hospital, I was welcomed by a special nurse dedicated to the new workers. Together with other new nurses and midwives, we had a full guided tour of the hospital buildings. We had opportunities to ask questions, and had a discussion about what working in that hospital meant (values, etc.).

Each time I started to work in a new ward, I had a doubled team for work during 3 days (three shifts). My referent midwife was experienced, but not specially dedicated to the NMPs, or specially paid or trained for it. I think she was chosen thanks to her qualities of patience and sharing. Unfortunately, when the workload was heavy, my referent had not much time for coaching and I had to learn many things by myself. It is important to note that the team was really hospitable with me and I

knew that I could rely on them if I had any doubts or problem. In relation to this, it is important to emphasise that knowledge and skills are not enough to feel good in a new job as midwife. One must also have to be able to fit into a new team, which involves that you be sociable and committed. Fortunately for me, I think that was my case. That is why I feel pretty good in my new team.

About the content of my coaching, I consider that my referent was coaching me 75% about administration work (for hospital) and 25% about mothers and baby caring.

I was once asked to help for solo night shifts in the post-partum ward when I was still working in neonatology. It was a challenge as I had not worked in the post-partum ward yet, but I'm not used to saying 'no', so I agreed to do it. I also think I didn't dare to say 'no' because of my short-term contract status. I got stressed at the beginning of the first nightshift, but at the end of the nights, I felt proud to succeed in doing it.

What Helps you to Face the New Practise?

I had a special compulsory 2-day session about breastfeeding held by a midwife IBCLC (International Board Certified Lactation Consultant) of the ward. We were about five NMPs and it helped me to answer parent's questions. I gained self-confidence and coherence of the team.

Furthermore, I have no personal experience of breastfeeding yet, and I know I am looking young. Mothers need to trust in midwives and need reassurance so I try to show self-confidence towards mothers, even if I am afraid or not sure. This breast-feeding session is really helpful in that way, and I feel I need more up-to-date sessions to develop my competencies and support mothers.

Do You Have to Mentor Midwifery Students?

I have to work every day with midwifery students (2nd or 3rd year), and it is a challenge! I try to talk and explain in a sharing-practises model. I luckily do not take part yet in their final assessment, I only evaluate on time. I don't like to negatively assess, if necessary, I prefer to have a face-to-face conversation rather than to write it down. I feel that midwifery students love to work with me because I take time—when it is possible—to give them explanation and advices. I like following the student's evolution during the placement, it is interesting and also helps me self-assessing.

What About Your Preparation to Practise During Midwifery Curricula?

I think I was well prepared for the job during my midwifery curricula. First of all, I consider that my theoretical bases are pretty good. And, about my practise, I think I was well prepared through all my multiple clinical placements. I wish it would have been better to have longer clinical placement in the same ward (more than 4 weeks), rather than many different shorter placements (2–3 weeks). This could allow me to better commit in the team and the job, and enhance my knowledge. I know that this is on study at school, we already talked about it, but it seems difficult to realise because of the general organisation of midwifery studies in Belgium.

On the whole, I developed adaptability and resourcefulness mainly through my international motilities in midwifery placements (6 weeks in Italy during my 2nd year, and 5 weeks in Cambodia during my 4th year). These were great opportunities for me to share different visions of midwifery and mother-and-baby care. I had to go through the language and culture barriers to provide appropriate care and support and that made me feel stronger and more self-confident.

How Do You Feel After 8 Months Working as a New Practising Midwife?
The very first days of my new job as a midwife, I felt the work was rather stressful but I very quickly managed to cope with it. I think it is related to each person's nature, and I consider myself as a permanent committed and open-minded person, so it helps a lot! Feeling and acting as a responsible midwife makes me learning quickly, becoming autonomous and relying less on others. I now feel more confident, at ease. I have not seen everything yet of the job, such as emergencies or critical situations, and I know I need much to improve myself, but I really enjoy my new job. My staff seems to appreciate me, I have the luck to work in a hospital I chose, in wards related to my midwifery diploma, and I will have opportunities to grow professionally.

Isn't this really great and exciting for an NMP?

2.6 To Conclude…

Belgium is a small but administrative complex country and this influences midwifery education and practise (Embo and Valcke 2016). The regulation for midwifery is according to different legal levels of region, community and Europe. In 2014, the fertility rate was 1.74, and the mean age for the first child was 28.5 years old for Belgium. In the French-speaking part Wallonia, we graduated 262 new midwives, from nine midwifery university colleges and in the Flanders we graduated 330 new midwives from nine midwifery university colleges (Benahmed et al. 2016). Most of the Belgian midwives work in hospital settings as salaried midwives (Cellule Planification des professions de soins de santé 2018), mainly in physician-led models, but new midwifery-led models are emerging. Preparing NMPs to transition to their first year of practise is a concern for all midwifery schools and lecturers, and especially around the mentorship, or 'compagnonnage' as developing in Wallonia.

It is unfortunate that there is a paucity of evidence linked to transition to practise for new midwifery practitioners (NMPs). Research should be done to highlight the roles of the midwifery school, the block placements, the 'mentor midwife' and the new team in transition to practise.

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Midwives in Brazil: Education, Regulation of Practice and Professional Association

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Abstract

The International Confederation of Midwives (ICM) defined three pillars through which to strengthen midwifery worldwide. The present paper aims to describe how these three pillars—education, regulation and association—have progressed in Brazil. Following a brief overview of midwifery in Brazil and of the background behind the creation of the midwifery program at the University of São Paulo, Brazil, the characteristics of midwifery training are described in detail, as well as the peculiarities of the regulations governing the profession of midwifery and the relevance of social movements and associations in the process of the inclusion of midwives into the labour market, in achieving social visibility and fostering consolidation of the profession in the country. Next, the reports of two midwives regarding their first years of work in different settings are presented as a means of characterizing maternal and perinatal healthcare in Brazil. In conclusion, midwifery training has a visionary nature that seeks to transform the current obstetric care model in Brazilian society both quantitatively and qualitatively.

Keywords

Midwifery training · Midwifery regulation · Midwifery association · Midwifery care · Brazil

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3.1 Introduction

Brazil is a country of continental dimensions, with considerable socioeconomic inequalities and a cultural diversity that is reflected in the healthcare system. There are regions, particularly in the north and northeast of the country, where the healthcare system is precarious and trained professionals and vital equipment are sparse. On the other hand, the more economically favoured regions are concentrated in the south and southeast of the country. The majority of healthcare institutes in the country are situated in urban centres in the southern regions, and some of these institutes are highly specialized. Therefore, the healthcare system in these regions tends to be better organized and more intensely focussed on a biomedical and interventionist model.

In addition to these regional differences, the striking multicultural aspect of the country means that ethnic diversities impact on the healthcare system, particularly on maternal healthcare. Women from indigenous populations, black women and, more recently, immigrant women from Bolivia and Haiti and from the community of Portuguese-speaking African countries have caused the issue of cultural diversity to be raised in obstetric care centres, demanding that the healthcare system respects their habits, their customs and their beliefs.

A great number of problems have been identified in maternity care in Brazil, including the fact that the health workforce consists primarily of doctors, who provide care at 89% of childbirths (Victora et al. 2011). The number of nurse-midwives is officially unknown, although they are generally recognized to be few and present at only 9% of deliveries in hospitals (Victora et al. 2011), where they are often not even involved with midwifery care, but only with nursing care (Merighi and Gualda 2009; Narchi et al. 2010). The number of midwives is insignificant since their training was only recently started, as presented below, and their participation in care still does not produce changes.

This panorama often results in inequities in maternal and perinatal healthcare (Narchi et al. 2010, 2013; Leal and SGN 2012; Lansky et al. 2014) that are associated with:

- High rates of maternal mortality (60 deaths per 100,000 live births) and of early neonatal mortality (11.2 deaths per 1000 live births).
- Increasingly higher prematurity rates (11.5%), possibly related to anticipating childbirth by permitting elective Caesarean sections.
- Of the three million deliveries that take place in the country each year, there is a remarkably high proportion of Caesarean sections (55.5%), which has resulted in Brazil being heralded as the world record holder for this type of surgery.
- The medicalization of childbirth, which results in high rates of episiotomy (53%), in the abusive and routine use of oxytocin during the first stage of labour (in 46.3–75.1% of cases) and in a lack of willingness to allow accompanying persons to be present during childbirth (in 47% of cases), among other practices not supported by scientific evidence.
- The lack of integration between prenatal care and the care provided during and following childbirth.

- The poor quality of prenatal care as shown by the numbers of cases of congenital syphilis (6.5 cases per 1000 live births), of adolescent pregnancy (18%) and of vertical transmission of the human immunodeficiency virus (HIV) (between 15 and 30%).
- The high rates of obstetric violence resulting from medicalization, with women's sexual and reproductive rights being violated.

In view of this situation, which has improved very little over the past 20 years, the issue of teaching midwifery in a way that would focus particularly on the care provided during labour and childbirth began to be discussed around the end of the 1990s, principally in the state of São Paulo. Meetings and seminars, promoted and organized by specific societies and universities, highlighted the shortcomings in the current method of teaching in this field, including the high financial investment and excessively long time required to train professionals qualified to provide obstetric care.

The conclusion of that debate was that advanced specialization in midwifery care provided to nurses as the only means of gaining entry to work in that area failed to fully meet the demand for professionals. Indeed, a greater number of trained professionals and better qualification were both required in order to achieve the desired social return in terms of teaching, research and midwifery care. Therefore, a course had to be developed whose structure would be adequate and whose duration would be sufficient to qualify professionals with the right profile and competencies needed to help promote the necessary transformations in the care model and in the epidemiological status of maternal and perinatal health.

Consequently, Professor Dulce Maria Rosa Gualda[1] and some faculty members at the University of São Paulo (USP)[2] proposed the creation of a direct-entry midwifery program within the setting of the School of Arts, Sciences and Humanities, with this program eventually being inaugurated in 2005.[3] A decision was then made to train midwives through a system of direct-entry midwifery education[4] that would enable women's healthcare to be provided under a new perspective. Within this perspective, the scientific evidence associated with the importance of midwives' work in the physiological and naturalized management of childbirth and in the personalization and humanization of care at childbirth was also taken into consideration.

[1] Professor Dulce Maria Rosa Gualda, PhD, is a midwife who graduated in 1969 from the direct-entry midwifery course at the University of São Paulo. That course was terminated in 1971.

[2] Created in 1934, the University of São Paulo is one of the most important institutes of higher learning and research in Brazil. It rates high in the rankings created to measure the quality of universities worldwide. The university offers undergraduate courses in all fields. All courses are free of charge, lasting from 4 to 6 years. Admission to the university is achieved through highly challenging entry exams. The University of São Paulo is characterized by its inextricable relationship between teaching, extension and research in all undergraduate courses.

[3] Regular midwifery training programmes began in Brazil in 1832, first in the state of Rio de Janeiro and then in the states of Bahia, Rio Grande do Sul, São Paulo and Pará. In 1971, the last such course still in existence, that at the University of São Paulo, was closed and incorporated into the nursing school under the pretext of the university reform that took place in the country at that time.

[4] Undergraduate midwifery program resulting in a bachelor's degree.

3.2 Midwifery Training

The need to create a new direct-entry form of qualification for midwives similar to that already adopted in countries that include the United Kingdom, the Netherlands, Canada, New Zealand, the United States, Chile, Peru and Italy, among others, resulted in the elaboration of an educational policy project for a midwifery program based on the definition of midwifery as a profession according to the ICM Global Standards, Competencies and Tools, the Pan American Health Organization (PAHO)'s Toolkit for strengthening professional midwifery in the Americas (Organización Panamericana de la Salud (OPS) 2006; Pan American Health Organization (PAHO) 2014), the documents developed by the World Health Organization for the Promotion of Safe Motherhood (World Health Organization 2001; World Health Organization and Department of Reproductive Health and Research 2004) and a proposal to qualify professionals capable of actively participating in improving the quality of care, in humanizing and, principally, in transforming the care model.

The direct-entry midwifery program was, therefore, conceived as a resource to train professionals to provide quality care to women and their families during the childbirth process, with the objective of meeting their physical, emotional and sociocultural needs based on their sexual and reproductive rights; to actively work towards transforming the epidemiological status of maternal and perinatal health; and to strengthen a healthcare model whose focus would not be the biomedical model (Narchi et al. 2010).

This program, taught by faculty from the areas of biological, human and social sciences, health sciences and midwifery, was designed to be held over a total of 4.5 years with a minimum of 4290 h, of which 1260 h is dedicated to the integrated curricular internship, which occurs in the last 2 years of the program. The course was to be developed within the setting of an educational facility equipped to provide solid training involving different fields of knowledge, thus enabling students to study the multiple social, human and biological dimensions that characterize health.

The curriculum proposed for the midwifery program is regulated by Brazil's public policies, by interdisciplinarity, by women's rights and those of their families, by the perspective of integrated healthcare for women and children and by the essential competencies required to practise the profession of midwife. Therefore, the program focuses predominantly on the essential skills for integrated healthcare, enabling students to problematize and consider the different actions implemented in different practice settings during their internship experiences. These settings include the primary healthcare units, general hospitals and maternity hospitals, delivery wards and maternity homes that make up the public healthcare network of the greater São Paulo metropolitan area.

The educational policy project for the direct-entry midwifery program is based on producing professionals with midwifery skills, as defined by the ICM recommendations for the teaching and practice of midwifery worldwide (Fullerton et al. 2011). The proficiencies required for working in midwifery involve knowledge, abilities (psychomotor skills) and attitudes (communication and decision-making skills) learned and developed during the theoretical and hands-on approaches of the

program. Training is aimed at preparing midwives capable of contributing towards improving the health and well-being of women and communities.

In addition to the essential competencies, care, management, research and teaching are also included in the course and constitute pillars of midwifery training. Therefore, to enable midwifery students to become skilled in midwifery, during their theoretical and practical hands-on training, they need to be able to acquire knowledge and skills related to general care, to promoting women's health within the context of the family and the community, to managing healthcare units and services and to caring for women, their newborn infants and their families during pregnancy and in the early, intermediate and late postpartum periods, during emergency obstetric care and during the clinical stages of childbirth.

Discussions on the midwifery model of care have revolved around questions on interventionist practices and their outcomes and demands for an integrated healthcare model. Therefore, the perspectives adopted during midwifery training encourage students to consider actions in women's healthcare aimed at respecting the woman's sexual and reproductive rights, her autonomy, her right to information and her right to choose and make decisions on questions involving her body, her health and her life. Within this perspective, midwifery training is committed to humanized maternal care in which delivery and childbirth are conceived as universal events, simultaneously determined both physiologically and culturally.

Hence, even if the physiology of childbirth is indeed universal, it is also correct that each society, at any given time, has developed a specific way in which to deal with this critical event in human life. Accordingly, the universal biological aspect and the sociocultural aspects of childbirth are intrinsically articulated, allowing childbirth and midwifery care to be managed within a new perspective, as an emotionally rich and medically safe social event.

Therefore, midwifery training is guided by ethical principles that guarantee women's reproductive rights within the context of a care model that focuses on the woman and on her reproductive health needs. Contrary to the technocratic model that focuses on biomedicine, the midwifery student learns how to offer women humanized care that also brings their network of relationships, particularly their families, into the picture. Hence, this is a relational care model in which the future professional interacts continually with the woman, her partner and her family, offering integrated care during pregnancy, labour and childbirth to all those participating in the pregnancy process, both with respect to maternal and child healthcare and the social and cultural context in which the woman is inserted.

By directly experiencing the challenges of obstetric care in primary and secondary healthcare services, the midwifery students are able to recognize the importance of transforming relationships, the settings in which labour and childbirth take place, the ways in which the services are organized and obstetric practices based on scientific evidence.

Unfortunately, and unlike practices in other countries, this context involves no participation whatsoever by the professionals working in the midwifery setting.[5]

[5] Field training or practical settings consist of healthcare institutes used for practical teaching and for supervised internship.

Only university faculty members, duly qualified to provide midwifery care, can, according to the current legislation in the country, monitor and supervise training internships, a factor that limits the effectiveness and integration required between the healthcare services and schools.

Since the midwifery students are supervised by the university faculty members only during the period in which they are enrolled in the course, following their graduation, there is no form of further supervision, either in a supportive, regulatory or clinical sense, as recommended by PAHO in the document entitled: "Toolkit for strengthening professional midwifery in the Americas" (Pan American Health Organization (PAHO) 2014). Note that the same occurs with the other health-related professions, i.e. there is no type of surveillance or formal support for individuals newly entering the healthcare work market, irrespective of whether they are doctors, nurses or midwives.

Despite this limitation, the practical experiences and reflective efforts of students and professors are proof that the midwifery program has succeeded in qualifying professionals who are capable of developing integrated healthcare actions and willing to undertake the challenges involved in attempting to alter the current panorama of maternal and perinatal health in Brazil, which is strongly focussed on a hospital-based and technocratic model dominated by doctors and the biomedical model.

In this process, it is noteworthy that midwives, constantly concerned with protecting the women, mothers and newborn infants, have endeavoured to progress professionally through continued education[6] and/or by undertaking postgraduate studies, as well as by working in teams that include more experienced professionals, either in the public or private healthcare networks. The midwifery program is already benefitting from graduates who are now working as teaching staff, enriching their own training and, principally, contributing towards defining the profile of those currently being trained for this profession.

3.3 Regulating the Work of Midwives

Former direct-entry midwifery programmes existed in Brazil until 1971, and for this reason the profession of midwifery has been regulated under the legislation that governs professional nursing (Brazil 1986, 1987). Nonetheless, midwives graduating from the only midwifery program currently operating in the country, that of the University of São Paulo, still encounter numerous difficulties in achieving entry to the work market due to the corporative resistance of nurses and doctors, to the considerably unfavourable context of care and, principally, to the lack of a midwifery care model within the Brazilian healthcare system (Gualda et al. 2013; Castro et al. 2017; Narchi et al. 2017).

Brazil's federal constitution guarantees that any profession can be freely exercised in the country. The legislation governing nursing as a profession, as already

[6] Common, and often promoted by public entities, scientific societies, professional associations and healthcare institutes in scientific events of varying descriptions.

mentioned, also governs the profession of midwife, regulating the work of midwives, irrespective of whether they are Brazilians or foreigners living and working in Brazil. Therefore, in Brazil midwives are necessarily an integrated part of the nursing profession and must be registered with the Nursing Council, the government agency responsible for overseeing nursing as a profession in the country.

According to Girardi et al. (2000), occupational regulation in Brazil is principally the responsibility of the following entities:

- The Brazilian Congress, which creates the laws that regulate the profession and authorizes the councils that supervise the activities of the profession.
- The Ministry of Labour and Employment, which defines regulated occupations.
- The Ministry of Education, which regulates aspects regarding the curriculums and the general protocols of the teaching system.
- The councils that supervise the professions, with these being publicly acknowledged and authorized by the state. Without the existence of a professional council, no occupation can be recognized as a profession in Brazil.

Insofar as the formal aspects of education are concerned, the field of midwifery is regulated by the São Paulo State Council of Education, the agency responsible for evaluating undergraduate courses at the University of São Paulo and other public universities in São Paulo. Lamentably, up to the present moment, the Ministry of Education completely disregards the need to regulate direct-entry midwifery programmes, and the profession of midwife is not included in the Brazilian Classification of Occupations by the Ministry of Labour and Employment. Furthermore, neither the class entities nor the professional associations have established any accreditation system whatsoever for technical- or university-level professional undergraduate courses in health. What exists is a system of periodic evaluation promoted by the Ministry of Education; however, this is exclusively for university-level courses and fails to encompass the University of São Paulo's midwifery course.

The reasons why the Ministry of Education and the Ministry of Labour and Employment fail to formally regulate midwifery programmes and the profession of midwife are directly related to the ineffectiveness of the Brazilian civil service and to the obstacles established by the corporations of nurses and doctors, which are renowned for opposing the incorporation of new professions into the field of healthcare so as to secure the market for themselves and guarantee their exclusive right over these fields of practice.

The healthcare sector in this country has been plagued by low salaries, unemployment and high turnover and the precariousness of work contracts (Wermelinger et al. 2007; Machado et al. 2011; Narchi and Silva 2014). Changing these characteristics requires that public policies addressing healthcare become more closely related to those addressing the training of health workers and the regulation of labour and of the employment market. Therefore, universities, public and private healthcare institutions and the ministries of Education, Labour and Employment and Health need to be effectively integrated in a coordinated way in order to meet

the actual demands of society, a state of affairs that has yet to be achieved in Brazil (Varella and Pierantoni 2008; Silva et al. 2013).

The Ministry of Health has slowly and gradually recognized the importance of including midwives in midwifery teams in improving care, which should lead to a consequent positive impact on maternal and child indicators. Accordingly, documents have been drawn up establishing guidelines for the organization of integrated and humanized healthcare for women and their newborn infants in which the participation of midwives is included in the obstetric care teams (Brazil 2014, 2015). Conversely, the Ministry of Health is influenced by the class entities representing the nurses and doctors in Brazil and, consequently, makes no real effort towards officially defining and regulating the profession of midwife, which would guarantee their participation in the Brazilian healthcare system. Girardi et al. (2000) argued that the role of the Ministry of Health in regulating the professions is performed unsystematically and in a highly casuistic manner. Among other things, this results in favouring the professions with the greatest prestige, economic power and organizational and political resources, which are best able to follow up on the progress of their requests and block the requests of their rivals. In fact, medicine is articulated in such a way that ultimately ensures that all the power is held by the doctors to the detriment of the other professions considered beneath them, while nurses act by preventing the profession of midwife from being regulated.

Contrary to the situation in other Latin American countries, the Ministry of Health in Brazil is not responsible for registering and monitoring the way in which health professions are exercised. Additionally, the Ministry of Labour and Employment has not permitted the creation of new occupations in the field of health. Therefore, midwives still encounter obstacles when seeking work, even those who have already successfully had their professional registry accredited by the Nursing Council (Gualda et al. 2013; Castro et al. 2017; Narchi and Silva 2014).

In this way, the more traditional health-related occupations have managed to keep the market relatively closed and limited by the professional corporations. Nursing constrains the market in Brazil, defending the exclusive right of nurses to work in midwifery. Likewise, the medical profession also places constraints on the market, defending the exclusive right of doctors to practise obstetrics, disregarding and discrediting the importance of other professions, particularly those such as midwives that are still relatively unknown to the population. This situation has hampered the work of qualified professionals and the creation of new midwifery training programmes that could improve women's healthcare and foster changes in the assistance-based care model that would ultimately make motherhood safer and improve epidemiological statistics.

Therefore, although the training course and the profession are recognized from a legal point of view, there are still hurdles to be overcome for midwives to find employment in healthcare services in the country. These hurdles are manifold: the profession remains unregulated, with no specific directives; there is resistance from the healthcare professionals already working in the field, particularly nurses and doctors, who discredit the training of any new professional, refusing to recognize

that profession and preventing or limiting the entry of these professionals into the labour market; and, finally, there is the resistance from the class entities of nursing and midwifery nursing in Brazil that, by seeking to politically deconstruct the idea that Brazil needs midwives, insist that the scope of action should be limited only to providing care during normal, low-risk childbirth, disregarding the other possible tasks midwives are able to provide in promoting health and in delivering integrated healthcare during pregnancy and in the postpartum.

Social status has to be achieved in which the profession of midwife is clearly seen as being attractive, skilled and regulated, and, principally, it needs to be guaranteed that midwives will go on to become an integrated part of the healthcare system. For this to happen, the number of midwives needs to increase substantially to enable them to produce an effect on the type of care provided, to improve the training of the different categories of healthcare professionals, change the current model of care and practices, create space for the profession in the healthcare institutions and develop policies, encouraging the production of knowledge in the field of obstetric care and, finally, boosting the visibility of the profession.

The entry of midwives into the profession follows the patterns defined to develop the necessary skills with which to exert the profession. The Nursing Council concedes a licence to applicants who can produce a diploma issued by the University of São Paulo; however, the council does not check the qualification in any way. The skills of each individual student are evaluated at the end of their midwifery training period and when they are admitted to a job through specific selection procedures for the area and for the type of healthcare service.

After registration is granted to a midwife, there is no mechanism whatsoever for periodic renewal based on a re-evaluation of skills or updating of knowledge. A midwife, nurse, physiotherapist, doctor or any other Brazilian healthcare professional will only have his or her licence temporarily or permanently revoked by the class entity if misconduct is identified and proven through ethical and legal procedures instituted by the professional council.

In summary, healthcare professionals in Brazil, irrespective of what type of professional they are, are not monitored after they have qualified and have been registered with their professional entity. Consequently, civil society and governmental entities play no role whatsoever in regulating the health professions, unlike the situation in other countries. Since there is no formal regulation, professional self-regulation only occurs when the professionals spontaneously seek to improve their training through various means, both in the form of continued education and by participating in teaching and research activities that provide support to professional practice.

3.4 The Association of Midwives

The inclusion of midwives in the health labour market is defended not only by those involved in their training but, principally, by governmental and non-governmental entities in Brazilian society, as well as by researchers involved in the field of

women's healthcare. Within this movement, professional organizations are of the utmost importance, since they are essential if a profession is to become viable.

Within the coercive setting that preceded the judicial decision guaranteeing the registration of midwives, the Brazilian Association of Midwives and Nurse-Midwives (ABENFO), an entity that was inspired by the Brazilian Association of Midwives created in the 1920s by the midwives of that time, failed to resist pressure from the Nursing Council and from the Brazilian Association of Nursing that fought for the midwifery program at the University of São Paulo to be closed. The disruption in that entity reverberated and continues to echo in the discontent of those who understand that the inclusion of midwives in women's healthcare in Brazil is both possible and indeed necessary.

For this reason, a professional association of midwives, the Association of Midwives of the University of São Paulo, was created in 2011. Together with activists and organized social movements, this association has actively assumed the social and political positions necessary to obtain the inclusion of midwives in the health-related labour market and, principally, fights to achieve social visibility of the work they do.

Midwives who have graduated from the University of São Paulo can count on the support and representation of this entity, which is active socially and politically in disseminating comprehension of the innovative potential of this profession. Furthermore, ABENFO has also worked towards achieving the acceptance of midwives, recognizing that they should form an integral part of the association.

The process of recognizing the profession has already begun in Brazilian society. Empirically, it is already clear that more opportunities have been created for midwives to work in public or private maternity hospitals, childbirth centres or maternity homes, where they are slowly but steadily introducing changes to the care model. They have already managed to broaden their spectrum of activities, working as self-employed individuals to provide services to women and their families, such as, for example, during planned home births, which have gradually been increasing in popularity in the country.

Midwifery training does not exclude nurse-midwives from midwifery care. On the contrary, the intention is to strengthen a care model that is neither focussed on the biomedical model still predominant in general nursing courses nor restricted to care during childbirth. This is a complaint made by many nurse-midwives, who, when reflecting on the model of training they received and consequently on their work, make an effort to change the way in which they do their job. Within this process, they also encounter various obstacles resulting from the fact that the market remains restricted and dominated by the power of the doctors despite the legislation and governmental incentives aimed at guaranteeing and legitimizing their autonomy to provide care to women during pregnancy, childbirth and in the postpartum (Gualda et al. 2013; Castro et al. 2017; Narchi et al. 2017; Narchi and Silva 2014).

In this respect, it has been found that many nurse-midwives actually refer to themselves as midwives and support the training of "new" midwives, in the belief that by working together, they would be better equipped to oppose the biomedical, hospital-based model that is predominant within the Brazilian healthcare system.

By participating in the aforementioned professional midwifery associations, nurse-midwives and midwives seek not only to take an active part in decisions that affect the professions but also to develop health strategies and policies aimed at improving the care provided to Brazilian women (Narchi et al. 2013).

Based on the need to develop the capacity of midwives, improving their qualifications and training them to an international level in terms of prestige and respect, the Association of Midwives of the University of São Paulo affiliated itself to the Latin American Federation of Midwives, which, in turn, is part of the International Confederation of Midwives. This partnership, established in 2015, tends to strengthen the profession and facilitate or promote the articulation of public policies that support the development of care models and the training of appropriate professionals.

Creating a professional council with its own regulation system, separate from that of nursing, requires a greater number of midwives, a complex political articulations and a greater time of insertion in the labour market. To enable their own regulatory system to be implemented in Brazil, midwives need to show the importance of what they do within the healthcare services; they need to be recognized by the legal system and obtain recognition and legitimacy in the opinion of the general public. In order to implement this process, the barriers imposed by the profession need to be overcome. This will certainly occur as the number of midwives increases and the profession of midwife is no longer considered less prestigious, as the jurisdictional issues are resolved and the sheer capacity of midwives convinces those who still need to be convinced (Narchi et al. 2013).

Despite the discord, midwives persist in their attempt to conquer their social space, seeking to maintain and strengthen the profession while fighting to achieve their effective insertion into the job market. In this, they stand together with entities of civil society, supported by legal and political representatives and by organized movements in support of humanization and of change in the care model.

The following reports of the experience of two midwives who graduated in 2013 from the midwifery program describe their training, regulatory process and professional association, how they achieved placement in the job market and the challenges they faced to do so. The reports of these two particular graduates were selected for inclusion here because they both fought inspirational, albeit different, battles to establish themselves and maintain themselves within the profession, which, as previously mentioned, still involves an array of challenges in Brazil, particularly the lack of a guaranteed professional field regulated by healthcare managers.

3.5 Testimonial Reports

3.5.1 Raphael

I grew up wanting to be “the kind of doctor who takes care of women”, because, for me, as a child, that was the only profession I was aware of that would enable me to

do that. I studied hard to try to get into medical school; however, in the last year of high school (in 2007), I heard about the direct-entry midwifery program and became interested in it, although I knew little about it. I passed the university entrance examination for the midwifery program at the University of São Paulo in 2009 and discovered that it was very different from the medical school curriculum: the aim of the midwifery training was that it should be multidisciplinary, also encompassing biopsychosocial care; not at all what I had expected from an undergraduate medical course.

I studied midwifery for 2 years, often thinking about giving up and transferring to medicine. There were various problems between 2009 and 2011: the program itself was under risk of closure, and recognition of midwifery as a profession was difficult.

The movement to promote the midwifery program made me realize that the true meaning of the profession of midwife went way beyond the struggle for professional space; it is a fight for women's sexual and reproductive rights and to train highly qualified professionals to provide care that must always be based on current scientific evidence.

At the end of the entire 4.5-year program, which passed amazingly quickly, my class (the 2013 graduation class) succeeded in becoming registered in the professional register at the Nursing Council for the first time since the initial graduation class of 2008 with no difficulty whatsoever. From that moment onwards, another struggle began: that of having to fight for space within the profession.

The extracurricular activities involved in the undergraduate research program attracted me to an academic career, and I remained engaged in basic research even after my graduation, albeit with no formal contract. Simultaneously, I coordinated free pregnancy and maternity support groups aimed at disseminating information on reproductive rights, the physiology of pregnancy and childbirth and non-pharmacological methods of pain relief, as well as answering any questions the women might have. I also managed to work as a volunteer for 6 months in a public maternity hospital in the outskirts of São Paulo. At the end of 2013, I began to study for a master's degree in basic sciences while simultaneously maintaining the pregnancy support groups and occasionally providing care to pregnant women in the form of prenatal consultations, accompanying planned home births,[7] referring women to hospital and accompanying women during childbirth.

In the following 2 years, I dedicated my time predominantly to the academic area; however, I continued working with the groups of pregnant women, doing some consultations and working with activist movements. In 2015, I began to attend planned home births, although I had little time for this activity, since my postgraduate studies demanded much of my time.

At the end of 2015, I enrolled in the Doctors Without Borders organization (*Médecins Sans Frontières*—MSF). I was recruited and sent to a refugee camp in Africa, a setting of extreme poverty with extremely precarious public health

[7] In Brazil, there is no law prohibiting home birth, and Brazilian women have the right to choose where they will deliver their child.

conditions that required the support of other non-governmental organizations to improve sanitation, education, health, safety and rights. I first worked as a supervising midwife and was responsible for seeing patients, but I was principally in charge of the continued training of 3 midwives and 18 assistant midwives (traditional birth attendants, generally women who had learned midwifery by tradition or necessity). I worked in all the areas related to obstetrics, prenatal care, postnatal care, family planning, sexual violence, antepartum, delivery room, postpartum, healthcare of the newborn infant (even intensive care), neonatal resuscitation, abortion care and data collection, as well as qualifying and training the local workers to perform these functions. I attended at least 400 deliveries, resuscitated some babies and cared for premature infants. Later, I was promoted to midwife activity manager. Then, in addition to those other tasks, I participated in meetings with other non-governmental organizations to discuss subjects of common interest, particularly sexual violence. Before returning to Brazil, I took a course on advanced life support in obstetrics with the MSF in Copenhagen, Denmark.

When I returned to Brazil at the end of 2016, I started working in a public maternity hospital run by the state of São Paulo. To work in this hospital, I had to be selected through a public tender that only considered midwife candidates thanks to the Midwives Association of the University of São Paulo that battled for midwives to be included in all selection processes or public tenders intended to recruit professionals for midwifery practice. I have been a member of the Midwives Association of the University of São Paulo since it was founded in 2011, and I believe that the board plays a significant role for this class, particularly because of its association with the Latin American Federation of Midwives (FLO) and the contact it maintains with other institutions and organizations such as the ICM, PAHO and the United Nations Population Fund (UNFPA), giving us greater visibility and the opportunity to receive training at international level.

Early in 2017, I began working in that maternity hospital. This was a novel setting for me: a hospital with a natural childbirth centre and an obstetric centre, many obstetricians and medical residents, midwives, nurse-midwives, general nurses and nurse technicians. There are still no protocols at the hospital to allow midwives and nurse-midwives to perform many of the tasks; therefore, this remains a constant challenge, since we have less autonomy and little credibility. The doctors are responsible for all the procedures, from admitting the woman to hospital to carrying out her delivery, even if that delivery takes place in the natural childbirth centre where, according to various guidelines, the responsibility should be the midwife's. I started working together with another eight midwives in separate shifts, which increased our power slightly, since we have similar practices; however, it takes an enormous effort to achieve a little autonomy and improve the care we provide to the women. Working in this public service, however, has its advantages. For example, I took a course in neonatal resuscitation of full-term and preterm infants given by the Brazilian Society of Paediatrics and sponsored by the hospital.

In addition to working in this hospital, I have been working sporadically in a birth centre, "Angela's House", working shifts on a freelance basis. I have also been a temporary professor in the direct-entry midwifery program at the University of

São Paulo, supervising intern students. As a temporary faculty member in the same program from which I graduated, I work only 12 h a week as an internship supervisor, with no obligation to perform any activities of research or extension that fully contracted staff would have to do. However, I always need to keep myself up-to-date and be prepared to answer any of my students' questions, in addition to knowing when to intervene during childbirth and how to help or encourage my students to think critically.

Working in different settings has provided me with a broader view of midwifery. I have seen how necessary it still is for professionals to work together towards remodelling the provision of care to Brazilian women and their families.

3.5.2 Thalita

I always say that it was not me who chose my profession; it was my profession that chose me, with the university turning me into a more sensitive human being. I was born through a completely unnecessary Caesarean section and brought up hearing that vaginal delivery was extremely painful and that what was normal was birth by Caesarean section. The midwifery program taught me the meaning of empathy and made me understand childbirth as a physiological, family event that is unique in the life of each individual woman.

The curriculum of the midwifery program encompasses subjects that focus on biopsychosocial aspects that stimulate the students to think critically. Discussions on gender, sexuality, care models, psychosocial aspects and life cycle were present throughout the entire course, providing a rich content that allowed me to break with all the taboos that are so common in our society with respect to motherhood, pregnancy and childbirth.

The supervised internships were my first real contact with the midwifery model. Seeing how babies are born in the healthcare system was a reality shock compared with everything that we had learned in theory and had expected to put into practice during the periods of internship. In this process, our professors were our guides, listening to us, supporting us, developing our autonomy and showing us how to adapt to the tortuous pathways of the profession. Little by little, we took every opportunity to show what we could do in the hospitals in which we were interns, emphasizing the difference that our work could make and even succeeding in changing how the other professionals worked.

The 4.5 years of the undergraduate program was troubled by the difficulty in gaining recognition from our regulatory council and having our course under threat of closure at various moments. However, we did not give up, as we knew that our struggle went far beyond our efforts to achieve space in the job market. We were fighting for the women, for their babies and for midwifery to be practised with respect and based on scientific evidence. In 2013, after graduating, we achieved a major victory: we were the first graduating class to acquire professional registration at the Nursing Council in a process that proved smooth. Finally, we had become part of healthcare in Brazil.

In the 3 months that preceded my graduation, I participated in a public selection process to enable me to work in a public maternity hospital in the outskirts of the city of São Paulo. Initially, applications from midwives were not accepted in the selection process, but thanks to the political movement headed by the Association of Midwives of the University of São Paulo, we were eventually allowed to participate. My application was accepted, and I worked there for a year and 9 months, attempting daily to deconstruct the team's view of "abnormal" childbirth, showing them that they did not need many of the expensive resources or materials, just patience and knowing the exact moment at which it was necessary to intervene. Of course, as with every transformation process, this was extremely arduous and quite exhausting. At that hospital, childbirth was focussed on the figure of the doctor. The women were not given the freedom to choose the position they wanted to be in and were not allowed to eat anything. The episiotomy rates were as high as 80%. For the first time at that maternity hospital, nurse-midwives and midwives were providing care at normal deliveries and offering care with fewer interventions and with greater satisfaction rates among the women. Little by little, curtains were provided to give the women greater privacy during labour; the presence of an accompanying person became more common; and we even received a donation of a birth ball to encourage active childbirth.

In 2014, I left that hospital and went to work at "Angela's House", a birth centre located in the southern region of the city of São Paulo, where midwives and nurse-midwives alone provide prenatal care, as well as care during delivery and in the postpartum, to women with low-risk pregnancies. There, the women and their respective family members or accompanying persons were the focus of care, i.e. they participated actively throughout the entire process.

In 2015, while I was still working at "Angela's House", I started offering my services at planned home births, a care model that still faces much resistance from the corporations in Brazil.

At the end of 2015, I was recruited by the MSF organization, and in July 2016 I left Brazil to go to a country in Muslim Asia. I spent 6 months in that country, working in a maternity hospital that was part of the local healthcare system, offering prenatal care, as well as care during childbirth and in the postpartum, and providing family planning consultations. The hospital carried out around 1600 childbirths a month with a team consisting of 70 midwives and 7 obstetricians. I worked there for 6 months, not only providing direct care but also as a supervisor and manager. I attended many deliveries, assisted at many others and performed vaginal breech deliveries, twin and premature deliveries. I provided care in cases of miscarriage and learned in practice how to work with different contraceptive methods, as well as their importance in the midwife's broad array of activities.

I returned to Brazil in December 2016 and went back to work at "Angela's House". Today, the lack of continuous monitoring of the healthcare professionals is apparent. Once registered with the regulatory entity, there is no required recycling, training or even evaluation. Professional development and continued education depend on the individuals' decisions and directly affect the quality of care encountered in the different services. After graduating, I tried to participate as much as

possible in symposia and congresses that focussed on midwifery practice based on scientific evidence and on humanized care. I dedicated much time to studying the holistic techniques used in pregnancy and childbirth. I qualified as a yoga instructor for pregnant women with the intention of working with their bodies to reduce the discomfort caused by pregnancy and to encourage women to actively participate in childbirth. I took part in training courses on medical urgency and emergency such as advanced life support in obstetrics and a course on neonatal resuscitation offered by the Brazilian Society of Paediatrics.

3.6 Final Considerations

Throughout all these years, midwifery training has had to confront a great deal of resistance from agents working in education and in health and has also had to challenge the biomedical model of women's healthcare, which is focussed on biological sciences and based on interventions that are often unnecessary.

Nevertheless, the direct-entry midwifery program promotes the training of professionals committed to humanized care that focuses on the health needs of the woman and her family. Midwifery training has thus become part of a wider movement that unites activists and women in denouncing obstetric violence and in demanding humanized care during pregnancy, childbirth and the postpartum.

Based on these reports provided by former students who graduated from the midwifery program, it is obvious that this profession has grown in strength, highlighting the various possibilities of work for the midwife that include public and private maternity hospitals, birth centres, planned home births and humanitarian associations.

Finally, the importance of the university in training midwives is undeniable, as it is a pathway towards guaranteeing their autonomy and professional quality and minimizing the influence of the professional corporations. Although this is the only direct-entry midwifery program in Brazil at this moment, midwifery training has a visionary nature that seeks to transform the current obstetric care model in Brazilian society both quantitatively and qualitatively.

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The Transition to Clinical Practice for New Registrant Midwives in Ontario, Canada

4

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Abstract

Midwives in Ontario are integrated into the provincial health-care system, providing primary antenatal, intrapartum, and postpartum care to low-risk women throughout pregnancy and for 6-week postpartum. Midwives are educated through a 4-year direct-entry, university-based Bachelor of Health Science program or, if internationally trained, through a 9-month bridging program. During the first year of clinical practice, newly qualified midwives are known as *new registrants* and are subject to a number of practice restrictions outlined by the College of Midwives of Ontario (CMO). While there is limited research regarding the new registrant year, a qualitative study identified three phases—*building*, *bridging*, and *being*—through which new registrants progress as they transition to clinical practice. There is considerable variation with respect to the experience of new registrants during the transition to clinical practice; however, four elements—preparation, orientation, mentorship, and ongoing education—help new registrants navigate the experience of commencing clinical practice. In order to offer a more standardized approach to supporting Ontario midwives in the first year of clinical practice, it may be beneficial for midwifery stakeholders to look to established transitional models employed in midwifery communities outside of Canada.

Keywords

Midwifery · Midwives · New graduate · New registrant · Transition to practice · Ontario · Canada

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Abbreviations

AOM	Association of Ontario Midwives
BCC	Billable course of care
CMO	College of Midwives of Ontario
CMRE	Canadian Midwifery Registration Exam
MEP	Midwifery Education Program
MFYP	Midwifery First Year of Practice Program

4.1 Midwifery in Ontario

The model of midwifery care in Ontario is defined by the College of Midwives of Ontario (CMO) and is consistent with the international definition of the midwife (International Confederation of Midwives 2017; College of Midwives of Ontario 2014d). According to the CMO:

> Midwifery care is offered in community settings where midwives act on their own authority to deliver primary care. Midwives provide prenatal care in the community, attend births in the setting chosen by the woman, and provide early postpartum care in the woman's home. (College of Midwives of Ontario 2014d)

Midwives in Ontario provide comprehensive antenatal, intrapartum, and postpartum care for low-risk clients throughout their pregnancy and birth and for the mother and baby until 6 weeks (Canadian Midwifery Regulators Consortium 2010; College of Midwives of Ontario 2014d).

Midwifery is regulated and funded in all provincial and territorial health-care programs across Canada except for two: Prince Edward Island and Yukon (Canadian Association of Midwives 2017bb). Midwifery in Ontario is fully funded through the Ministry of Health and Long-Term Care (MOHLTC), a division of the provincial government, and thus there is no financial cost for Ontario residents to access the care of a midwife (Ontario Hospital Association 2010). Midwifery across Canada is a self-regulated profession, with all midwives maintaining membership to their provincial regulatory college; in Ontario this organization is the College of Midwives of Ontario (CMO).

Midwives across the province work out of autonomous, community-based clinics that vary in size, location, and scope of practice (Association of Ontario Midwives 2017b). Within each community, midwives maintain hospital privileges, allowing their clients to choose to give birth either in a hospital, at home, or at one of the two birth centers in Ontario (College of Midwives of Ontario 2014d; Association of Ontario Midwives 2017a).

There are two avenues through which midwives in Canada may become registered. Individuals may complete a 4-year Bachelor of Health Science program at one of six Canadian universities that offers a Midwifery Education Program (MEP) (Canadian Association of Midwives 2015; Butler et al. 2016). All MEPs are

university-based, direct-entry, 4-year baccalaureate degree programs (Butler et al. 2016). Alternatively, individuals who have practiced midwifery outside of Canada can obtain qualification through a 9-month bridging program (The G. Raymond Chang School of Continuing Education 2014; University of British Columbia 2015). Both the direct-entry and bridging programs include a combination of in-class learning and clinical placement.

Midwifery is a small but rapidly growing field of health care across Canada. According to the Canadian Association of Midwives, the number of practicing midwives in Canada is over 1500, with approximately 52% of midwives practicing in Ontario (Canadian Association of Midwives 2017bb; Mattison and Lavis 2016). In Ontario, the number of midwives has increased from 177 midwives in 2000 to 608 midwives in 2013, an increase of approximately 244% (Mattison and Lavis 2016). Midwives occupy a unique position in the Canadian health-care system; they provide primary care in both the hospital and community setting; work interprofessionally with nurses, physicians, and allied health professionals; have a model of care that requires extensive time on call; and complete a direct-entry education program.

4.1.1 Regulation

The College of Midwives of Ontario (CMO) functions similarly to other regulatory colleges; it sets guidelines within which midwives must practice and determines what is required for ongoing registration and competency. Midwifery in Ontario is guided by three tenets: choice of birthplace, continuity of care, and informed choice (College of Midwives of Ontario 2014d). Ontario midwives work in autonomous midwifery clinics and hold privileges at local hospitals, enabling midwives to continue as the primary care providers for their clients while they are admitted to the hospital for their birth and the immediate postpartum period.

As a professional association, the role of the Association of Ontario Midwives (AOM) is to support midwives and the midwifery profession as a whole (Association of Ontario Midwives 2015). The work of the AOM includes advocating for and representing midwives within the Ontario health-care system, negotiating and providing professional liability insurance to midwife members, publishing clinical practice guidelines, and offering a variety of educational and professional development opportunities for midwives (Association of Ontario Midwives 2015). The AOM is also involved in supporting and advocating for the interests of midwives and midwifery clients at the provincial policy level.

4.1.2 Midwifery Scope of Practice

Midwives provide 24 h on-call primary care to low-risk clients during the childbearing cycle (Lavis and Hammill 2016). During labor, a midwife attends a client for the duration of the active stage of labor, calling a *second midwife* to come closer to the

time of delivery so that there are two registered midwives in attendance at every birth (Canadian Midwifery Regulators Consortium 2010). The CMO outlines what clinical situations constitute "low risk" and are within midwives' scope of practice and when midwives are required to consult with or transfer care to a physician (College of Midwives of Ontario 2014a).

For some clinical situations, there is variation in how the scope of practice is enacted among midwifery practices and in the hospital setting. For example, according to the CMO, managing the care of clients who have epidural analgesia or whose labor is being induced or augmented with oxytocin infusion is both within the scope of midwifery practice (College of Midwives of Ontario 2014b, c). For both of these procedures, once the appropriate consultation has occurred with an obstetrician, family physician, or anesthesiologist, and orders are obtained, midwives remain the primary care provider and continue to manage the clinical care of the client (Ontario Hospital Association 2010). Within the profession, when midwives maintain care for oxytocin infusion and epidural analgesia, this is known as *full-scope* midwifery care. For these same procedures—epidural analgesia and oxytocin infusion—some midwives transfer care to an obstetrician. In some cases hospitals place additional limitations on the scope of midwives, requiring them to transfer care to an obstetrician; in other cases it is the midwifery practice that chooses not to maintain care in these clinical situations. In a situation where a client's clinic care is transferred to an obstetrician, the midwife then assumes a supportive care role, and all clinical decisions are the responsibility of the obstetrician. When midwives are required to routinely transfer care for one or more of these procedures, this is known as *limited-scope* midwifery care. A position statement published by the AOM argues that full-scope midwifery practice offers a number of benefits including keeping birth as normal as possible, enhancing continuity of care, maximizing efficient use of health-care resources, and fostering inter-professional relationships (Association of Ontario Midwives 2011). Despite these benefits, approximately 50% of midwives in Ontario are required to transfer care when clients require oxytocin induction or augmentation (Ontario Hospital Association 2010).

4.1.3 Choice of Birthplace

Choice of birthplace is one of the key tenets of Ontario midwifery care (College of Midwives of Ontario 2014d). Midwives maintain admitting privileges at one or more hospitals within their catchment area, giving midwifery clients the option to choose to birth either in hospital or out of hospital (Ontario Hospital Association 2010). While approximately 80% of Ontario midwifery clients choose to deliver in-hospital, clients choosing out-of-hospital birth may opt to deliver at home or at one of the two birth centers in Ontario, located in Ottawa and Toronto (Ontario Hospital Association 2010; Association of Ontario Midwives 2017a).

4.1.4 Midwifery Clinics, Caseload, and Call Schedules

Midwives in Ontario work out of autonomous, community-based clinics and are not linked to the funding of a particular hospital. In Ontario, there are 103 midwifery practices which vary in terms of the number of active midwives working at each practice, the urban or rural community in which they are located, and the on-call schedule of the midwives at the practice. Midwifery practices range in size from small, solo, and two-midwife practices, typically in remote and rural areas, to large practices with upward of 15 midwives in urban centers (Association of Ontario Midwives 2017b).

A midwife taking on a full caseload provides primary care to 40 clients per year.

There are a variety of call schedules that midwifery practices utilize; however the two most common models are the *primary call* model and the *shared call* model. In the traditional, primary call model, individual midwives book four clients with a due date in a given month and have approximately 8 weeks of vacation per year taken in 2–4-week blocks. During the on-call months, midwives have one to two weekends "off call" where another midwife at the practice provides call coverage for the "off-call" midwife.

An increasing number of practices are adopting shared call models. Shared care models are organized in a variety of ways, depending on the needs of the midwives. In general, midwives are grouped into teams, typically of two to four midwives. Clients are assigned to a team rather than to an individual midwife and meet all of the midwives on the team throughout their prenatal care. The midwives within the team rotate call coverage, with at least one team member being on call at all times. Midwives practicing in a shared call model may take on a full caseload or may choose to reduce their annual caseload. If all midwives working in a shared call team take on a full caseload of four clients per month, the number of clients an on-call midwife is providing care for increases proportionally. For example, in a primary call model at any given time, a midwife is on call for approximately 4 term, 30 prenatal, and 6 postpartum clients. In a shared call model where a team of three midwives each books a full caseload, at any one time, a midwife may be on call for approximately 12 term, 90 prenatal, and 18 postpartum clients. As one may expect based on these numbers, the on-call time for midwives working in shared call models is usually more demanding. However, these models may appeal to some midwives because they typically require fewer days on call over the course of the year. There is currently no literature examining the various call models utilized across Ontario, why midwives prefer primary or shared call models, and what, if any, impact the various models have on midwives' job satisfaction, client care, or students within the midwifery practice.

4.1.5 Funding and Remuneration

Midwives are compensated individually and are paid a set fee per billable course of care (BCC) which includes all care provided during pregnancy, labor, birth, and 6-week postpartum (Ontario Hospital Association 2010). Midwifery practices apply

for and are approved for a set number of total BCCs that a midwifery practice may bill for annually.

Midwifery practice groups apply for separate funding to hire new registrants; thus, the BCCs that are billed by new registrants are separate from the total annual BCCs allocated to a midwifery practice group. Following the completion of the new registrant's allocated BCCs, the new registrant may be able to continue working at their current midwifery practice if the practice has sufficient funding to support the ongoing caseload and BCCs of an additional general registrant midwife. If a midwifery practice is unable to accommodate the caseload of an additional midwife, once the midwife completes her new registrant year, the midwife is required to move to a different midwifery practice that has sufficient caseload available.

4.2 Midwifery Education

The 4-year midwifery curriculum comprises a combination of classroom learning and clinical placements. Ontario midwifery students complete a total of 56 weeks of placements in midwifery clinics and 18 weeks in related community settings over the course of the 4-year program (Butler et al. 2016). Throughout their clinical placements, midwifery students are supervised by clinical preceptors. Although there is no formal selection process, clinical preceptors are encouraged to maintain their competency through attending preceptor workshops offered through the Midwifery Education Program.

Over the course of their clinical placements, midwifery students take on an increasing level of responsibility with respect to clinical skills and client care. The final 3-month clinical placement is known as *clerkship* and, although midwifery clerks are still under the supervision of a clinical preceptor, midwifery clerks are expected to take on the complete responsibilities of full-scope midwifery, providing primary care as if the clients were their own (Midwifery Education Program 2017; Butler et al. 2016). When midwifery students first embark on the clinical placement component of their education, they are supervised closely by their clinical preceptor as they gain increasing confidence and competence in all of the clinical skills relating to midwifery. Midwifery students take on an increasingly active clinical role with respect to clinic prenatal appointments and care during labor and birth and during the postpartum period throughout their education. Whereas at the beginning of their clinical placements students are closely supervised and guided by their preceptors, in their final semester, midwifery clerks may conduct prenatal visits independently, provided a registered midwife is on-site for consultation. Clerks may also conduct up to three postpartum home or clinic visits without another midwife in attendance and may attend deliveries with a registered midwife at both home and hospital in the role of the second midwife (Midwifery Education Program 2017).

4.3 New Registrants

Approximately 140 midwives graduate from Canadian midwifery education programs annually, with the majority—approximately 90—graduating in Ontario (Canadian Association of Midwives 2017aa). Once a midwifery student graduates

from a recognized Canadian MEP or bridging program, they must successfully complete the national licensing exam, the Canadian Midwifery Registration Examination (CMRE), which is offered once annually (Canadian Midwifery Regulators Consortium 2011). Following successful completion of the CMRE, new graduates apply to their respective provincial midwifery college to obtain registration under the category of *new registrant* (College of Midwives of Ontario 2005). Each provincial midwifery college has their own new registrant policy that outlines what clinical competencies must be demonstrated over the course of the new registrant year and outlines any restrictions to clinical practice during the new registrant period.

In Ontario, the new registrant policy outlines the restrictions to clinical practice and requirements that new registrants must meet during their first year of clinical work (College of Midwives of Ontario 2005). The CMO requires new registrants to work at an established midwifery practice for a minimum of 12 months (College of Midwives of Ontario 2005). An established practice is defined as a practice that has midwives who have been funded for at least 1 year and who currently hold hospital privileges in the community being served (College of Midwives of Ontario 2006). During their new registrant year, midwives must attend a total of 60 births—30 in the role of the primary midwife and 30 in the role of the second midwife (College of Midwives of Ontario 2005). Of these 30 primary and 30 secondary births, a maximum of 20% of each may be attended with another new registrant (College of Midwives of Ontario 2006, 2015). A new registrant may choose to complete a portion of their new registrant requirements outside of Ontario; however, a minimum of 6 months of the new registrant year must take place in Ontario (College of Midwives of Ontario 2006). The final CMO restriction to new registrant practice applies only to those who are working at a practice where there is only one other midwife and requires that new registrants participate in monthly peer review meetings with at least one other midwifery practice (College of Midwives of Ontario 2006).

Once a new registrant has attended 30 births in the role of both the primary and the second midwife, she or he may then apply to the CMO for a change of status from new registrant to *general registrant*, *with conditions*. With this status, the midwife may now attend births with another new registrant but is still required to work at an established midwifery practice until 12 months from the date of registration (College of Midwives of Ontario n.d.). Following the new registrant's year at an established practice, the midwife's status becomes *general registrant*, *without conditions* (College of Midwives of Ontario n.d.).

4.4 Orientation, Supervision, and Mentorship of New Registrants

In Ontario, aside from the requirements and restrictions set by the CMO in the new registrant policy, there are no formal guidelines to facilitate transition, orientation, or mentorship during the first year of clinical practice. With no systems or regulations in place to guide midwifery practices, there is the potential for significant variation with respect to the support, mentorship, and supervision that new

registrants receive during the first year of clinical practice. While some midwifery practices have independently established their own standard orientation, supervision, and mentorship protocols, other practices take a more informal approach to mentorship (Sandor 2018).

Most midwifery practices and hospitals require that midwives who are new to the community and who are applying for hospital privileges, new registrants included, conduct a specified number of births with another midwife in attendance for supervision. This number is highly variable across communities and in some cases may even be entirely up to the discretion of the new registrant based on their own perceived learning needs. In addition to supervised births, in communities where managing epidural analgesia and oxytocin inductions and augmentations are part of the midwifery scope, a number of each of these procedures may also require supervision before full hospital privileges are granted. These supervision numbers are not defined by the CMO and are instead based on numbers set by individual midwifery practices or hospital policies. As such, the supervision requirements during the first year of practice are highly variable across the province.

There are currently no policies or guidelines that discuss new registrants accessing the support of a mentor during their first year of clinical practice, yet midwifery practices can access funding to support midwifery mentors. This funding is intended to compensate midwives for activities such as providing orientation to clinical, hospital, and professional systems and protocols and on-call clinical support in the form of remote or in-person advice and supervision of new registrants (York Community Services Centre & Community Midwives of Hamilton MPG#110 2009). While supporting midwifery mentors financially is helpful, individual midwifery practices are responsible for outlining the details regarding the structure of their own mentorship program and defining the roles, responsibilities, and expectations within the mentor-new registrant relationship.

4.5 Previous Canadian Research on Transition to Practice

The literature surrounding the transition to clinical practice for Canadian midwives is less comprehensive than in other countries; however, two Canadian studies have examined the self-reported preparedness for clinical practice of new midwifery graduates. Kaufman (2007) and Ellis (2013) surveyed midwifery graduates in Ontario and British Columbia, respectively (Kaufman et al. 2007; Ellis 2013). Similar to the findings of studies examining the transition to clinical practice for other health-care professionals, new midwives required assistance with organizing and scheduling the demands of a full caseload, navigating inter-professional relationships, and understanding the business and financial aspects of midwifery practice (Kaufman et al. 2007; Ellis 2013). Graduates viewed clinical placements as highly valuable elements of their midwifery education, providing them with effective learning environments in which to develop clinical skills related to all aspects of midwifery care through pregnancy, labor, birth, and postpartum periods (Kaufman et al. 2007; Ellis 2013; Butler et al. 2016). In both of these studies, graduates

perceived that, overall, they were prepared for clinical practice (Kaufman et al. 2007; Ellis 2013). From the perspective of mentors working with new registrants, while the new graduates' clinical skills were adequate, mentors felt that new registrants were not fully prepared for the realities of autonomous midwifery practice (Ellis 2013).

The sustainability of midwifery hinges on a complex network of factors, including transition to practice and mentorship, which were explored through two studies in 2010 that examined midwifery retention and attrition in Ontario (Versaevel 2011; Cameron 2011). The authors identified that many midwives entered the profession with great optimism and excitement, and their self-identity was closely linked to their professional identity as a midwife (Versaevel 2011; Cameron 2011). Midwives who remained in clinical practice enjoyed their work, wanted to make a difference in the lives of clients, and had positive relationships with colleagues with whom they share a similar philosophy (Versaevel 2011). Conversely, Cameron found that between 1994 and 2007, the attrition rate for midwifery in Ontario was 21%, and many midwives cited the stress of an on-call lifestyle and the difficulty in attaining work-life balance as key reasons for leaving midwifery (Cameron 2011). Challenging relationships with clients, other midwives, and inter-professional colleagues were also factors that influenced midwives' decisions to leave the profession (Cameron 2011).

Midwives experienced significant disappointment when their perhaps idealized expectations of what it meant to be a midwife were not met when they entered clinical practice (Cameron 2011). This finding aligns with research from other health-care fields showing that new practitioners commonly experience feelings of frustration and disillusionment with the realization that their student perception of what clinical work would entail does not align with the reality of clinical practice (Duchscher 2008; Robertson and Griffiths 2009; van der Putten 2008; Heitz et al. 2004; Jordan and Farley 2008). The gap between idealistic expectations and reality is evident in areas including the quality of health care provided to patients, relationships with colleagues, and differences in philosophies of care (Duchscher 2001, 2008; Charnley 1999). Cameron found that for some midwives, it becomes impossible to reconcile their previous perceptions of midwifery with the realities of clinical practice, and this discordance drives them entirely from the profession (Cameron 2011).

While the decision to leave the profession is perhaps an extreme outcome, these studies highlight some of the professional obstacles that most midwives experience to a greater or lesser degree. The support systems that a midwife has in place influence her ability to cope with the challenges of clinical practice. Versaevel (2011) found that one's partner, work colleagues, and family were the fundamental sources of support for midwives. Many midwives who left the profession expressed that they did not receive adequate support from senior midwifery colleagues (Cameron 2011; Versaevel 2011). These findings are interesting in the context of new registrants since it draws attention to the importance of support from midwifery colleagues in overall midwifery retention and emphasizes the need for supporting and mentoring new registrants. As new registrants enter clinical practice, they will

undoubtedly encounter challenging aspects of midwifery, and ensuring that new midwives receive adequate support during their new registrant year may help create a solid foundation to promote overall retention within the profession (Cameron 2011; Versaevel 2011).

4.6 Current Research with New Registrants

The scarcity of literature and scholarship on Canadian on midwives' transition to professional practice was identified, and a qualitative, grounded theory research study was undertaken to answer the question: *How do new registrant midwives in Ontario navigate the transition from student to clinician during their first year of clinical practice?* (Sandor 2018). In this study 13 semi-structured interviews were used to collect data from Ontario midwives in three participant groups: (A) new registrants in their first year of clinical practice, (B) registered midwives with 1–5 years of clinical experience, and (C) registered midwives who worked with new registrants as supervisors or mentors. Each participant took part in a semi-structured interview which was recorded and subsequently transcribed verbatim. In keeping with grounded theory, the transcripts were coded line by line to generate open codes, and then axial coding was used to draw connections between similar concepts and categories. These categories were then clustered together to form three themes, *building*, *bridging*, and *being* (Fig. 4.1), which represent the transitional phases that new registrants in Ontario experience as they navigate the first year of clinical practice (Sandor 2018). The characteristics that comprise the building, bridging, and being theory fall into four themes: clinical, emotional, practical, and cultural.

4.6.1 Building

The building phase occurs during the final year of midwifery education when students take on increasing responsibility in preparation for their upcoming role as independent clinicians. During this final year, students are expected to take on a growing level of clinical responsibility and, in the final months, to perform all clinical responsibilities with minimal supervision from their preceptors.

While always keeping client safety at the forefront, an effective mentor during this phase offers a senior student the autonomy to carry out clinical care plans independently, even if those plans differed from one the preceptor themselves would make. However, some students may not be given as much opportunity to practice clinical management and thus commence clinical practice with very little experience managing care independently. Specifically, managing emergency situations is an area of clinical skills that students do not feel entirely prepared for upon graduation.

In addition to exposing them to clinical management, preceptors have an integral role in building up the confidence of the senior student during this building phase by

BUILDING	BRIDGING	BEING
	CLINICAL	
• Opportunities to practice clinical management • Exposure to various clinical situations	• Dealing independently with clinical situations • Completing supervised clinical procedures	• Confidence in clinical situations • Learn from and adapt to unfamiliar clinical situations
	EMOTIONAL	
• Confidence from clinical preceptors	• Feeling the weight of clinical responsibility • Dealing with interpersonal conflict	• Freedom to develop personal practice style • Self-identity as a midwife • Professional satisfaction
	PRACTICAL	
• Exposure to practical aspects of midwifery	• Navigating midwifery practice and hospital logistics • Developing time management and prioritization strategies • Adapting to call models • Coordinating business aspects of clinical practice	• Confidence in logistics
	CULTURAL	
• Integration into midwifery practice • Develop interprofessional relationships	• Developing support networks – colleagues, peers, mentors • Integrating – into midwifery practice and hospital culture and broader midwifery community	• Accepted as an equal team member

Fig. 4.1 The building, bridging, and being theory

offering support and encouragement as students become progressively independent in dealing with complex clinical situations. Having a positive relationship with preceptors and receiving positive encouragement during the senior year can foster feelings of self-confidence. When the relationship with the preceptor is challenging or negative, or when the relationship involves unresolved conflict, this can negatively affect the midwifery student's confidence.

Senior midwifery students also need the opportunity to experience the practical aspects of midwifery, including learning the intricacies of urban or rural practice, working in a large or small midwifery practice group, and working in either full-scope or limited-scope communities. The location, scope, and model of care that midwifery students experienced during the final year of education influences how they view and practice midwifery in their first year of practice.

They also need to build inter-professional relationships and develop the professional communication and interpersonal skills that are essential as a practicing midwife.

4.6.2 Bridging

The "bridging" phase typically occurs once midwifery students graduate and are practicing as new registrants. During this phase, they experience true independent clinical practice for the first time and fully take on the professional responsibilities of a registered midwife without the supervision of a clinical preceptor. This phase is characterized by dichotomous feelings of satisfaction for one's career choice and also feelings of fear and vulnerability. During this phase, new registrants struggle with balancing the multitude of clinical tasks and responsibilities and navigating the logistics of their midwifery practice and hospital. The mentorship that new registrants receive and the support networks that they build during this phase are critical. Even new midwives who, as students, were given ample opportunity to manage clinical care notice the absence of their clinical preceptor once they begin practicing as a new registrant. They no longer have the "safety net" of a clinical preceptor and are acutely aware that they are now the ones taking on the responsibility for clinical decisions.

This transition to clinical practice can feel like being on a roller coaster. The low points of this emotional rollercoaster occur when new registrants realize the true weight of responsibility they have in caring for clients. Fear of missing something, feelings of inexperience and vulnerability, and regret or anger when looking back on particularly difficult clinical situations are common during this phase. These challenging emotions may manifest in physical symptoms, such as insomnia, or mental stress with questioning management decisions and re-living clinical scenarios.

Another significant emotional challenge for new registrants occurs when they encounter personality conflicts with their midwifery colleagues. These conflicts are often unanticipated by new registrants and can carry even more stress than the weight of responsibility associated with clinical practice. Further, as a new registrant, individuals no longer have the emotional support of a clinical preceptor or tutor to mediate inter-professional relationships, and instead new registrants have to independently negotiate challenging interpersonal situations in a professional and collegial way.

In addition to the emotional challenges of taking on the weight of responsibility and navigating interpersonal relationships, new registrants must work through the logistics related to their midwifery clinic and hospitals. For many new registrants, the multitude of logistic and organizational tasks associated with clinical work is just as demanding as managing complicated clinical situations; these included coordinating the day-to-day responsibilities of managing a caseload, running a clinic, managing paperwork, and prioritizing tasks; keeping track of policies and protocols related to work within the hospital; adapting to the midwifery practice call schedule; undertaking the process of joining and registering with professional associations

and obtaining hospital privileges; and, finally, understanding the financial aspect of midwifery, including fees and billing.

Within a midwifery practice group, expectations surrounding call scheduling is another challenge new registrants need to address. A midwifery practice's call schedule impacts on-call and off-call time, caseload, vacation, call coverage, relief, and, ultimately, work-life balance. Ideally, call schedules are mapped out equitably, include regular off-call time for weekends and vacation, and have clear guidelines for accessing relief following extended periods of being awake. Some midwifery practice call schedules are extremely complicated, or the practice culture is such that midwives feel pressure to stay on call despite scheduled time off. There doesn't appear to be one clear call model that is best for new registrants; however, most new registrants appreciate when call models are well organized and when there are clear guidelines surrounding off-call time.

During this "bridging" phase, new registrants also learn and adapt to the relationships and expectations both within their midwifery practice group and in the wider hospital and community. They work to develop support networks, integrate into the midwifery practice and hospital culture, and negotiate group and power dynamics. It is essential to access support from various sources including friends, family, peers, and colleagues. Other new registrants and those who just completed their first year of practice are often a key source of support. Also, peer relationships formed as students can develop into supportive collegial relationships.

The other common source of support for new registrants comes in the form of mentorship from experienced midwives at their practice. This is particularly beneficial when new registrants have to work through the complex emotions related to difficult clinical situations and poor outcomes. Considering that there are no provincial guidelines regarding mentorship of new registrants, the mentorship experience is highly dependent on how the midwifery practice has organized its mentorship program. In many practice groups, even though a mentor midwife is assigned to each new registrant, the mentor does not necessarily provide actual mentorship. When this occurs, new midwives end up seeking out support from various midwives at their practice based on factors such as convenience, approachability, and previous interactions.

While mentorship from individual midwives is pivotal in the adjustment to clinical practice, the overall culture of a midwifery practice also contributes to how supported new midwives feel during their transition to clinical practice. The midwifery practice group culture, overall, has the ability to support new registrants in their transition to clinical practice and can be valuable as new midwives build professional networks of support.

At the same time, there may be issues related to power dynamics and hierarchy within midwifery practices. New registrants may feel vulnerable and sense that they must prove themselves to be hard workers and team players. The power dynamics within the midwifery practice may lead new registrants to feel pressure to take on more work, stay on call during scheduled off-call time, and work longer hours before calling for relief than other individuals at the midwifery practice. When new registrants view themselves as having little power within the practice as a whole,

they have difficulty seeking help and advocating for themselves. Conversely, in midwifery practices with a structured mentorship system in place, they are more likely to be able to ask appropriate questions and seek help from more senior practice members without worrying that their questions or concerns would be held against them in the future.

4.6.3 Being

In the final phase of their transition, new registrants are comfortable and confident with their professional identity as registered midwives and exhibit maturity in their interaction with the elements of midwifery practice. New registrants shed their student skin and see themselves as autonomous health-care professionals. During this phase, they gain confidence in their clinical skills and in the environments where they practice, recognize the importance of strong professional and personal support systems, and acknowledge the inherent unpredictability of midwifery practice. Aspects of clinical practice that were once a source of anxiety become familiar and even second nature; clinical decision-making doesn't require as much mental and emotional energy. They also realize that their clinical learning will continue beyond the new registrant year.

While, technically speaking, as soon as new graduates are registered with the college they are registered midwives, for many new registrants, it is not until partway through their first year of clinical practice that they truly see themselves as midwives. Their self-identity as a midwife and job satisfaction are also closely linked to the relationships they form with clients. They grow to see themselves as part of the team, both in their midwifery practice and in the hospital setting, they begin to feel included in the day-to-day activities of the midwifery practice, and they have confidence to offer input and suggestions that contributed to the operation of the practice group.

4.7 Discussion

Our exploration of the experiences of new registrants in Ontario highlighted four key elements that were influential in facilitating an easier transition to clinical practice (Sandor 2018). These four elements were (Fig. 4.2):

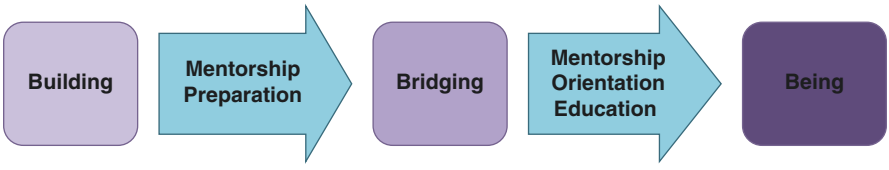

Fig. 4.2 Preparation, orientation, mentorship, and ongoing education in the building, bridging, and being theory

(a) Preparation for clinical practice through the opportunity to experience clinical management
(b) Orientation to midwifery and hospital logistics and expectations
(c) Mentorship
(d) Ongoing education

4.7.1 Preparation

When senior midwifery students were given the responsibility to make clinical decisions and follow through with care management plans with minimal assistance or modification from their preceptor, they were better prepared to handle the multitude of clinical tasks and responsibilities that came with the independent clinical practice.

The transition to practice includes time and opportunity to develop confidence, refine clinical skills, and hone clinical judgment and decision-making. In order to do this, there must be ample opportunity as a student, prior to graduation, to deal with both normal and complex clinical situations, proposing, initiating, and following through with care management plans during all phases of pregnancy, birth, and postpartum. In learning to manage clinical care, students must be given the space to make decisions independently and to learn from these experiences. When this occurs, new registrants are able to use their knowledge and skills more confidently and move through the transition to confident and competent midwife more smoothly then their peers who did not have similar opportunities. New registrants who did not have adequate opportunities to practice clinical management as students relied more heavily on the support of midwifery colleagues and experienced more stress and anxiety related to the weight of clinical responsibility.

For these reasons, supporting both senior students and their preceptors in developing students' clinical management skills during the final year of clinical placement is beneficial for new registrants and may help new registrants be better prepared for the increased clinical responsibility of the bridging phase. An emphasis on the importance of clinical management during discussions between clinical preceptors and midwifery learners may help preceptors adjust their teaching style to support senior students in practicing clinical independence. A focus on clinical management may also help senior students advocate for themselves and take on the necessary level of clinical responsibility so they are better equipped clinically, emotionally, and professionally to be fully independent after graduation. Experience with clinical management as a student has far-reaching implications for the transition to clinical practice as new registrants move toward the self-efficacy and clinical confidence of being a midwife.

4.7.2 Orientation

Upon commencing clinical practice, new registrants must learn to navigate the practical logistics and the cultural expectations of both the midwifery practice and the

hospitals where they are working. New registrants benefit from a consistent approach to orientation of both of these environments, and all new registrants, regardless of previous clinical experience, need a comprehensive orientation to both midwifery practice and hospital logistics (Sandor 2018). The importance of thorough orientation for Ontario midwives is consistent with the literature regarding the transition to clinical practice for both nurses and midwives outside of Canada (Clements et al. 2012; Rosenfeld et al. 2004).

Most new midwives expect that they will receive some sort of formal, organized orientation to their clinic and hospital workplace as new registrants; however, we found that the orientation new midwives receive was inconsistent. Some key element in the orientation to the midwifery practice included an introduction to the physical space of the clinic and an explanation of the expectations regarding call schedules and off-call time, calling for relief, scheduling clinic appointments, booking ultrasounds, and organizing lab investigations, communication and paging, documentation, and the process of completing monthly billings. Orientation to the hospital setting should similarly include a tour of the physical space where midwives work, as well as common hospital procedures such as triage assessments, admissions, consultations, ultrasound and lab investigations, postpartum admission, discharge protocols, and documentation (Sandor 2018). Individuals who received comprehensive orientation to the practical elements of the midwifery practice and hospital were better prepared to embark on independent practice and felt more supported and welcomed into their role as professional midwives (Sandor 2018). Conversely, individuals who did not receive organized orientation struggled to understand the practical and cultural elements of clinical practice (Sandor 2018).

4.7.3 Mentorship

During clinical placements, midwifery students receive clinical teaching, professional guidance, and evaluation from their assigned clinical preceptors. One preceptor is assigned to each midwifery student for the duration of their clinical placement. Positive relationships with clinical preceptors and midwifery colleagues enhanced learners' confidence, which translated into confidence as new registrants (Sandor 2018). Once midwifery students graduate, there is no formal program in place for new registrants to access mentorship; instead individual midwifery practices must/may establish their own mentorship program for the new registrants they work with.

It has, however, been well established in the literature regarding the transition to clinical practice in other health-care fields that having a consistent mentor is helpful in developing strategies to address the demands of clinical practice (Zinsmeister and Schafer 2009; Chandler 2012; Casey et al. 2004; Fink et al. 2008; van der Putten 2008; Fenwick et al. 2012). Consistent with this literature, new registrants who work at midwifery practices that have established structured mentorship programs are better able to navigate the experiences of the new registrant year (Sandor 2018). Positive mentor relationships also facilitate participation and integration into the midwifery practice and hospital culture and helped foster intra-professional and

inter-professional relationships (Sandor 2018). Unfortunately, not all new registrants in Ontario experiences effective mentoring due to the variation in mentorship between midwifery practices.

Mentorship during the initial months of clinical practice may also offer long-term benefits in a midwife's career. In 2011, Versaevel conducted a survey examining the reasons that midwives in Ontario remain in the profession (Versaevel 2011). The results found that facilitating support systems for newly graduated midwives has a positive impact on individuals beyond the new registrant year and may even contribute to overall improved retention of midwives within the profession (Versaevel 2011). Consistent with these findings, Cameron (2011) found that Ontario midwives who left the profession identified that they did not receive adequate support at the beginning of their career (Cameron 2011). If mentorship during the first year of clinical practice does, in fact, impact midwives' continuation in the profession, it should be a focus for midwifery practices and, in a broader context, presents a clear approach to enhancing the sustainability of the midwifery profession.

One final element that must be considered when discussing mentorship is the training and support for midwifery mentors. While training and support programs exist for clinical preceptors, there is currently no formal process for selection, training, or assessment of midwifery mentors. Although there is financial compensation available for midwives who take on the role of a mentor, there are no clear expectations of what the relationship between new registrants and mentors involves, nor are there guidelines to clarify the roles and responsibilities of midwifery mentors. Instead, individual midwives or midwifery practices are responsible for developing their own mentorship programs and do so with varying degrees of success. Formalizing the expectations, responsibilities, and processes related to mentorship, defining clear goals of the new registrant-mentor relationship, and providing training and support for midwifery mentors are the first steps toward developing a more structured, supportive, and effective mentorship program for Ontario new registrants.

4.7.4 Ongoing Education

One of the most difficult elements of the new registrant year was the conclusion of the formal support systems and the deterioration of the informal support networks that midwifery students relied on throughout their training. Communication with peers, interaction with clinical tutors and preceptors, and opportunities for formal and informal evaluation provided midwifery students with multiple sources of feedback. With the start of the new registrant year, most of these regular interactions were eliminated, leaving new registrants to build new networks of support and feedback. In addition to feeling disconnected from midwifery peers, new graduates also felt disconnected from the profession as a whole. The challenge of feeling connected to one's peers and profession upon commencing clinical practice was supported by studies of new graduates in other health-care professions who experienced

similar feelings of abandonment when faced with independent clinical practice (Chandler 2012; Casey et al. 2004; Duchscher 2001).

The months following graduation present a unique opportunity that may be particularly suited to establishing peer support networks and nurturing new registrants' professional identity. For many new registrants, there are several months between the time of graduation and when new registrants obtain hospital privileges and begin on-call clinical practice. Offering ongoing educational opportunities during these initial months can address some of the common experiences and challenges that new registrants encounter while also allowing new registrants to feel better connected with peers within the profession. A 2011 qualitative study that examined the experience of newly qualified midwives in England found that the transition to clinical practice was more difficult when there were more than 12 weeks between the time of qualification and new graduates' commencement of clinical practice (Hughes and Fraser 2011); this finding is important to consider in the context of midwifery in Ontario given there is often a delay of several months between new registrants becoming qualified and commencing clinical practice.

A variety of formats would be well suited to providing ongoing support for new registrants through their first year of clinical practice, particularly online discussion forums and in-person or web-based workshops. Workshops specifically focused on topics relevant to new registrants would help address some of the common challenges faced during the transition to practice; for example, topics may include financial planning, emergency skills management, working with mentors, and interview skills.

Aside from the content and timing of professional development sessions, one important consideration is accessibility. New registrants are situated across the province, and although offering professional development sessions online helps address geographic barriers, one additional obstacle for all midwives is the ability to participate in workshops while on call. Midwives may struggle with organizing call coverage to participate in professional development activities such as workshops and conferences, and new registrants have additional difficulty requesting time off call when they are just learning the expectations of their own midwifery practices. If, as part of the transition to clinical practice, new registrants were expected to participate in "required" professional development sessions and be off call at designated times for these sessions, these clear expectations would alleviate some of the anxiety related to negotiating additional off-call time.

Educational sessions and the professional networks fostered through professional development have been found to help new midwives feel better supported and included midwifery as a profession (Clements et al. 2012; Pairman et al. 2016). In addition to enhancing knowledge and skills, professional development sessions for new registrants would provide a forum for new registrants to share clinical experiences, debrief, and create new professional networks and may allow new registrants to feel integrated into the wider midwifery community and develop their own sense of identity as a midwife.

4.8 Conclusions

The question of how new registrants navigate the transition from student to clinician is relevant to individuals and organizations who invest time, energy, and resources into the integration of new registrants into the midwifery profession; this includes new registrants themselves, midwifery educators, midwifery practices, hospitals, professional associations, and regulatory bodies. All stakeholders stand to benefit from the development of a more standardized approach to introducing new registrants into the midwifery profession.

The findings of our work highlight the importance of preparing student for clinical management and also bring to light instances where midwifery students did not receive adequate opportunity to manage clinical care prior to graduation. Despite there being clear expectations of clinical competencies upon entry into midwifery clinical practice, for some individuals their final clinical placement does provide adequate experience to integrate these core competencies into providing comprehensive care (Canadian Midwifery Regulators Consortium 2010).

In considering ways to meet the remaining three challenges to the transition to clinical practice—orientation, mentorship, and ongoing education—it may be helpful for Ontario midwives to explore the models that other countries use to support new midwives in their transition to clinical practice.

The findings of our work highlight the strengths, shortcomings, and inconsistencies that exist for new registrants in Ontario. In order to ensure new midwives are prepared for and supported through the transition to clinical practice, it will be important for midwifery stakeholders to strengthen the preparation, orientation, mentorship, and ongoing education of new registrant midwives. Enhancing these domains for new midwives as they enter clinical practice will help to strengthen the midwifery profession as a whole and to ensure the sustainability of Canadian midwifery for the generations of midwives yet to come.

4.9 New Registrant Reflection

{Corey Bryant}

4.9.1 On Transitioning to New Registrant in Ontario

Corey Bryant
I accepted a New Registrant position at a practice where I had been a learner during my second year of Midwifery education. I hoped that my previous experience working in this community would make the transition from learner to practicing midwife a little easier, and I was surprised to find that the learning curve was still quite steep. I am still learning the nuances of working in two different hospital systems, though overall I have become comfortable in both.

The practice I joined has a well-structured mentorship program in place. New Registrants are paired with a seasoned midwife for orientation to clinic and community, who also commit to being available for ongoing support. Previous New Registrant midwives have compiled a comprehensive to-do list, complete with instructions and contact details, that is helpful in organizing hospital privileges and really helped with my transition to practice. I have found that the midwives at this practice understand that New Registrants have different needs from senior midwives and are always happy to take time to answer questions or help me navigate situations I haven't yet encountered.

The midwives at this practice work in several different call models, making the call schedule somewhat complicated. Some work in primary care, some in shared. Primary care midwives are sometimes covered by other primary midwives and sometimes by midwives in shared care. There has been confusion about whom I should be calling for backup or relief at times. I appreciate that this allows midwives at this practice to work in the way that best suits them, but it is confusing to come into as a New Registrant, especially if you switch from primary to shared care, as I have.

The main struggle I've experienced as a New Registrant transitioning to practice has been financial. Because of the way midwives are compensated in Ontario, I did not start earning substantial income until I had been practicing and working on call in my community for several months. Further, because of the way government funding is organized, I was unable to start practicing for several months after I had graduated and passed my national exam. In the interim, I was expected to pay several thousands of dollars in fees in order to maintain good standing with both my college and my professional association, as well as living expenses and the costs of being a practicing midwife. The structure of midwifery funding is unrelated to how practices help midwives transition, but it bears consideration, as new midwives who are struggling with the financial burden of practicing without earning an income may choose to leave the profession or may have trouble transitioning to practice if they aren't able to ensure their basic needs are met. Some practices are able to offer interim funding, and I was grateful that I could receive a small loan from my practice, but it was only minimally helpful and I continued to accrue debt in order to make ends meet.

All in all, my experience transitioning from learner to practicing midwife has been positive. Midwives at my practice are supportive, and the practice has a good mentorship program in place. My struggles have been mainly structural and beyond the scope of any one midwife or practice to address. After an initial period of feeling overwhelmed with all of the new things I needed to learn to practice in this community, I have settled into a role I am comfortable with and feel increasingly confident each day.

List of Terms

Full scope Midwives who maintain care for low-risk clients who require oxytocin infusion for induction or augmentation of labor and/or epidural analgesia

Limited scope Midwives who are required to transfer care to an obstetrician when a client requires epidural analgesia and/or oxytocin infusion for labor induction or augmentation

New registrant Registered midwife in the first year of independent clinical practice

Primary call Call model where midwives carry a caseload of four clients per month; off-call time typically includes one or two weekends off call per month and 2–3-month vacation per calendar year

Primary midwife Midwife who assumes responsibility for the care of a women during the intrapartum and immediate postpartum period (Ontario Regulation 168/11 1991)

Second midwife Midwife in attendance at a birth who assumes responsibility for the immediate assessment and care of the newborn following birth (Canadian Midwifery Regulators Consortium 2010)

Shared call Call model where midwives work in teams of two to four and clients are assigned to a team rather than to a particular midwife; midwives within the team rotate call coverage with at least one midwife from the team on call at any time

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Ethiopia

5

Annette Bennett

A traditional Ethiopian proverb

'ቀስ በቀስ እንቁላል በእግር መራመድ ይችላል'

'Slowly, slowly the egg; she will learn to walk'
– Plan well, and be patient in order to see a good result

5.1 Introduction

Culturally rich and unique, the east African country of Ethiopia is both ethnically and geographically diverse. Land locked in the 'Horn of Africa', Ethiopia is a country of geographical extremes, dissected by the mighty Rift Valley, with arid regions to the east, chilly mountain ranges in the north, savannah and tropical lowland forest in the south and west.

The population of Ethiopia has increased rapidly in recent decades and now sits above 106 million with a youthful median age of 18.8 years (Worldometer 2018). Although the majority of Ethiopians reside in rural areas with an ancient dependence on subsistence farming, Ethiopia now boasts one of the fastest growing economies in Africa (Monteiro and Thukwana 2018).

Presently the fertility rate in Ethiopia is 4.1 (UNFPA 2017). Providing consistent and quality reproductive and maternal health care to all women in Ethiopia is an enormous challenge, geographically, economically and culturally. With the expansion of health facilities and educational programs for midwives, access to services and community awareness has increased and improved in cities as well as in many rural areas.

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The Federal Ministry of Health reports that having a skilled attendant at birth is increasing, most significantly in the last decade; however, it remains low overall: 5.62%, 6.3%, 10.8% and 28% in 2000, 2005, 2011 and 2016 (EDHS 2016). There is a strong correlation between antenatal attendance and being birthed by a skilled attendant; Fifty-eight per cent of births to mothers who attended four or more antenatal visits were delivered by a skilled attendant compared to 10% of births where women had less than one or no visits (EDHS 2016, p. 138). Women in urban areas are significantly more likely to birth with a skilled attendant (80%) than those from a rural area (21%) (EDHS 2016, p. 138).

There are increasing services providing reproductive health including family planning with an overall contraceptive prevalence rate of 41% (UNFPA 2017). Ethiopia has decreased its maternal mortality rate from 470 in 2008 to 353 based on 2015 estimates (UNFPA, Population dashboard 2017; Index Mundi 2018).

The health sector has benefited greatly from the expansion and development of health infrastructure throughout the country. Similarly, the Ethiopian government and their partner's heavy investment in the education sector has expanded infrastructure throughout the regions, particularly in rural areas (World Bank 2016). Increasing the number of schools, primary, secondary and universities, is the focal point to the strategy of improving access to education for people in rural and remote areas throughout the country. The challenge for Ethiopia, however, is the providing of experienced educators to ensure quality education across the growing number of institutions.

Midwives have been part of the Ethiopian health system on and off since the mid-twentieth century (Russon et al. 2006). The number of midwives currently registered in Ethiopia is 13,973 (Abebe 2018). The majority, 90%, completed a diploma in midwifery, the remaining 10% are made up of midwives with a Bachelor's degree in midwifery and a small number who have also achieved a Master's degree following midwifery in various disciplines such as reproductive health, education, public health and more recently midwifery (Abebe 2018).

5.2 A Brief History of Midwifery in Ethiopia

The first recorded formal education in midwifery for Ethiopia commenced in Gondar Hospital in 1954 (FMOH and UNFPA 2014, p. 3) followed by the Asmara Nursing School, Eritrea in 1955, formally the Itegue Menen School (Russon et al. 2006, p. 3). Eritrea was part of Ethiopia until it gained independence in 1991. Midwifery was taught as a 'post basic' (following nursing) course at this time.

The first recorded midwifery training in Addis Ababa, Ethiopia was established by doctors Reginald and Catherine Hamlin in 1960 at the Princess Tsehai Hospital (Hamlin and Little 2001, p. 49). The training involved recruiting experienced nurses to complete an 18-month course in midwifery. Following the first graduation in 1961, the midwives appealed to the Ministry of Health for a pay increase as recognition of their extra training and responsibilities. Sadly, this resulted in the closure of

the fledgling school with the Ministry of Health deciding that nurses were sufficiently trained to provide maternal health care (Hamlin and Little 2001, p. 130). The Gondar Hospital program also closed soon after in 1964 (FMOH and UNFPA 2014, p. 3).

In 1977, the midwifery profession suffered another setback, following a review of the midwifery training in Eritrea and a decision to cease training midwives and to only train 'comprehensive nurses' (Russon et al. 2006, p. 26). In other parts of Ethiopia 'community nurses' were mandated with providing maternal and child health care (FMOH and UNFPA 2014, p. 3). This system continued throughout the 1970s and into the early 1980s (FMOH and UNFPA 2014, p. 3; Russon et al. 2006, p. 26). It was not until 1985 that midwifery was taught separately again in Ethiopia as a post-nursing course, in the Addis Ababa Midwifery School and then in 1989 in the Asmara Midwifery School (Russon et al. 2006, p. 26).

The first 'direct entry' diploma program commenced in 1998 at the Addis Ababa Midwifery School (FMOH and UNFPA 2014, p. 3) and in 2000 the first Bachelor of Science in midwifery was offered by Gondar University (FMOH and UNFPA 2014, p. 3). Midwifery education at this time was considered to be of a high standard (Gaym et al. 2008). An unexplained decline took place after this time and by 2007 an assessment carried out by the Ethiopian office for the (WHO) concluded that midwifery education and particularly practical skill development was of an extremely poor quality (Gaym et al. 2008) resulting reduced levels of confidence and capacity in midwives themselves, stalling progress in improving maternal and neonatal outcomes.

5.3 Midwifery Education Today

The last 10 years has seen a rebirthing of midwifery in Ethiopia with the commencement of numerous and innovative midwifery programs. There has been increased investment in up-skilling educators, providing educational resources for teaching hospitals, higher education institutions and rolling out improved curriculum. The FMOH has been supported by the UN organisations, the NGO community and in 2007, the Addis Ababa Fistula Hospital opened a model midwifery course and midwife deployment program (FMOH and UNFPA 2014; Bennett 2014). Motivated by wanting to reduce obstetric fistula and improving maternal and neonatal health particularly in rural areas, the college developed their own unique midwifery education and deployment model, recruiting only women from disadvantaged rural areas (grade 12 complete). The HCM course focused on developing problem-solving skills, integrated simulation and theory, quality clinical exposure and skill competency. Sponsored by the FMOH, midwife educators throughout the country were hosted to observe first hand and learn from HCM students and educators alike (Bennett 2014). There are presently 46 institutions providing a pathway to midwifery, 18 of these programs are at the bachelor level while the rest offer a diploma in midwifery (FMoH and UNFPA 2014, p. 4).

Today both the diploma and bachelor programs in midwifery are primarily 'direct entry', requiring a completion of grade 10 or grade 12, respectively (Abebe 2018).

The short-term strategy supported by the UNFPA of admitting large numbers of newly graduated diploma level nurses into an 'accelerated' 6-to-9-month midwifery training, leading up to the 2015 millennium development goal deadline, has been phased out (FMoH and UNFPA 2014, p. 1). At present if a qualified nurse desires to enter midwifery, they would be required to complete a full 3 or 4 year program at either the diploma or bachelor level to become a midwife (Abebe 2018).

5.4 Entering a Midwifery Program

Students wishing to enter a many tertiary courses can pay for their tuition and complete their education in a private institution; however, employment is not guaranteed. This route is often chosen when a student has not matriculated into a government university. Most prospective students prefer to compete for places in the government universities where tuition is 'free'; however, graduates will be 'bonded' to the national health system. The graduate will theoretically be required to work 2 years for every year of tertiary education, in a public hospital or health centre, in a location determined by the FMOH (Bennett 2014; Abebe 2018).

Entering midwifery programs at the university level (public institutions) is not based on a student's preference. For students hoping to apply to a government university the opportunity to 'choose' the direction of their future career, in a broad sense, occurs in grade 10. At the end of grade 10, students chose to either pursue the 'science stream', for example, physics, chemistry, biology or the 'social science stream' such as history or geography. Following matriculation those students who chose the 'science stream' are then funnelled into a science based university course such as engineering, science teaching or the medical fields including midwifery. Prospective students are assigned to a specific course of study based on their score and the number of places to be filled for a particular course. Unfortunately the lowest ranking students are assigned to midwifery (Bennett 2014).

The Hamlin College of Midwives offers an exception to the above student recruitment method. HCM students are recruited from rural high schools and choose to enter a 4-year bachelor program in midwifery (Bennett 2014). The college is a 'not for profit' institution offering full scholarships in return for a period of bonded service back in the graduate's area of origin, practicing midwifery in a rural Government Primary Health Care Centre (Bennett 2014).

5.5 Licensing of Midwives in Ethiopia

Once completing their midwifery course, graduates are required to pass a centralised examination and achieve a certificate of competence (COC).

For those graduating with a bachelor in midwifery the COC examination is set by the Federal Ministry of Education (FMoE), and the result is sent to the Regional Health Bureau (RHB). Graduating diploma students are required to take a COC examination which is prepared and administered by the Technical and Vocational Education and Training (TVET) department of each Regional Health Bureau (Abebe 2018). The licensing office of the Regional Health Bureau (RHB) will compile both the COC result, the academic transcripts and process the registration and license to practice (Abebe 2018).

Registration is renewed every 5 years and presently does not require proof of current practice or evidence of continuing professional development (Abebe 2018).

5.6 Deployment of Graduate Midwives in Ethiopia

Deployment of health graduates, including midwives into government health facilities, has shifted from the federal to the Regional Health Bureaus (Abebe 2018). Ethiopia has many people groups with diverse cultures and more than 80 distinct languages. Regional Health offices are well positioned to fully appreciate and meet the particular needs of their region. RHBs now strive to deploy midwives and nurses as close to their home areas, imitating a similar deployment model championed by the Hamlin College of Midwives since 2010 inspired by the phrase 'the right person for the right place' (Bennett 2014).

5.7 Professional Organisation

The Ethiopian Midwives Association (EMA) was established in 1992 and became a member of the ICM in 1993 (FMOH and UNFPA 2014, p. 57). The EMA has more than 5000 members and aside from playing an important role in advocacy and representation of midwives within Ethiopia, membership also offers opportunities for midwives to contribute to research and publications, support towards participation in national and international conferences and opportunities for continuing professional development (CPD) including e-learning through their website (EMA 2018).

5.8 The Experiences of Two New Graduates

Below are two accounts of the experiences of two new graduate midwives in Ethiopia. The very different experiences shared bellow by two young midwives demonstrates the need for country specific, 'fit for purpose' midwifery programs, competency based and paired with a deployment strategy that includes comprehensive support and mentoring.

5.9 A Young Midwife Graduate's Experience: Story #1

5.9.1 Alemnesh's Story[1]

In the semi-arid and mountainous area of north eastern Ethiopia there is a well-built government health centre, typically servicing a population of approximately 125,000. The rocky ground is both a blessing and a curse, the rocks can be used to construct solid cool dwellings but make life extremely challenging for the subsistence farmers trying to plant crops. On a weekly basis families walk great distances to bring their produce to the market. Women, donkeys and camels laden with foodstuffs, fire wood or handicraft walk along the perilous tracks cut into the mountain side. Rock falls are common and it is not unusual to see a boulder that has come to rest on a track or road, having recently rolled from higher up the mountain.

The new health centre stood out in the ancient village of stone 'tukals'. The young midwife, Alemnesh greeted us and explained that a woman had given birth two hours previously. My midwife colleague and I asked if we could be of any assistance and permission was given by the new mother for us to enter the delivery room. We were encouraged to witness Alemnesh assisting Mary (see footnote 1) to breastfeed her baby but confused to find her still lying on the very narrow delivery 'couch' and not on the more comfortable 'postnatal bed'. Alemnesh explained to us that at 34 years of age Mary was an 'old primip' and because of this she thought and feared that she would have a postpartum haemorrhage (PPH). To reduce this happening Alemnesh went on to explain that she had instructed Mary to lie flat with her legs crossed as she had been taught by an older nurse in the health centre. Despite her fear Alemnesh had not, however, examined the placenta to ensure that it was complete, palpated Mary's uterus to check if it was firm and contracted, checked her blood pressure, pulse, her blood loss or assisted Mary to empty her bladder. Alemnesh's fear was compounded by not having many resources such as essential drugs, intravenous (IV) fluids or a means of transporting a woman in an emergency. We gently worked together carrying out a full postnatal check and assisted Mary off the couch to empty her bladder and wash. We discussed the normal postnatal physiological processes, management, risk factors and signs and symptoms of a PPH. It was a privilege to work alongside Alemnesh to see her genuine care and concern for Mary and her baby. Alemnesh had a passion for midwifery and was keen to learn and to share her own experiences.

Alemnesh explained that she felt anxious and stressed each time a woman came to the health centre as there had not been much work and she lacked confidence with her skills. She also explained that as a student she had very little clinical instruction or experience and like many of her peers had graduated having assisted with only two births. Teaching of midwifery skills, in the university were not demonstrated or simulated using equipment.

[1] Names have been changed.

Another new graduate midwife was expected to join her in the health centre but at this stage they had not been assigned. Alemnesh explained that sometimes the nurses reluctantly assisted her but they were also not very experienced.

Alemnesh was not from the area where she was assigned and did not speak the local language; she felt that traditional belief's, a lack of trust in her as an outsider and in modern medicine in general, prevented many women from coming to the health centre.

Alemnesh shared that she did not feel accepted or trusted by the local women. Very few came to receive antenatal care, fewer for family planning and women in labour only came if they felt that something was not going well. Alemnesh explained that with so few women coming to the HC she had little exposure to uncomplicated birth, lacked the expertise to manage the women with complications who did present and was losing confidence in the skills she had.

When it came time to leave, crying, Alemnesh explained that this had been the first time since her graduation that she had worked with colleagues and she asked when we would come back to visit and work with her again. Some months later we learnt that Alemnesh did not finish her 'service' in the health centre and like so many health workers in rural areas she moved back to the city closer to her family. Sadly the health centre was left without a midwife for more than a year after her departure (Bennett 2014).

5.10 Tinadem's Story: A Graduate Midwife's Experience in Rural Ethiopia

Tinadem[2] is one of a team of four midwives assigned to a FMOH Primary Health Care Centre in the rural town of Birrakat, Amhara region, North Western Ethiopia. Tinadem graduated from the Hamlin College of Midwives with a bachelor in midwifery (4 year, direct entry). This midwifery program was designed to prepare midwives for the challenges of working in a rural health centre. The demands on a midwife, even in her graduate year in such a resource poor setting, require competence, confidence and resilience.

Birrakat is approximately 30 km from the main road on a very poor quality dirt track that is often impassable during the rainy season (approximately 4 months a year). From the point where the track meets the main road, it is another 35 km to the referral hospital in the city of Bahirdar.

Tinadem and two of her colleagues were the third generation of midwife graduates from the Hamlin College of Midwives (HCM) working in Birrakat. The fourth midwife had been assigned from a different institution. The HCM graduates work in government health centres close to where they grew up and continue to receive support both in materials and ongoing mentoring from the HCM (Bennett 2014). The uptake of maternity services in Burrakat Heath Centre had grown from only a handful of births in 2010 annually to more than 800 in 2016 (Bennett 2014, 2017).

[2] The name has been changed.

Tinadem explained that their work in the health centre was very demanding and the transition from student to qualified midwife was a challenge. When Tinadem and her colleagues started their new graduate year just over eleven months ago the overlap time with the outgoing midwives was very short. Once they had left there were no senior midwives and there are no doctors at the health centre level.

> We have conducted more than 800 deliveries [sic] (births) in the last year and sent more than 100 women with complications beyond our capacity to Felege Hewit Hospital (the large teaching hospital in the city) after we gave them care and stabilised them'. Tinadem proudly explained that they had not experienced any deaths of woman in their care

Tinadem and her three midwife colleagues worked shifts to care for all women birthing, night and day, 7 days a week. The four young midwives were also responsible for providing antenatal care, postnatal care, family planning and overseeing the maternity waiting areas.

> So many women from the community are coming to the health centre now that we needed to build a maternity waiting area. Women who live outside the village will come and stay until they give birth. The women mostly care for themselves and we have a small cooking area where they can prepare their own food

The maternity waiting area consists of two rooms with six women staying in each. The women have a mattress on the floor and a mosquito net suspended from the roof. Some of the women are also caring for toddlers. There is a small shared kitchen where the women can prepare their own meals. Family members travel 10–20 km, usually on foot to visit and bring food. The sense of comradery between the women was evident as was the close bond that was formed between them and the midwives.

Tinadem described busy days with increasing numbers of women coming for their services as they are now well known in the community.

> Our work is well known, people, they know us. We are born [sic] from near this place. My home; that of my parents, is in the nearby village. When we first came people did not believe that we could have [the] knowledge to help them. They knew our 'seniors', who had worked here before us and some of them knew that we were trained in the same way (in the same midwifery program) and they were happy because they (their peers before them) had been strong midwives and people trusted them but did not know our work in the beginning. Then slowly, slowly we talk with them and care for them and they see that we have skills and we want to work.
>
> Hanna, our mentor, she comes to visit and stay with us for a week in [every] month to work with us, [and work] beside us. This is the number one support for us here. In the beginning, we had some fear to be away from our tutors, but Hanna, she helped us in some of the things we were still building confidence in, [such as] using the vacuum (for assisted births), neonatal resuscitation and breech. We know these things and got [sic] some good practice when we were students but still we need some more
>
> Having our mentor here made us strong. We are more confident and the people see our skill and we help save mothers and babies and they trust us. Hanna has also helped our

> friend who is working with us but came from another midwifery school. She did not have the same chance as us in the school and clinical attachment. She did not have the chance to practice skills using the models and only did a little practice in the clinical place. She had only a small number of births before she graduated. We are stronger and are helping her to learn and Hanna is also teaching her when she visits us

Hanna is an experienced midwife from the regional centre, Bahirdar and has been the midwife mentor for the Amhara region for more than 6 years. Employed by the Hamlin College, Hanna travels around the rural areas in her region to stay with, work alongside and mentor Hamlin 'new graduate' midwives. The midwives are also able to call Hanna for advice when she is not with them.

> We also go into the villages and give health education; in the market place on market day and in the high school. We did that (going around the villages) more times [more often] in the beginning because we had the time, and Hanna came with us to help us. Now it is difficult because of the work but still one of us will go, maybe once in a month. The [school] students and people who hear our message then talk to their parents and families and some of the people come [to the health centre] because they heard about us from this community outreach.

Aside from conducting births, the small team of midwives also provide antenatal and postnatal care and family planning services. Tinadem proudly showed me around the small facility. There was a well-organised antenatal clinic where the midwives had recycled cardboard boxes to create dividers and labels for the records. They were kept neatly on shelves made from bricks and planks of wood. The birthing room was basic but clean with a sterile 'delivery set' ready for use.

Tinadem proudly pulled out a plastic covered mattress that she said they were using increasingly for births on the floor rather than making women lie on the small birth bed with their legs in stirrups. Empowering women to choose how they want to birth is very new for births conducted in a health facility in Ethiopia. The young midwives were excited that they could accommodate traditional expectations and felt strongly that this was drawing mothers to the health centre where they felt safe and well cared for.

> The mothers are happy to deliver their baby by squatting like they do in their home. This makes the old women - the grandmothers, happy too because it is traditional. Also they can make their traditional porridge in the kitchen which is important for them to feed the mother after she has given birth'. Some of the other staff don't like this and they tell it's not good, they don't think it can be the modern way but we support it, we can still do our work and the women are happy.

The midwives had converted a storeroom into a separate consultation room to provide privacy for women seeking family planning information and services. During the previous year the midwives had conducted more than 2000 antenatal checks and more than 1300 family planning consultations (Bennett 2017).

5.11 Hope for the Future

Investment in midwifery in Ethiopia, directly into building the capacity and quality of midwifery programs, has had a positive effect in growing the numbers of midwives over the last 5–10 years. Large amount of support has been contributed to supplying textbooks and simulation equipment to teaching hospitals and universities as well as the training of educators (FMOH and UNFPA 2014). Three key initiatives that improve the quality of midwifery education and deployment (pioneered by the Hamlin College of Midwives) have been embraced nationwide and are having an impact on successful midwifery education and deployment; Firstly, the FMOH has supported midwifery educators to be trained in innovative teaching methodologies such as enquiry based learning and for programs to become more competency based with increased expectations on graduates to acquire fundamental competencies throughout their learning experience and as a requirement for graduation (Bennett 2014; Abebe 2018). Secondly, the FMOH has implemented a policy that midwives be deployed to rural areas in teams of two, at a minimum, and not a sole midwife as in the recent past (Bennett 2014; FMOH and UNFPA 2014). Thirdly, the FMOH has installed experienced midwife mentors throughout the regions to support new graduates, focusing on supporting new midwives working in rural and remote areas (FMOH and UNFPA 2014, p. 8; Abebe 2018).

5.12 The Future Is in the Hands of Midwives Like Tinadem

After asking permission Tinadem showed us into the postnatal room where a new mother was being assisted by another midwife while breastfeeding her new baby. Tinadem introduced us to the mother and the grandmother. Both women praised the care of the young midwives. The older woman explaining that they were happy for the care that they received from the midwives,

> These are our daughters and they know well how to care for us and even stop the mothers from dying.

The grandmother raised her hands in the air and in a typical traditional way, thanked God, for blessing their family, for the midwives, for her new grandchild and asked for a blessing to be given to the midwives (Bennett 2017).

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Midwifery in Germany: Practice, Education and Transition for Newly Qualified Midwives

6

Marina J. Weckend

6.1 Introduction

Around the world, midwives support women and families during an exciting and vulnerable time of their life. Although there are general aspects of midwifery, such as the support during labour and birth, the scope of practice differs greatly between countries and regions around the globe. The education of midwives also varies, with the aim to prepare aspiring midwives successfully for their work environment. Despite this, there might be a little (or larger) gap between what students are taught and what they will be confronted with as junior midwives. This chapter presents insights into midwifery practice and training in Germany and illustrates how junior midwives in Germany master the transition from student to midwife. The chapter will commence with some background information about Germany to provide the context to midwifery. It will then present the scope of maternity services and the variety of educational pathways which lead to registration as a midwife in Germany. At the end, one midwife illustrates her own transition process as a newly qualified midwife.

6.2 Background

Germany has borders with nine other European countries and a small coastal line in the North, with a total area of approximately 357,000 km^2; you could place the whole of Germany into the Australian state of New South Wales—twice. On the other hand, with a population of over 8,300,000, Germany is on average 75 times more densely populated than Australia and has a higher average population density

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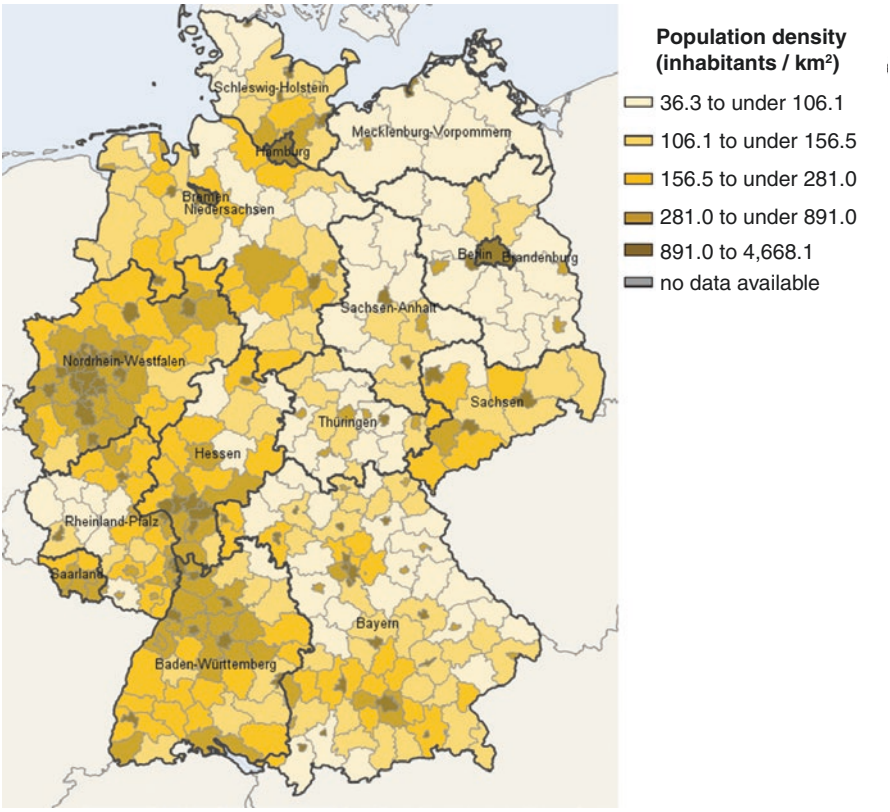

Fig. 6.1 German federal states and population density (2014)

than any Australian territory.[1] The ethnicity of the population in Germany is predominantly white European with about 20% of the population having a background of migration.[2] Population growth is at 0.4% with a live birth rate of approximately 800,000 children annually (Destatis 2019). Throughout the past two decades, the birth rate continued to increase at a slow rate (Destatis 2019). The perinatal maternal mortality rate is very low at approximately 0.002%; the perinatal neonatal mortality is at 0.50% (IQTIG 2018).

The population age pyramid in Germany has the typical contractive shape of an industrial country and resembles the age distribution of the Australian population. Germany has no single area where the population density or economic activity concentrates but a number of densely populated urban areas across the country, including the metropolis of the Ruhr region in the West and conglomerations around larger cities such as Munich or Hamburg (Fig. 6.1).

[1] The Australian Capital Territory counts approximately 167 inhabitants/km^2; German average is 232/km^2.

[2] Including German reimmigration.

The country is divided into 16 federal states, which is important when we look at differences in midwifery regulations and healthcare provision across the states. Furthermore, for historical reasons, there are differences between the former East and West states in terms of population attributes, birth rate and healthcare. This resulted from a separation of the country between 1949 and 1990 with the West states being under Anglo-American and French influence and the East states being under Soviet influence. Despite reconciliation of the country in 1990 and government programmes to support a distribution of wealth, many differences between the former East and West states persist to date. For example, the East states have a significantly lower rate of caesarean sections when compared to the West states (Destatis 2015).

Bearing these demographics and geographical differences in mind, let us have a look at the provision of maternity services and midwifery in Germany.

6.3 Maternity Services and Midwifery in Germany

Maternity services in Germany are largely provided by midwives and gynaecologists with only few exceptions (e.g. general practitioners can provide antenatal care but only do so in exceptional circumstances particularly in rural areas). In the following, the common pathway of a pregnant woman through German healthcare system will be described with a focus on the legislation related to the regulation of midwifery in this country.

6.3.1 Antenatal Care

The majority of women find out about their pregnancy with the help of a self-administered pregnancy test. The typical first step after this is to contact a gynaecologist[3] or (less commonly) a midwife to book antenatal care. The vast majority of women will receive antenatal care through their gynaecologist or shared care by a gynaecologist and a midwife. Fewer women, frequently multiparous, access only midwifery care in their pregnancy. The legislation around antenatal care in Germany is somewhat conflicting. The national midwifery law declares midwives as the main primary care providers in pregnancy, during labour, birth and in childbed (Hebammengesetz 1985). It states that midwives should refer care to a medical specialist only in case of suspected pathology. The normal process is to refer the client to a gynaecologist or to another medical specialist, depending on the nature of pathology. In addition to national law, each federal state has its own midwifery regulations with mostly similar content but minor variations in the responsibilities and authority of midwives. Generally, both German national and federal state legislation promote midwifery as primary care for pregnant women. In contrast to this, the most widely accepted guideline for antenatal care in Germany

[3] In Germany, gynaecologists have specialised in women's health including obstetrics. There exists no separate specialisation for obstetric medicine.

(Mutterschaftsrichtlinie) is directed to doctors and states the following: "[Antenatal] examinations […] can also be carried out by a midwife within her respective qualification […] if the doctor ordered this in individual cases or when the doctor has diagnosed a physiological pregnancy and therefore holds no reservation against further antenatal care by a midwife. The delegation of examinations to a midwife does not release the doctor from his/her responsibility to carry out the examinations which necessarily have to be carried out by doctors […]" (Mutterschaftsrichtlinie 1985). The guideline was published in 1985 by the Federal Joint Committee (Gemeinsamer Bundesausschuss, GBA) and has been last amended in April 2016. To date, there is no other general guideline on antenatal care in Germany. The position adopted by the existing maternity guideline is in contrast to national and federal state legislation. However, due to the value of the document in litigation affairs, it has become common practice that gynaecological care is the standard and antenatal care by midwives is (frequently) seen as an additional option. This misconception is shared by many women and healthcare professionals. In addition, a common source of confusion and conflict of women receiving antenatal care is that some gynaecologists actively discourage women from seeking midwifery care. As previously mentioned gynaecologists are the most common point of entry to maternity care, and therefore, if they withhold information about midwifery services or discourage women to use these, women are easily influenced to remain in gynaecological care throughout pregnancy. Several studies which explored women's experiences of maternity care in Germany found that women frequently complained about inconsistent information surrounding the professions providing antenatal care but also a lack of inter-professional collaboration (Baumgärtner and Stahl 2011). Therefore, those women who rely on antenatal care solely or largely by midwives are frequently multiparous and often have learned about antenatal midwifery care only at a later stage of their previous pregnancy.

Finally, in addition to national and federal state legislation and next to medical guidelines, the fee structure of health insurance companies shapes the daily practice of antenatal care provision. All insurance companies cover antenatal care by gynaecologists or midwives (or both). At the same time, midwives are subject to increasingly strict regulations to prove their service provision and quality management. For instance, midwives must collect signatures from women for every contact they have, and they must use contracts governing medical treatment for every client. In general, this might be a good tool to prevent insurance fraud and to ensure a high quality of service. At the same time, these strict regulations only apply to midwives and not to gynaecologists, which leaves an unpleasant slant on the side of midwives and women.

Overall, international evidence which recommends placing midwives at the centre of antenatal care has had little influence on the German healthcare system to date. There is a call for new evidence-based guidelines, but these are still in the planning and development stage. In the meantime, the German Society of Midwifery Science (DGHWi) was established in 2008 and promotes the position of midwifery and evidence-based maternity care in political discussions, inter-professional discourse and medical guidelines.

6.3.2 Labour and Birth Care

In Germany, midwives are the primary care providers during labour and birth. National law requires a midwife to be present at all births, irrespective of the mode of birth or the level of physiology or pathology. Midwives must involve a medical specialist (usually a gynaecologist) in case of pathology. When a gynaecologist is involved, the midwife steps back to an assisting position and is subject to the orders of the gynaecologist. However, midwives must remonstrate if they judge the proposed medical action as being not evidence-based or harmful. When the pathology is resolved, the care responsibility returns to the midwife. There is little room for misinterpretation of this law. At the same time, the practice of labour care provision differs greatly depending on the employment mode of the midwife. Women in Germany are free to choose between a birth in a hospital setting, in a midwifery-led birth centre or at home. Hospital settings again differentiate between (common) medical-led models and (rare) midwifery-led models of care. In 2017, approximately 98.7% of women gave birth in a hospital, 1.3% of women gave birth in a midwifery-led birth centre or at home (QUAG 2018). When comparing these different care settings, there exist differences between the demographics of women, the intervention rates, outcomes and satisfaction of women and midwives. A detailed discussion of these differences would go beyond the scope of this chapter.[4] In terms of legislation, it is important though to look at the different models of employment for midwives. Therefore, the following two paragraphs will look at legal differences depending on the setting and employment type of midwives who provide labour and birth care.

6.3.2.1 Hospital Settings

Women who wish to give birth in a hospital may use one of three different models of care depending on the local availability. The options include obstetrician-led care, midwifery-led care and "external midwifery". The last model is also midwifery-led but with the exception that midwives who provide this kind of service are not employed by the hospital. This will be later explained in detail. In an employment model (both obstetrician-led and midwifery-led), midwives care for women "as they come in". There is no intended continuity of care, and the midwife is responsible for the woman in labour only "from door to door", hence from point of entry to the labour ward to transferral to postnatal ward or home. Furthermore, midwives work in shifts of varying lengths and care for as many women in labour as present at any given time, ranging frequently from one to four labouring women (but can be more in busy times).

To start with, obstetrician-led care in hospitals is most common. Internal hospital guidelines are developed by doctors or together with midwives. Sometimes, hospitals have no internal guidelines, which means that every woman that comes in may

[4] Recommended literature: QUAG, 2018: Quality report about out-of-hospital labour and birth in Germany (partly in English), available under: http://www.quag.de/quag/publikationen.htmhttp://www.quag.de/quag/publikationen.htm.

receive a different type of care depending on the skills and preferences of the doctor on shift. In obstetrician-led labour wards, doctors are, to a certain extent, involved in the labour care of every woman. Midwives often work as assistants for doctors and carry out their orders. Although this type of collaboration is not always specified in internal hospital regulations, it is common practice. Due to time constraints and staff shortages, individual midwifery tasks may be delegated to other professionals; e.g. doctors may suture perineal tears, or paediatricians may carry out the newborn examinations. While there is a large variety in the responsibilities and authority of employed midwives in labour wards, the national legislation remains the same: midwives are supposed to be the main care provider during labour and birth and must transfer care in case of pathology. Overall, the employed midwife must comply with national law, federal state law and internal hospital regulations, which occasionally might be in conflict to each other. Finally, next to legislation, the fee structure of health insurances has a great influence on daily practice in labour wards. Throughout the past decades, the existing fee structure and growing staff shortage have led to increasing intervention rates, higher rates of caesarean sections and a high probability of a labour that started off physiologically to "turn pathological" in hospital. This mechanism is known for years and not an exclusive characteristic in Germany, so it will not be discussed in detail in this chapter.

Instead, we will move to the second model of hospital care: midwifery-led labour wards. They are called "Hebammenkreißsaal" ("midwives' labour ward") and less frequent than obstetrician-led models. Within these models, internal hospital guidelines are developed mainly or with greater involvement of midwives. They frequently embrace a salutogenetic perspective on labour and childbirth and encourage what is frequently called "normal" labour and birth. Midwifery-led labour wards often have significantly lower intervention rates than obstetrician-led models and a higher rate of physiological births, but they also have a selected clientele that invariably presents without pathology at the start of labour. Doctors are not commonly involved in the care of women in this model.

Finally, opposed to an employment model, midwives can provide labour and birth care in hospitals while being self-employed (or "independent"). This is called "Beleghebamme" (external midwife[5]) and requires a contract between the hospital and the midwife regulating their cooperation. Typically, an external midwife provides continuity of care including antenatal, labour, birth and postnatal care. At hospital, external midwives can practise largely independently from the internal hospital regulations (but always within national and federal state law). Hence, they may decide not to carry out standard clinical procedures (e.g. routine insertion of an i.v. line), they always provide one-to-one care and their type of care often tends to be less medicalised than the hospital standard.

6.3.2.2 Birth Centres and Home Birth

Midwives who provide out-of-hospital births are largely self-employed but may work in an employment model if the birth centre or midwifery practice has an

[5] There is no standardised English term for this model of care, but it is sometimes called an "attached midwife" or "external midwife".

employer-employee structure. This type of care is always midwifery-led and frequently follows a continuity of care model. The applicable legislation is the same as for all other midwives. However, in addition, midwives providing out-of-hospital births must maintain an extensive quality management outlining their interprofessional cooperation, their standards and risk management, and they are subject to external review by representatives of the Federal Joint Committee (GBA). In a variety of aspects, out-of-hospital services may be more evidence-based than hospital services (e.g. they have significantly lower intervention rates, often provide one-to-one and continuous care, significantly less frequently make use of episiotomies or the Kristeller manoeuvre), and there exists high-quality data on this area of maternity care. However, the different demographics compared to women giving birth in hospitals (e.g. age and parity) needs to be considered when evaluating these models of care.

Overall, currently there exists no evidence-based national guideline on the provision of labour and birth care (either in hospital or out-of-hospital), and therefore the types of care, level and type of interventions and responsibilities and authority of midwives vary greatly across different regions and settings. Hospitals are the main place of birth for the vast majority of women in Germany.

6.3.3 Postnatal Care

Postnatal care usually takes place at the family's home, except for the first few days, when the family is at a postnatal ward in hospital. Midwives are the main care providers in this time with one exception. In hospitals, postnatal wards may be staffed with midwives, nurses and paediatric nurses in varying ratios. National and federal state legislation name the midwife as the primary care provider in the postpartum period. Again, day-to-day practice is influenced by the fee scheme of health insurers. Here, midwives and families in Germany are in an excellent position when compared to other countries, as postnatal care can comprise numerous home visits throughout the whole duration of the breastfeeding period. It does not matter, whether breastfeeding is stopped after a few days or after several years; the woman remains eligible for midwifery care throughout this time, which is covered by insurance. Midwives' care for families is on-demand; hence, the frequency of visits varies. Overall, midwives can charge up to 20 visits in the first 10 days, additional 16 visits up to 3 months and thereafter further 8 visits until cessation of breastfeeding or until 9 months postpartum, whichever is later. Again, midwives refer to medical specialists, mostly gynaecologists or paediatricians, when pathology is suspected.

6.3.4 Who Pays for Midwifery Care?

In Germany, it is compulsory for all public health insurers to cover the cost of midwifery care, including antenatal care, labour and birth support, postnatal care, birth preparation and postnatal fitness classes. This also includes recently immigrated

families, refugees, asylum seekers and "undocumented"[6] women and families (programmes providing anonymous care and birth services exist). Midwives' fees are prescribed in fee regulations, which may vary slightly across federal states. Many insurers cover extra services for their clientele for promotional reasons, for example, additional specialised counselling through the midwife. Generally, all women in Germany can have their maternity service costs covered, with few exceptions. One exception are women who have a private insurance that excludes some maternity services (but always must cover the basic care). Another exception is of practical and not legal nature: midwives who offer out-of-hospital births frequently charge an on-call fee roughly between 150€ and 500€ ($230–770 AU). Insurers are not legally bound to cover this fee, and some do cover the whole or part of this charge on a voluntary basis.

6.3.5 Current Hot Topics in Midwifery in Germany

A number of topics around midwifery are intensively debated at the moment. One continuous hot topic throughout the past years are the rapidly rising fees for professional indemnity insurance. Independent midwives who provide labour and birth care are most severely affected by this development. In the past years, this has caused many midwives to suspend their provision of labour and birth care. Currently, both rural and urban areas see a significant shortage of midwifery services. As an effect, it became very challenging for women and families to find a midwife who provides out-of-hospital births or clinical births in an external midwifery model. Therefore, women's choice of their birth place and circumstances are severely diminished. On top of decreasing opportunities for out-of-hospital births, existing hospitals with maternity units are at risk of closure due to economic constraints and a trend towards centralised service provision in fewer and therefore larger maternity units. The German Midwifery Association (Deutscher Hebammenverband, DHV) has launched a campaign where women can report if they were unable to find a midwife in their region (Fig. 6.2) or if a maternity unit in their area was recently closed (Fig. 6.3). This information is mostly used for awareness raising about the urgency of this problem, and is not designed to help women to find a midwife.

Next to a lack of independent midwives, most hospitals face a staff shortage with difficulty to recruit new employed personnel. Midwives who work in labour wards in hospitals frequently complain of issues resulting from staff shortage, such as a high workload, strong economic pressure, time constraints with no ability to take breaks and frequent overtime. Overall, there is significant job frustration, and for a number of midwives, this has led to quitting their profession altogether or discontinuing some parts of their services and reducing their overall hours in the job (either employed or independent). Nationwide, there is an acknowledgement of a shortage of qualified midwives. This also impacts on the current education of new midwives, as will be explained below.

One final hot topic in midwifery in Germany is the current transition of the midwifery education, which will be elaborated in the next paragraphs.

[6] The term, undocumented migrants, describes people who live in a country without the awareness or approval of the authorities. Sometimes this group is called "illegal" (im)migrants.

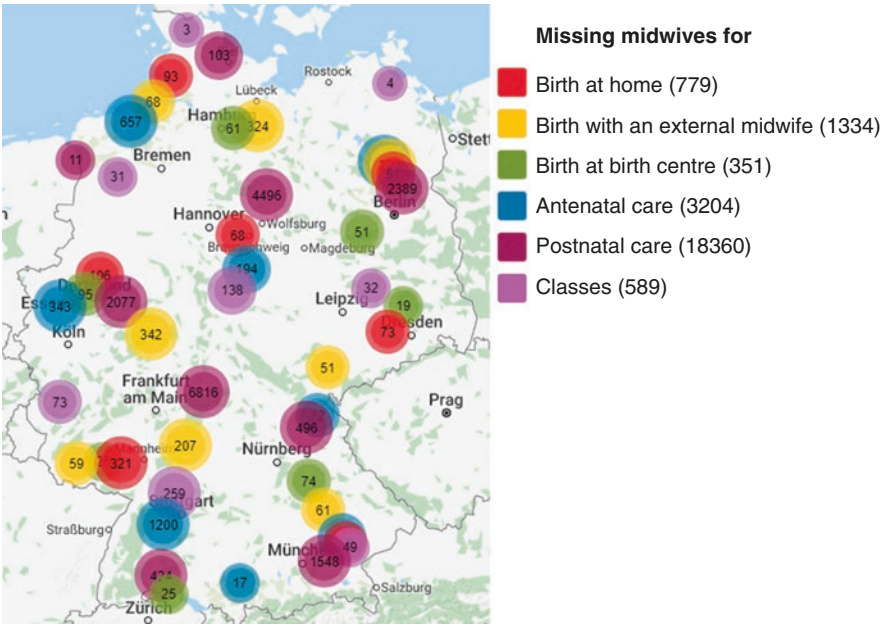

Fig. 6.2 Map of undersupply of midwifery services (DHV 2018). Available at: www.unsere-hebammen.de/mitmachen/unterversorgung-melden

Fig. 6.3 Map of closure of labour wards since 2015 (DHV 2018). Available at: www.unsere-hebammen.de/mitmachen/kreisssaalschliessungen

6.4 Midwifery Education

Currently, the German education system for midwives is in the middle of a transition process. Aspiring midwifery students have two options to gain eligibility for registration as a midwife. One option is the traditional state exam after 3 years of apprenticeship, and the other option is a bachelor's degree after 3–4.5 years of studies. Both options qualify for the same profession and will be outlined briefly.

6.4.1 State Exam in Midwifery

This traditional form of education prepares students in a standardised 3-year programme for the state exam. The 1981 established *Education and Examination Act for Midwives* ("Ausbildungs- und Prüfungsverordnung") prescribes a ratio of 3000 h of practical training and 1600 h of theoretical training. The act defines the areas of theoretical and practical education. Figure 6.4 illustrates the composition of the practical training. Within the scope of this Act, the focus of theoretical training and the individual practical placements may vary slightly across institutions.

External accreditation of midwifery schools is carried out by the individual Federal State Boards of Education ("Landesschulbehörde") to ensure compliance with the Education and Examination Act and other legal requirements. Usually, accreditation is carried out when a new school is established, and schools only apply for continuing reaccreditation if they make major changes, for example, in the staffing level, number of students or the available teaching facilities. Midwifery schools are formally attached to a hospital, and students' practical placements frequently take place in this hospital. However, schools are free to collaborate with any number of hospitals, practices and independent midwives and may send their students to any

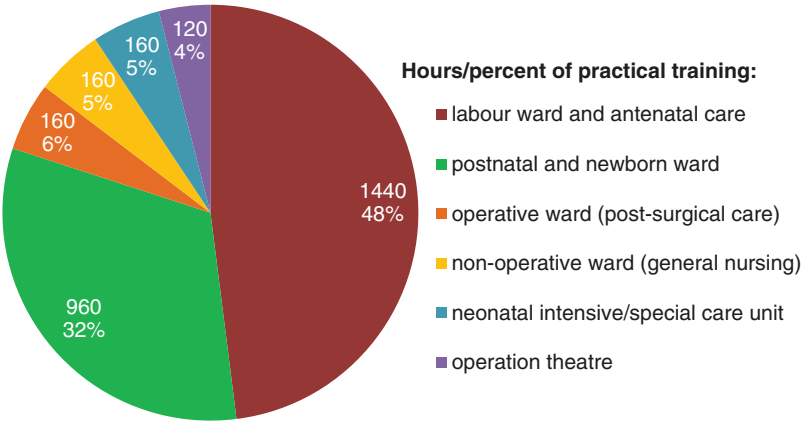

Fig. 6.4 Practical training of students as per German Education and Examination Act for Midwives (1981)

collaborating institution or midwife. New collaborations must be accredited by the Federal State Board of Education and must satisfy certain criteria, such as a qualified mentor and sufficient opportunities for students to gain experiences. Opposed to many other countries, the German healthcare system is not divided into public and private institutions. Instead, the same institutions provide different levels of care depending on the client's type of insurance. Therefore, midwifery students by default experience both public and private care.

After successful completion of the 3-year training and the final exams, students are awarded the state exam and receive a certificate that allows them to carry the occupational title midwife. Instantly, they are entitled to commence employment and to offer independent midwifery services.[7] There is no legal requirement for post-training supervision prior to practising as a midwife. However, it is common that junior midwives have some form of support in this transition phase, which will be described later.

6.4.2 Bachelor in Midwifery

In 2009 the national midwifery law was supplemented with a clause to instal model programmes for midwifery education at universities and universities of applied sciences (UAS). The aim was to pilot new university programmes to achieve a bachelor's degree in midwifery. Since then, several universities and UAS established programmes for midwifery students either offering primary qualification directly through the university/UAS or as mixed models in a collaboration with existing midwifery schools (dual training). The specifics of dual training will be outlined on page 17. Overall, a variety of different models are being tested; hence, these programmes vary in length, volume of work, structure and awarded title. The programme length, for instance, varies from 3 to 4.5 years. The total volume of work is expressed in ECTS (European Credit Transfer and Accumulation System), where one ECTS translates to roughly 25–30 h of work. Currently, midwifery students may study programmes with a work volume between 180 and 240 ECTS. Both degrees, the Bachelor of Science and the Bachelor of Arts, co-exist. Despite this variety of different programmes for midwifery students, all programmes must comply with the Education and Examination Act for Midwives. Therefore, the ratio of practical and theoretical training as well as the topics of studies are largely consistent. Universities and UAS do use a modular structure for their programmes, which is not necessarily the case in many midwifery schools, which traditionally structure their programmes rather by topics or areas of teaching. This is relevant when we look at mixed models in the so-called dual training.

[7] With one exception though, independent midwives can only charge midwifery services with health insurance companies, if they can attest to have been supervised for 480 h in community care, regardless whether this was a part of their midwifery training or if they were supervised after graduation. Most midwifery schools include 480 h or less in the training (in the curriculum, these hours are partly deducted from "labour ward and antenatal care" and/or "postnatal and newborn care".

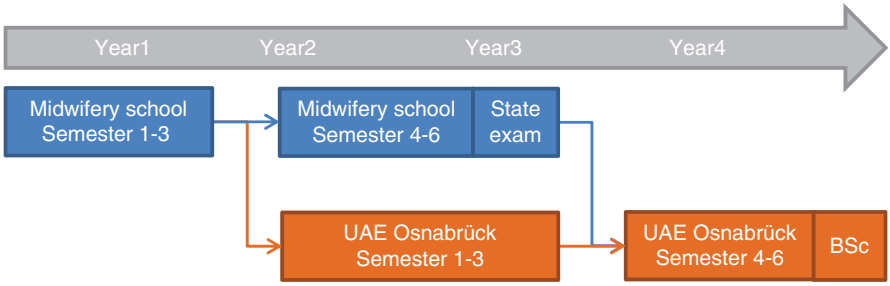

Fig. 6.5 Dual programme of study at the UAS Osnabrück and collaborating midwifery schools

6.4.3 Mixed Models (Dual Programme of Study)

In general, dual programmes of study in Germany comprise both theoretical and practical training. This system is sometimes called cooperative education as it implies the cooperation of two institutions, each adding a different component to the overall programme. In a dual programme of study, midwifery students are therefore enrolled at a midwifery school and simultaneously enrolled at university or UAS. The first programme of study for midwives established in Germany was a dual programme of study in Osnabrück. Figure 6.5 shows the programme structure at the UAS Osnabrück to illustrate one example of dual studies.

The institution collaborates with 25 midwifery schools across Germany, who teach part or all their content at bachelor level. All collaborating institutions use the same or a very similar modular programme structure and provide standardised performance records for their students. The 3-year apprenticeship at collaborating midwifery schools is then automatically accredited by the UAS Osnabrück and counts towards the overall study ECTS. Midwifery students, who did not learn at collaborating midwifery schools, also have the option to join the programme by certifying a certain amount of work experience and may skip the first three modules by passing an equivalency test. Overall, this is only one example of a dual study programme, and due to the ongoing transition process, existing programmes differ significantly from each other.

6.4.4 A Glimpse into Future Midwifery Education

The EU directive 2013/55/EU agreed on 20 November 2013 that all midwifery education throughout the European Union must be offered at a level corresponding with the European Qualifications Framework (EQR) level 6 by 18 January 2020, which equals a bachelor's degree at university level. Across the EU, 27 countries already teach midwifery at the required level, only Germany still has to change its educational system accordingly to implement this directive. Therefore, currently, there are intensive efforts across Germany to develop new and enhance existing

educational pathways for midwives. The German Midwifery Association (DHV) promotes this development and informs practice, stakeholders and politics about sensible steps on the way to achieve this goal. At the same time, there is professional and political debate about whether all midwives should be trained at EQS level 6 or whether both training options (apprenticeship at EQS level 4 and bachelor's degree at level 6) should co-exist in the future. Decisions about the education system are reached independently by the 16 federal states, and it is likely that there will be a certain transitional period beyond 2020.

6.5 Initial and Ongoing Registration as a Midwife

Midwives who wish to practise in Germany must register with their local public health office. This applies to all midwives and is defined in the national and federal state midwifery laws. However, there is no central data matching of public health offices at national or federal state level, and it is therefore not possible to state how many midwives practise in any given area in Germany. A recent study aiming to examine the midwifery workforce in the urban area of Hannover found that only about 80 midwives were registered with their public health office at that time. However, through comparison with other registries, such as the members' list of the Germany Midwifery Association (DHV), and through snowball sampling, close to 300 midwives offering their services were finally identified (Scholz 2017). The study raised awareness of the legal requirement for registration at a local level, but it remains likely that a considerable number of midwives practise without the required registration at their local public health office.

Next to the legal requirement for registration, midwives may enter a professional midwifery body on a voluntary basis. The largest professional body representing the interests of midwives is the German Midwifery Association (DHV) with currently about 19,000 members. Next to it, midwives may join a range of other smaller professional bodies.

Currently, there is a call to set up a national or federal state professional council for midwives comparable to the NMC in the UK or the AHPRA in Australia (Hebammenkammer, 2019). For the nursing professions, a council has been set up recently, and it is likely that similar developments will lead to the creation of a midwifery council in the near future.[8]

6.6 Transition of New Midwives After Registration

Following the graduation as a midwife, either with a state exam or with a bachelor's degree, junior midwives are immediately eligible to offer midwifery services on an independent basis or to enter employment. The transition from being a student to

[8] Current developments are reported online at: hebammenkammer.org.

becoming a midwife can be challenging, especially due to a significant theory-practice gap. Students are taught to practise responsibly and autonomously at current evidence-based level and may then enter positions where their practice is mandated by others (especially, when they enter an employment in an obstetrician-led hospital unit). In contrast, midwifery students spend a considerable amount of their practical training in a hospital setting, and students rarely feel prepared for the challenges of independent practice. When junior midwives enter employment, their employer may or may not provide a period of orientation. The duration and content of an orientation are not prescribed on a national or federal state level and may vary significantly. Most employment contracts specify a probation time with a shortened period of notice for both employer and employee. Junior midwives, who commence independent practice immediately after their graduation, often seek support from experienced colleagues. This may include a basic introduction into independent practice, work shadowing or supervision. In the following, one midwife describes her transition from trainee to midwife.

6.6.1 Annika's Experience of Her Transition from Student to Midwife

When I completed my training as a midwife with a German state exam, I decided that I wanted to provide the full spectrum of midwifery services, including antenatal counselling, labour and birth support, postnatal care and classes. I found that working as an external midwife would provide me with excellent opportunities to practice. The step from trainee to independent midwife was challenging, but I welcomed the experience and I had substantial support helping me to master this transition. During my apprenticeship, I trained at an obstetrician-led hospital with 1400 births per annum. I spent a total of eight weeks of my training in placements shadowing independent midwives in their community work. Of these, I spent six weeks at my future work place, which inspired me to become an external midwife. Having had the opportunity to shadow my future colleagues during my training was important to me as it helped me to envisage my future work place.

The setting in which I started to work, was a small hospital with no attached Neonatal Intensive Care Unit (NICU) and therefore we had a clientele, which presented mostly with physiological labour. At the time when I started, the hospital had around 650 births per annum and we were a team of 9 midwives, all self-employed, but working in close collaboration with the clinic. Three senior midwives were in charge of the team; they wrote the roster, ensuring that the labour ward was always staffed. We worked in 12 hour shifts and the hospital relied on our services as they had no employed midwives of their own. We were usually alone on the shift and after graduation I spent one month shadowing the senior midwives and working under their supervision to get accustomed to the standard procedures and internal hospital guidelines. As I was self-employed, during this month I did not earn any money. After this orientation period, I was assigned to my own shifts. At first, this was a little frightening, but I soon learned, that I could always call my senior colleagues or consult with a doctor, if I had questions. In addition to my work in labour ward, I provided antenatal consultations; antenatal and postnatal classes and community based postnatal care for those women who I had cared for during labour. I feel that my training had well prepared me for this part of my job. My colleagues also trained me in the administrative part of my work, namely in billing, accounting and organisational aspects. I often worked around 50 hours a week and quickly gained experience. When I look back, I feel that I had sufficient opportunity for supervised practice and I felt safe to do my own first steps as a midwife, because I knew that I could always call and rely on my colleagues.

6.7 Conclusion

Midwives in Germany have a broad scope of practice and numerous opportunities to shape their own practice. They may work in an employment or independently, in obstetrician-led or midwifery-led models, on rotating shifts within contracts or always on-call, providing continuity of care to women and families. The education leading to this profession is currently in a transition process. Aspiring midwives have the choice to do a state exam at a midwifery school, to study at bachelor's degree or to engage in a dual programme of study, comprising the benefits of both training models. For transition to practice, many different support mechanisms exist, helping to prepare students for the challenges of their role. Midwifery in Germany, currently, is on a journey: it faces a number of challenges with a general undersupply of midwives, staff shortages and increasing insurance fees. The future is likely to bring a new and more consistent educational structure, a regulatory body for midwives and, every day, an increasing implementation of evidence into practice.

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The Transition of New Midwives into Registered Practice Within Hong Kong

7

Wai Lei Hau and Wai Ki Lam

Abstract

Hong Kong is a Special Administrative Region of China, with a population of 7.3 million. Despite of the crowded living condition, it now enjoys a very low mortality rate and the highest life expectancy rate in the world. This success is tribute to a high-quality health-care system, including the maternity services. In Hong Kong, the Midwives Council of Hong Kong (the Council) is the regulatory body of the midwifery profession. The Council carries out the statutory duties assigned to it by the Midwives Registration Ordinance (Cap 162, Laws of Hong Kong) which include the registration of midwives and the discipline and regulation of the profession. It also sets up standards and requirements for training institute to develop the midwifery training programmes. Currently, the only midwifery training programme approved by the Council is an 18-month Post-registration Diploma in Midwifery conducted by the School of Midwifery in Prince of Wales Hospital. This chapter consists of a brief outline of education and regulation leading to initial and ongoing registration, the transition of new midwives after registration and a reflective experience written by a new midwife.

Keywords

Hong Kong · Midwifery profession and regulation · Midwife education · Midwife registration · Transition of new midwives

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7.1 Background

Hong Kong had been a British colony from 1841 to 1997. With the transfer of sovereignty in 1997, the Hong Kong Special Administrative Region (HKSAR) was established, operating under the unique 'one country, two systems' principle. Under the Basic Law, Hong Kong people continue to administer the city and enjoy a high degree of autonomy.

The current population of Hong Kong is about 7.3 million. The total land area is 1106 km^2, making up a population density of 6780 people/km^2. Despite the crowded living environment, the life expectation of male is 81.3 and female is 87.3 years, ranking one of the highest among the world. The median age is 43.4 years (Health facts of Hong Kong 2017).

7.2 The Health Service Context Within Hong Kong

Hong Kong's public and private medical sectors provide extensive health-care services, including a low-cost public health-care 'safety net' that ensures no one in Hong Kong is denied medical care due to lack of means. The public sector is the Hospital Authority, which was set up and funded by the Government to manage the public health services. By December 2016, the Authority was managing 42 public hospitals and institutions, 47 specialist outpatient clinics and 73 general outpatient clinics (HA Convention 2016).

The high-quality health-care system is supported by a highly professional team of workers. They have worked hard to continually enhance the quality and breadth of the health services to meet the changing needs of the community. It now enjoys a very low mortality rate and the highest life expectancy rate in the world. The infant mortality rate has fallen steadily over the past 20 years, from 4 per 1000 live births in 1996 to 1.6 per 1000 in 2016, one of the lowest in the world. And so as the maternal mortality rate, it has been kept below 5 per 100,000 registered live births over the past 20 years. In 2016, there was no report on maternal mortality (Hong Kong Year Book 2016).

7.3 The Legislation Related to Regulation of Midwifery in Hong Kong

The Midwives Council of Hong Kong ('the Council') is the regulatory body of the midwifery profession. Its function is to carry out the statutory duties assigned to it by the Midwives Registration Ordinance (Cap. 162, Laws of Hong Kong, 2012). Such duties include the registration of midwives and the discipline and regulation of the profession.

7.3.1 Ongoing Registration

Section 22(1) of the Midwives Registration Ordinance (Cap. 162, Laws of Hong Kong, 2012) stipulates that a registered midwife cannot practise midwifery in Hong

Kong unless she is a holder of a valid practising certificate issued by the Midwives Council of Hong Kong. Midwives who are practising or plan to practise midwifery in Hong Kong must renew their practicing certificate every 3 years. The Council Secretariat takes the initiative to remind practice certificate holders 3 months before renewal is due, and the registered midwives should complete the application form and submit with the required fee. Failure to comply will result in the removal of their name from the register, as section 6(3)(b) of the Ordinance states the Council may direct the removal from the register of a midwife's name if they are not practising midwifery in Hong Kong.

Since 2006 the Council has implemented a 'Post-registration Education (PEM) in Midwifery – Pilot Scheme on a Voluntary Basis'. Any registered midwife joining the pilot scheme should undergo PEM worth a minimum of 45 PEM points in 3 years. The scheme has been under review and no mandatory scheme is in place yet.

7.4 An Outline of the Education Leading to Registration as a Midwife

Since 2000, the only midwifery training programme approved by the Midwives Council of Hong Kong is the Hospital Authority 18-month Post-registration Diploma in Midwifery. The theoretical training of the programme is provided by the School of Midwifery of the Prince of Wales Hospital, while the clinical placement will be conducted in the maternity unit of various clinical training grounds approved by the Council. As the programme is a Post-registration Diploma, a person must be a registered nurse in Hong Kong to fulfil the entry requirement of the programme.

On completion of the training programme, the graduates have to attend and pass the Midwives Council examination in order to be eligible for registration.

Currently, the number of midwife trainees is around 80–100/year. The total number of registered midwife with a valid practising certificate is 4611 as listed on the Council website.

The Midwives Council of Hong Kong publishes the following documents in relation to midwifery training:

- A Reference Guide to the Syllabus of Subjects & Requirements of Midwifery Training Program for Registered Nurse (The Midwives Council of Hong Kong 2017a)

This document decrees a set of standards and requirements for a training institute to develop a midwifery training program. The program shall include both theory and practice elements with a minimum of 30% theory and a minimum of 60% practice. The minimum hours on directed study are 480 h and the minimum duration for clinical practice is 46 weeks. The requirements of clinical experiences includes *the conduct of antenatal examination of not less than 50 pregnant women; attendance at not less than 30 cases of labour; personal care of not less than 20 postnatal*

women and their infants; and supervision and taking care of at least 50 women at risk in pregnancy, or labour, or postnatal period.

- Standards for Midwifery Education (The Midwives Council of Hong Kong 2017d)

These standards provide an overview of the requirements of midwifery education to assist education institutes/teaching schools to comply with the standard requirements of the Council. These standards for midwifery education are largely adapted from the Global Standards for Midwifery Education (2010) by the International Confederation of Midwives. Currently, all training school and clinical training sites have met these standards.

According to the standards, 'a midwifery model of care has to be integrated into the curriculum, and it should reflect contemporary knowledge and address current development in midwifery, as well as uses evidence-based approaches'. Thus midwife-led care is highly promoted, and midwives are the main carer of the low-risk pregnant women and collaborate with obstetricians to take care of the high-risk pregnant women. As there is no home birth service, nearly all women give birth in hospitals. Women are given informed choice of their care, and some hospitals have initiated individual care through the use of birth plans.

- Handbook for Accreditation of Midwives' Education Programs/Training Institutes for Midwives Registration (The Midwives Council of Hong Kong 2017b)

This document sets out the framework and procedures for the accreditation system so as to assist the midwives' education programme providers and clinical training sites to comply with the standard and procedure in accreditation or reaccreditation and to guide the Accreditation Committee in the accreditation decision-making process.

According to the Midwives Ordinance, no course of training in midwifery shall be recognized unless it has been declared by the Council in the Gazette as a training school for midwives. All courses need to be accredited before intake of students. Generally, if the education programme met the accreditation criteria, it would be accredited for 5 years in maximum. Upon expiry of the accredited status, the institution has to apply for reaccreditation. To handle applications for accreditation and reaccreditation, the Council has set up the Accreditation Committee (AC) to assist it to carry out in-depth assessment. The AC consists of members from the Council, as well as co-opted members appointed by the Council. Members of AC come from diverse backgrounds, including but not limited to midwives, doctors and other professionals from the public, private and academic sectors to maintain the fairness and objectivity of the accreditation.

- Handbook for Accreditation of Clinical Training Sites for Midwives Registration (The Midwives Council of Hong Kong 2017c)

This document sets out the framework and procedures for the accreditation system so as to assist the midwives' education programme providers and clinical training sites to comply with the standards and procedures in accreditation or reaccreditation and to guide the Accreditation Committee in the accreditation decision-making process.

The accreditation of clinical training sites remains the same as the training institutes. Accreditation and reaccreditation have to be initiated and carried out before commencement of the training.

7.5 The Regulation Related to Initial and Ongoing Registration

As stated in the Handbook for Midwives (The Council 2014), the definition of a midwife is as follows: "A midwife is a person who has successfully completed a midwifery educational programme that is duly recognized in Hong Kong and that is congruent with the Core Competencies for Hong Kong Registered Midwives issued by the Council; who has passed the assessment as stipulated by the Council, and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery".

7.5.1 Qualification of Registration

The Council document 'Information to Applicants Applying for Registration with the Midwives Council of Hong Kong' (The Midwives Council of Hong Kong 2017) has clearly delineated the criteria for initial registration as follows:

A person is not qualified to be registered under the Midwives Registration Ordinance unless the Council is satisfied that the person:

(a) Is a person of good character
(b) Has completed such training as may be prescribed and has passed such examinations as may be required by the Council
(c) Possesses a certificate to practise as a midwife issued by such certifying body

A person who claims to be qualified for registration as a midwife may apply for registration.

7.6 The Transition of New Midwives After Registration as a Midwife

In Hong Kong, all student midwives are employees of the public or private hospitals/institutions. Upon graduation and registration as a midwife, they will be assigned to work in the maternity units as full-time paid midwives.

Currently, there are eight public hospitals with maternity service provision. Each hospital will have its own graduate programme designed to support new midwives in their transition to qualified practice. Mentors are appointed by the hospital to provide supervision for the new graduates. A qualified midwife clinical mentor should be a registered midwife who is currently working in the obstetric department and have at least 2 years post-registration experience in the related area. In principle, all the graduate programmes provide support from mentors, a specific training scheme consisting of different units and in-service training. The length of the programmes varies from a few weeks to a few months, depending on the complexity of the working units. Antenatal and postnatal ward are generally regarded as lower complexity units, while labour ward is regarded as a high complexity unit which requires a longer period of mentoring and coaching.

The objectives of these graduate programmes are to ensure that the new midwives will have the information, resources and support necessary to perform their jobs safely and competently. Mentors are usually arranged on a one-to-one basis, and the pair works together with the new midwife supported by the mentor who provides the necessary coaching and supervision. There is a log book to complete which consists of training items that the new midwife needs to learn or perform. When new midwives are able to complete all the training items, they can work independently. Most graduates will work in one specific area of the maternity units for 1–2 years before they will be rotated to other areas. Some hospitals will encourage the new midwives to attend post-registration training courses like the Advanced Life Support in Obstetrics, Neonatal Resuscitation Program and Crew Resource Management, etc. These training options are arranged on a voluntary basis.

The career ladder for midwives in Hong Kong starts from nurse midwives to advanced practice midwives. Generally, it takes at least 8–10 years post-registration experience. The advanced practice midwives can choose a managerial or a clinical practitioner role for further development. The top of the career ladder is either a department manager or a midwife consultant. Both of which take into account the academic qualification, working experience and the personal attributes of the midwife.

7.7 A Reflective Experience Written by a New Midwife in the First Year of Practice

A reflective experience written by the new midwife, Ms. LAM Wai Ki, Vicky:

> After graduation from the school of Midwifery, I have been working in the postnatal ward of a public hospital. The working environment in postnatal ward is busy but yet fulfilling and satisfying. A midwife has to take care of more than ten pairs of mother and baby. Therefore, immediately after my graduation, I find it hard to manage my duties in an organized way and I can only spare little time to observe mother breastfeeding. Fortunately, I have been able to adapt to my new role in the first 3 months. I have learnt a lot from my seniors and through ongoing practice. Since then, I have had more time learning to help mothers breastfeeding. I enjoy taking care of mothers and newborn babies very much

especially to observe the breastfeeding process. All are amazing and loving. It is a natural and innate behavior, which mother's love turns into food during the breastfeeding process.

I enjoyed working in the postnatal ward as I think it is important and meaningful to monitor mothers' and babies 'condition as well as to help establishing mother and baby relationship right after delivery. I love to communicate and share baby care knowledge with mothers. Most mothers will stay with baby in postnatal ward for 3 days and 2 nights which facilitates the development of good rapport.

Apart from monitoring mothers' and babies' physical condition, my role in the postnatal ward is to teach mothers about baby care and postnatal care knowledge as much as possible before discharge and most important is to enhance bonding and establish good motherhood through breastfeeding. When I observed the breastfeeding process between mothers and babies, I realized every pairs of mother and baby are unique and special. There is no universal breastfeeding education or counselling for them. The breastfeeding knowledge I have learnt in the midwifery programme is just the basic principle which may not be fully applied into clinical practice. Sometimes, I have encountered questions and circumstances which I am not able to tackle. Supervising mother breastfeeding is a process of mutual learning, I give and I take. When I have gone through more and more breastfeeding education and assessment, I discovered my knowledge is inadequate. Therefore, I decided to study lactation consultant courses and apply for the International lactation consultant examination to equip myself with more breastfeeding knowledge and skills as so to help more mothers and babies in future.

Other than daily ward routine, I have to conduct antenatal talks related postnatal and baby care to prospective mothers. I always conduct with pleasure in the interactive atmosphere. All mothers are attentive and eager to learn. I feel warm when I meet these mothers again in the postnatal ward as they are excited and happy to recognize me as the antenatal talk speaker.

I feel blessed to be a midwife. I enjoy being with woman at work. It is always fulfilling and enjoyable to take care of mothers and their precious babies. I have had job satisfaction here, especially at times when I communicate with mothers sincerely with empathy, and they respond to me with positivity and appreciation.

As for future development, I would love to be an all rounded midwife. I expect to be rotated to the antenatal ward as well as the labour ward in the near future to widen my horizon in midwifery career. I wish I could be a midwife who is competent in all aspects of midwifery. Before rotated to other obstetrics wards, I would like to enhance my communication skills as an educator, promotor and carer in the postnatal ward so as to provide the best care to all mothers and babies.

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Midwifery in Iran

8

Esbati Anahita and Salehi-Rad Ameneh

Abstract

This chapter explains about midwifery in Iran. Details are related to the background and definition of midwifery in Iran, the legislation related to regulation of midwifery, the regulation related to initial and ongoing registration, a brief outline of the education leading to the registration as a midwife, the transition of new midwives after registration, and a reflective experience written by a new midwife in their first year of practice. The first section of this chapter is an overview of midwifery background and the significant decline in maternity mortality rate in Iran due to governmental efforts in expanding preventative health facilities across the country. The main focus of the second section is on the legislation, regulation, and essential education related to midwifery in Iran. The third section is related to an experience written by a new midwife regarding all the challenges, barriers, and supports experienced by her during her work at a health-care clinic in Tehran (capital of Iran).

Keywords

Regulation · Legislation · Scope · Practice · Iran · Islamic Republic of Iran

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8.1 Introduction

Iran is a country located in Western Asia and as part of the Middle East having a young population due to the baby boom of the 1970s and 1980s, boosting the rate of population growth leading to a need for providing sufficient and essential maternity health services.

Iran has established an extensive primary health-care network to extend public health preventive services, resulting in a significant decline in child and maternal mortality rates (TorkZahrani 2008). Based on the WHO report, maternal mortality ratio (MMR) in Iran was at 25 per 100,000 live births in 2015 compared to 123 in 1990 (WHO 2015). However, there are no birth centers in Iran, and home birth is illegal due to the lack of a referral system leading to birth only being facilitated at hospitals (TorkZahrani 2008).

For Iranians culturally having children is a great blessing, and midwifery has always been a well-respected profession through history. A midwife is known as *Mama* in today's Iran, while it was known as *Ghabeleh* in the olden times, and this name is still used in some rural areas.

8.2 The Legislation Related to Regulation of Midwifery in Iran

The WHO supports the Iranian Ministry of Health and Medical Education as agreed during the World Health Assembly Resolution 59.27 via regular review of the nursing and midwifery-related legislation and regulatory processes as well as collection and use of related data (WHO 2010, 2017).

The definition of midwife based on the statements of the Iranian Ministry of Health and Medical Education is described below.

Midwife is defined as a graduated individual from a national or a recognized foreign educational center with a bachelor, master, or doctorate degree and has obtained a permanent license of midwifery from the Ministry of Health (MHMEI 2001).

8.2.1 The Regulation Related to Initial and Ongoing Registration

The Iranian Ministry of Health is the responsible authority to develop a national strategy and roadmap for midwives (WHO 2017). Midwives who intend to practice in midwifery must obtain a permanent license of midwifery from the Ministry of Health and registration from the Medical Council of Islamic Republic of Iran because this Council is the governing and supervising body of health practitioners including midwives' registration. Required documents for the Medical Council are described below.

8.2.2 Required Documents for Initial Registration for Midwives

Midwives who want to acquire registration from the Medical Council of the Islamic Republic of Iran must provide two types of documents for this Council. These documents are (1) general documents and (2) specific documents (MHMEI 2000). General documents include (1) three colored photos of the applicant, (2) two copies of their birth certificate, (3) two copies of their national identity card, (4) two copies of specific documents, (5) and recipients for two payments; one is to be paid to the regional medical council of their place of practice, and the other one is to be paid to the Medical Council of Iran (MHMEI 2000). Specific documents include (1) a permanent certificate to practice, (2) Bachelor's certificate, (3) an introducing letter (attached with their photo) in relation to sending them out to the national human resources program, (4) a confirmation letter from the university where they graduated from (attached with their photo), (5) a letter indicating whether they have completed their commitment to the national human resources program or not (they may have receive exemptions for this commitment), and (6) a temporary confirmation letter from the university where they graduated (MHMEI 2000).

8.2.3 Protocols Regarding Registration of Health-Care Professionals Including Midwives

All parts of Iran, except Tehran and other major cities (e.g., Shiraz and Isfahan), are considered as in-demand areas. Therefore, all medical practitioners and health-care professionals including midwives might practice voluntary in such areas to complete their mandatory services for 24 months for the government if they are needed (MHMEI 2000). The reason for the mandatory service is to repay for the support they received from the government during their education. Health-care professionals including midwives are not allowed to continue their services after finishing the 24 months in such centers unless their employment will be approved by the authorized organizations (MHMEI 2000). Married midwives might receive exemption from attending and completing their 2-year mandatory services (MHMEI 2000).

8.3 A Brief Outline of the Education Leading to Registration as a Midwife

It is almost 100 years since the first school of nursing and midwifery was established in 1919 in Iran. Academic nursing and midwifery education has evolved since and particularly after the Islamic Revolution of 1978 followed by the educational reforms in 1980 (WHO 2017). This reform included integration of health-care delivery with medical education as well as the establishment of Ministry of Health and Medical Education, which has been the governing body to train

midwives (WHO 2017). This Ministry delegates the training of midwives to Schools of Nursing and Midwifery that are part of medical universities.

Many universities have been established across the country such as the School of Nursing and Midwifery, Tehran University of Medical Sciences, that was established in 1936 (TUMS 2017). The nursing program began as a 2-year hospital-based diploma and then expanded to a 3-year Bachelor's degree program (TUMS 2017). This was developed to a 4-year Bachelor of Science degree in midwifery (1963), a Master of Science degree in midwifery (1988), a PhD in Reproductive Health (2006), and Continuing Education in Nursing and Midwifery (2007) (TUMS 2017).

The following standards must be met by midwifery students and approved by their lecturers and clinical coaches to ensure compliance (MHMEI 2013). Expected competencies of graduated midwives to meet these standards include professional communication skills, critical thinking, timely diagnosis of risks, resolution skills, analysis of findings and related tests, accurate decision-making based on the available information, counseling and referral, prescription of authorized medications, and follow-ups (MHMEI 2013).

Midwifery certificate to practice may be sought as a diploma (2-year degree), direct entry in Bachelor's degree (4-year degree), or continuous Bachelor's degree (completing 2 extra years of studies after acquiring the diploma degree in midwifery). A student entering direct entry in midwifery is required to pass 130 units in all courses (both theoretical and clinical) to gain Bachelor's degree (MHMEI 2013). These units and related courses as well as hours related to units are shown in Tables 8.1 and 8.2 (MHMEI 2013).

Table 8.1 Name of courses and numbers of units allocated to each course

Name of courses	Number of units
Theoretical mandatory courses (Core)	20
Basic theoretical science courses (Core)	20
Specialized mandatory theoretical courses (Core)	72
Specialized optional theoretical courses (non-Core)	2
Mandatory clinical courses (Core)	16
Total units	130

Table 8.2 Units and related hours allocated to each unit

Name of unit	Hours allocated to each unit (h)
One unit of theoretical course	17
One unit of laboratory-related course	34
One unit of clinical training	51
One unit of birth-related clinical training	72
One unit of clinical training within settings	51
One unit of birth-related clinical training within settings	102

All midwifery students must also participate in a final exam after passing all the essential theoretical and clinical courses and acquiring the required skills (MHMEI 2013). This exam includes all the necessary skills for practicing as a midwife such as pregnancy, birth, prenatal care, gynecology, maternal and children's health, family planning, and infants (MHMEI 2013). A total score of at least 12 out of 20 must be achieved by the student to pass this exam (MHMEI 2013).

8.4 Midwifery Practices in the Islamic Republic of Iran

The midwife is able to provide care for women during pregnancy, labor, and the postpartum period as well as educating them (MHMEI 2001). This definition is very similar to the definition provided by the International Confederation of Midwives for midwives' scope of practice recognizing the midwife as a responsible profession to provide the essential support, care, and advice during pregnancy, labor, and the postpartum period, to conduct births, and to provide care for the newborn and the infant (ICM 2017).

Midwives are also allowed to provide care to newborns, infants, and children less than 6 years (MHMEI 2001). These cares may include prevention, counseling, medical emergencies, diagnosis and treatment of common genital tract diseases, screening for cancers in women, implementation of midwifery emergency intervention in the case of no access to any obstetrician/gynecologist, and patients' referral to hospitals (MHMEI 2001). Preventative care includes diagnosis of high-risk mothers (e.g., diabetes and hypertension) and infants and children (e.g., delays in growth and development). Screening for cancers in women also includes the regular Pap smear test, breast screening checkups, and referrals to GPs and specialists for an early detection of cervical cancer and breast tumors (MHMEI 2001).

In Iran the midwife's scope of practice includes education and counseling for women, families, and community (MHMEI 2001). Education and counseling may be related to the preparation of parents for parenthood, reproductive health, puberty, menopause, risky behaviors that may increase the risk of STI transmission, and premarital and preconception counseling (MHMEI 2001). This role is also extended to the community, and midwives may practice at various settings such as at home, community, hospital, health-care clinic, university, and research center (MHMEI 2001). A midwife's job description during the pregnancy period based on the national regulations is described below.

8.4.1 Providing Care During Pregnancy

A midwive's role may be taking medical and midwifery history, determining the expected due date, conducting physical health assessment, sending requests for pregnancy-related tests (e.g. essential blood tests, radiologic tests, and urine tests

such as urine analysis and culture), and examinations (e.g. pelvic examinations for measuring the size of the uterus if indicated and performing clinical pelvimetry) (MHMEI 2001). Other examinations may include measuring the women's weight, checking vital signs, monitoring fetal growth and heartbeat, and conducting Leopold's maneuvers including measuring fundal height and fetus position and presentation (MHMEI 2001). Required blood tests, which can be requested by a midwife, include RH blood group, CBC-diff, creatinine, GTT, GCT Hb, Hct, HIV, FBS, VDRL, HBsAg, HBsAb, BUN, triglyceride, TSH, cholesterol, anti-measles antibody titer, and indirect Coombs (MHMEI 2001). Requests which may be requested by a midwife for radiologic tests may include ultrasound to check fetal health and growth, placental location, and amniotic fluid volume (MHMEI 2001). A midwife may also prescribe, dispense, and/or administer some medications, which they are authorized to do so (e.g., antibiotic, anticonvulsant, antimalarial, antihypertensive, and/or antiretroviral) to pregnant women in need (MHMEI 2001).

Identifying High-Risk Pregnancies A midwife must also be able to identify high-risk pregnancies and initiate the essential referrals to consult with an obstetrician (MHMEI 2001). Examples of high-risk pregnancies demanding a referral to a doctor may include malnutrition, suspected oligo- or polyhydramnios, molar pregnancy, IUGR, elevated blood pressure, proteinuria, presence of significant edema, severe frontal headache, visual disturbances, epigastric pain associated with elevated blood pressure, vaginal bleeding, multiple gestation, malpresentation at term, intrauterine fetal death, premature rupture of membranes (<37 weeks), HIV-positive status or AIDS, positive hepatitis B and/or C, and history of chronic disease (MHMEI 2001). A midwife must provide care and treatment to this group of mothers as per protocols and doctor's advice (MHMEI 2001).

Providing Education and Counseling During Pregnancy Pregnancy consultation and education provided by midwives for women may include personal oral and dental hygiene, nutrition, warning signs, medication, high-risk behaviors, environmental and occupational risk factors, exercise, importance of physical and mental health, advantages of natural birth, birth plan, disadvantages of unnecessary cesarean surgeries, breastfeeding, care of infant, postnatal care, and family planning (MHMEI 2001). A midwife may also be the responsible health professional for holding pregnancy training and birth preparation classes for mothers and their companions (MHMEI 2001).

The midwife may also provide culturally sensitive care for women who are experiencing particular conditions such as pregnancy termination[1] or fetus loss and inform them of available services, as well as supporting women in their choices about whether to continue their pregnancy or terminate it (MHMEI 2001).

[1] Termination of pregnancy (TOP) is only permitted based on specific grounds and must be approved by related regulations and authorities.

8.4.2 Providing Care During Birth and After Birth

Conducting the essential care during birth is the midwife's duty. Examples of such care are physical and psychological support to woman and families, promoting normal birth, facilitating the presence of a support person, physical examinations (e.g., mother's vital signs and fetal heart rate), abdominal assessment for fetal position and descent, assessing the effectiveness of uterine contractions, IV therapy, life-saving interventions in obstetrical emergencies (e.g., prolapsed cord and shoulder dystocia), referrals, preparing the mother for the cesarean section, and pain management (MHMEI 2001). Pelvic examination should also be performed by a midwife for assessing dilatation, effacement, descent, presenting part, position, status of membranes, and adequacy of pelvis for passing out the baby from the birth canal (MHMEI 2001). The midwife may also request for essential tests (e.g., ultrasound, blood, urine, and fern tests) and may use essential tools such as partogram and/or the cardiotocogram (CTG) to monitor the progress of labor (MHMEI 2001). The midwife could potentially perform venepuncture, induction, and/or augmentation of labor under the supervision of an obstetrician (MHMEI 2001).

Both pharmacological and non-pharmacological methods may be used by the midwife for pain management during labor (MHMEI 2001). Non-pharmacological methods may include massage, aromatherapy, acupressure, intradermal injection of sterile water, thermotherapy, music therapy, and TENS (MHMEI 2001). The midwife may also take care of the woman who chooses to use epidural or Entonox anesthesia under the supervision of an anesthesiologist (MHMEI 2001).

After birth the midwife must be able to perform fundal massage to stimulate postpartum uterine contraction; check the placenta and the umbilical cord for any abnormality and intactness; manage postpartum bleeding and hemorrhage; repair an episiotomy or laceration; provide the birth certificate; provide care after the CS, neonatal care, and assessment; facilitate skin-to-skin contact between mother and newborn; support breastfeeding; manage mother and infant resuscitation; send requests for tests (e.g., Coombs test); perform timely referrals if indicated; prescribe permitted medications according to the instructions; and instruct postpartum rehabilitation exercises to the mother (MHMEI 2001).

The midwife may also be involved in care of high-risk cases (MHMEI 2001). Therefore, she must also give appropriate advice such as kangaroo mother care to mothers of the low birth weight babies (MHMEI 2001). The midwife may also perform cares in emergency situations and non-availability of an obstetrician such as manual removal of placenta and/or curettage in case that the placenta does not exit and/or partially remains (MHMEI 2001). This excludes the use of forceps and vacuum because based on regulation only a midwife with a master's or PhD degree is authorized to use manual or electric vacuum (MHMEI 2001).

8.4.3 Providing Other Types of Care by Midwives

Midwives may be involved in supporting and educating infertile couples, providing premarriage and divorce consultation, and training the public for participation in

reproductive health-care programs such as encouraging men to participate in family planning programs (MHMEI 2001). Vaccinating pregnant women, infants, and children under 8 years old and offering family planning methods such IUD are also included in midwifery care (MHMEI 2001).

8.5 The Transition of New Midwives After Registration as a Midwife

For completing the 24 months mandatory services, graduate midwives are required to apply via related medical universities depending on where they want to lodge their application. For example, if they intend to practice in Tehran, they could lodge an application with medical universities located in Tehran (e.g., Tehran University, Iran University, and/or Shahid Beheshti University). Each university is responsible for supervising health-care facilities located in particular parts of the city and allocated suburbs. After lodging their application, the applicant might be asked to participate in theoretical exams and/or interviews based on the university preferences to be selected for placement. Applicants may apply via a couple of universities simultaneously to gain a placement as soon as possible for them.

After passing the selection criteria, graduate midwives will be sent to facilities such as health-care clinics or hospitals that are in need of staff and are practicing under the supervision of the related medical university. As a start, graduate midwives are required to participate in related training programs and/or workshops such as practicing under the supervision of experienced midwives for a designated period of time (e.g., 2 weeks) to ensure their competence. During their services they are also asked to participate in training workshops held by supervising bodies regularly and at no cost for them to keep their knowledge and clinical practices up to date.

In relation to the transferability of the Iranian midwifery qualification at international level, it mainly depends on the university that the qualification has been obtained from. For example, qualifications obtained at Tehran and Shiraz Universities are internationally recognized in most countries. However, particular standards might be required before applying at targeted registering bodies. For example, a prerequirement to apply for midwifery registration in England for those coming from non-English speaking countries is to pass an English test and achieve the required score in each of the four skills of reading, writing, listening, and speaking (NMCUK 2017).

8.6 A Reflective Experience Written by a New Midwife in Their First Year of Practice

L. S. is a registered midwife who completed her bachelor's degree in midwifery as a direct entry midwife. She lodged her application via the Shahid Beheshti University located in Tehran, covering for some parts of North and East suburbs of Tehran. She passed both theoretical exam and an interview held by a panel of experts. Then, she

was on a waiting list, and it took her few months to be accepted for a placement. Her experience in her first year of practice is described below:

- I was very excited to be able to start my profession as a midwife. First, I was sent to a training clinic for 2 weeks where I was mentored and supervised by two expert midwives before starting my job at the clinic A. They were very kind and patient with me and gave me the confidence to do my job.
- When I started my first day of work it was at a clinic in a family health care centre. I was a bit nervous. The manager of the clinic introduced me to all staff and different sections of the clinic. There was another midwife working at the clinic who was very experienced and had a wealth of knowledge. My duties included routine pregnancy check-ups, family planning, prescribing essential blood tests (e.g. pregnancy related blood and urine tests), routine screening test such as breast check-ups and Pap smear test, referrals, vaccination, providing education (e.g. for mothers and young couples for conception), and referral arrangements for vasectomy and Tubal Legation (TL).
- At our clinic, there were two general practitioners, one specialist psychiatric doctor, one psychologist, a pharmacist, a dentist, three health practitioners; and two of us as midwives. At times, I was very busy and there were long queues waiting at my door, which was very overwhelming. Therefore, the manager made sure that somebody came to help me if they were not busy. It was all about team work, my colleagues were great and we got along very well. I myself also went to help them if they were busy.
- Services provided at our clinic were mostly free of charge or only minimum costs for the patients. For example, all midwifery care was provided for free for women except for the Pap smear test that incurred cost to cover the cost of the lab test. Some women, such as Afghan refugees, were not in a financial position to pay and couldn't afford essential blood tests. Therefore, we referred them to a laboratory where they didn't charge individuals with financial difficulties.
- If there was any concern, my experienced colleagues always advised me to share that information with women. My mentors guided me within their capacity and expertise. Our supervising body was also very supportive and if there was any complicated cases that we were not sure about what to do, they could have been contacted and made the essential arrangements and referrals. They also sent a supervising team to our clinic at a regular basis to check our practices and patients files to ensure that we were performing our duty of care appropriately and based on the protocols.
- There were some workshops held within the supervising office every few months and they asked me to attend those workshops to keep my knowledge up to dated. Information provided at those training sessions was mainly based on the latest recommendations by the World Health Organisation (WHO). I found those workshops very beneficial in improving my knowledge about providing the best evidence based care possible for our patients. It was also very useful to become aware of up dated protocols because those were changed now and again.

- I found women very trusting in our care and capacities. Some even brought their friends and families to our clinic to be checked.
- I found midwifery a very rewarding kind of job. I consider myself very lucky to be able to care for mothers and their babies.

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Blooms and Mushrooms: Midwifery Experience in Jamaica

9

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Abstract

Jamaica has a long history of maternal care practices, evolving from deliveries in "hot houses" by unregulated experienced elderly enslaved women to home deliveries by traditional birth attendants called "nanas" and currently by regulated trained professional midwives. These older experienced enslaved attendants and nanas developed their craft from their predecessors. Formalized training and legal regulation of midwives' training are linked to the establishment of the Lying-In Hospital in Kingston and the renaming of the Lying-In Hospital to the Victoria Jubilee Hospital to commemorate Queen Victoria's jubilee in 1892. The changes over time are associated with recommendations from British Parliamentary investigations, demographic and sociopolitical forces and government strategies to address the problem of high infant and maternal mortality rate and to integrate maternal and child health into the primary health system.

The purpose of this chapter is to explore the evolution of maternity care in Jamaica from slavery to the twenty-first century. The legislative and educational factors that have influenced the development of midwifery practice in Jamaica are also highlighted. The chapter ends with descriptive notes of the lived experience of newly graduated midwives during their first year of midwifery practice here in Jamaica.

Keywords

Jamaica · History · Midwives and midwifery training

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9.1 The Historical Perspective on Midwifery in Jamaica

In the earliest beginning from slavery in 1655 and immediately post emancipation leading up to 1962, maternity care in Jamaica although not well defined resembled that of the British system. During that time the majority of the population was of African descent enslaved by the British to provide labour on the plantation to amass their wealth. The African descent labour force was stratified as house slaves and field slaves. Back then Jamaica had a two-tier health-care system, one for the free people—the colonizer from England—and the other for those who were enslaved. Majority of those who were called upon to give care during colonialism were elderly women, sickly and those who were too lame to work in the fields. The enslaved people were cared for in "hot houses" on the plantation, while health care for the British was comparable to that obtained in England.

Some house slaves who acquired experience from their homeland were birth attendants to their owners. Mathurin-Mair (2009) noted that birth attendants made up 8% of "women with skills" on the plantation during colonialism. Some of whom were slaves rendered unfit, by age or infirmity for field labour. Lady Nugent recounted in her diary her experience with a birth attendant during childbirth by stating that she "brought a cargo of herbs, and wished to try various charms, to expedite the birth of the child, and told me stories of pinching and tying women to the bed-post, to hasten matters, that sometimes, in spite of my agony, I could not help laughing, and, at others, I was really in a fright, for fear she would try some of her experiments on me" (Wright 1907 reprinted 1966, p. 124). The birth attendants were also expected to care for the children (Mathurin-Mair 2009), and some enslaved women were used to breastfeed their owners' babies preventing them from the arduous job of breastfeeding.

Children born in slavery and who were fathered by the plantation owners were given the opportunity to purchase their freedom. Among the freed slaves was Mary Seacole's mother who was a "doctress", from whom Seacole learned the skills of "nursing" (Mary Seacole 1857). She was able to provide general care to British soldiers and their families. In addition, to the care provided by the doctresses, the colonizers and the freed people were cared for at a cost by medical doctors visiting from England.

In 1776 a Bill was established for a public hospital for "the support and maintenance of the poor sick, maimed, infirmed and the disabled transient poor of the island" (Jamaican Nurse 1967, p. 7). It turned out that the hospital was solely for the white population, and the enslaved people continued to be treated in "hot houses" on the estate of their owners. Tulloch (1971) concurred that the hospital was for the white population as well as sick soldiers when the ships docked in Kingston. This continued until in 1856 when some charitable ladies led by Lady Barkly recognized the need for a lying-in institution for poor women of Kingston. It was envisioned that the institution would be used for training native women who were excellent in caring for the generally sick but had no expertise in caring for women in labour and delivery.

Lady Barkly and her colleagues set up the Charitable Hospital for Women with a school in conjunction with government-funded Kingston Public Hospital (KPH)

and the Lunatic Asylum. Lady Barkly's intent was to train nurses on the KPH wards and provide free service there. Her effort was short lived as KPH commenced training of a small number of nurses (Johnson and Khalid 2012). The author indicated that Bartly's effort seemed to have been the precursor for midwifery training. The clergy and medical practitioners supported her efforts, but the question of dealing with the products of parturition, sanitation and peculiar needs of women in labour and delivery at KPH necessitated a different construction. The Governor and Lady Barkly were later reassigned to Australia, and they were replaced by Captain Darling and his wife. Mrs. Darling succeeded Barkly as patron of the Lying-in Hospital (Adam et al. 1859–1860).

It is widely believed that midwifery training in Jamaica started as early as 1856 at the Lying-in Hospital. Midwifery training followed the British apprenticeship tradition as well as the quality practised by colonial matrons. In 1887, in recognition of the jubilee anniversary of Queen Victoria, a public subscription was requested, and in memory of this event, the hospital for women was named the Victoria Jubilee Lying-in Hospital (VJH). It was not until 1891 that the government took the responsibility of midwifery training at the VJ Lying-In Hospital (Anderson 1986). The building was opened for occupancy by His Excellency Sir Henry Blake, Governor of Jamaica, in that same year. The bed capacity was 12, and it was staffed by a matron and 14 pupil midwives (http://serha.gov.jm/hospitals/vjh). According to Sargent & Rawlins 1992 labour interest, unemployment, incidence of endemic diseases, and decline in food crops all of which were associated with malnutrition and high infant and child mortality rates and were some of the reasons for the authority to expand the obstetrics and maternity services in Jamaica. Included in the expansion were measures put in place to regularized midwifery services. The colonial hierarchy also proclaimed a Midwifery Law in 1919, which provided registration for midwives and defined qualification criteria to become midwives (Sargent and Rawlins 1992). Registration to practise midwifery was at the Registrar General's Department in Spanish Town, the first capital of Jamaica. A formal syllabus was implemented in 1932. The restiveness of the peoples of the Caribbean prompted the British Colonial Office to commission committees to investigate the deploring conditions such as the high infant mortality and morbidity of the West Indies including Jamaica and make recommendations. The first of such investigation was the Moyne, which was later followed by the Rushcliffe and Irvine Commissions.

The Moyne Commission Report indicated that "two of the most serious aspects of the ill-health are, first the very high infant mortality and secondly the large amount of morbidity…" (p. 154). The Report recommended "the creation of at least one School of Hygiene in the West Indies, for research and teaching in preventive medicine, and for the thorough training of auxiliary medical personnel" (Moyne Report 1945a, 435). The Commission also recommended that "immediate progress with definite preventive measures, including housing, general sanitation…both in dwellings and schools, the control of malarial areas, maternal and child welfare work, venereal disease clinics…" (United Kingdom, Moyne 1945a, pp. 435–436). Based on these recommendations, the West Indies School of Hygiene was

established as a training centre for sanitary inspectors and public health nurses to address preventable diseases and reduce the infant mortality and provide maternity care at the community level.

There was still need for improvement, and in 1943 Lord Rushcliffe and his team were commissioned to "examine the question of training, both in Britain and overseas who are to serve in the Colonial territories, and to make recommendations having regard also to the need in those territories for increased public health activities and for the fostering and development of community welfare" (United Kingdom, Rushcliffe Report 1945b, p. 3). The Commission recommended that the training of midwives in the colonies be comparable to that obtained in Britain and also that the setting up of a Midwives' Council in the colonies should be established under the Nurses Registration Ordinance 1945. These Councils were to control the admission, training, certification and practice of midwives (1945). Regarding training of midwives, Rushcliffe recommended that the minimum period of instruction before registration to practice should be at least 2 years for those without registered nurses training and 1 year for RNs (1945). Special guidelines were also recommended pertaining to domiciliary midwifery. The Rushcliffe Committee also recommended that midwifery teachers, "except for a few specified post, candidates for the colonial nursing service should be State Certified Midwives…. Candidates should have had, before appointment to the Service, at least 1 year's hospital experience after State Registration… As a matter of long-term policy, we favour the selection for posts as Sister Tutors and midwifery teachers. Nursing Sisters who have already had Colonial experience…midwifery teachers for Colonial Training Schools should hold…the Midwife Teacher's Certificate" (1945c, 34). The Rushcliffe recommendations formed the framework for modernizing and standardizing midwifery education in Jamaica.

Recommendations from Lord Moyne and Lord Irvine's investigations catapulted the commencement of medical education and nursing education at the University Hospital of the West Indies (UHWI) (formerly University College Hospital of the West Indies) in 1948 and 1949, respectively. The Hospital was opened in 1953, and as the services increased, the need for greater number of midwives increased. By 1954 the need for training midwives for the hospital was endorsed by the Board (Patterson 1974). By 1955 a ward sister was sent to Britain to obtain the Midwifery Teacher's certificate. In the meanwhile Sister Fearon a British-trained midwifery teacher was recruited to set up the Midwifery School which opened in 1957 offering a 9-month course to 6 pupils who were registered nurses (Patterson 1974).

McCaw-Binns and Moody (2001) recalled that the concept of the health team was developed in the 1970s by the international community and was later adopted in Jamaica. They remarked how the role of the midwives underwent changes. The authors claimed that the midwives were retrained, and their role expanded to that of a maternal and child health provider at the antenatal clinic. Immediately antenatal coverage rose when the health team concept was adopted throughout Jamaica and the impact on national antenatal coverage was dramatic (McCaw-Binns and Moody 2001).

The Jamaica Midwives Association (JMA), the first midwives association in the English-speaking region, was founded in 1960 by Ms. A.M. Anderson, a former

British matron at the VJH (Midwifery News 1967). Mrs. Omphroy Spencer served as Honorary Secretary. She succeeded Ms. Anderson becoming the longest-serving president. The association later became a member of the International Confederation of Midwives (ICM) 2005. Mrs. Omphroy Spencer represented the JMA at an ICM meeting and lobbied for a day to be put aside in recognition of the work and worth of midwives internationally. The recommendation was officially accepted on May 5, 1992, and is now celebrated annually worldwide as the International Day of the Midwives.

As the practice of midwifery and midwifery training evolved the recommendation of the Taskforce on Health Sector Manpower, Education and Training (Ying 1996) and the Jamaican Cabinet (Cabinet Decision 9/99), the government transferred its midwifery training programmes from the Ministry of Health through the Ministry of Education Youth and Culture to the University of Technology, Jamaica (UTech), in 2004. The UTech, Jamaica, commenced its direct-entry midwifery baccalaureate programme with the first cohort of students in 2014, and these students are expected to complete the programme in 2018. The UTech, Jamaica, post-RM direct-entry midwifery programme is also expected to begin in the very near future. The University Hospital of the West Indies (UHWI) School of Midwifery which is governed by a statutory body continues to offer the certificate for post-RNs. However, accelerated plans are in progress for transferring the delivery of the programme from UHWI to the Nursing School at the University of the West Indies at the Mona Campus. The programme will then be offered at the baccalaureate level for both the direct-entry midwives and the post-RNs.

9.2 The Legislation and Regulation of Midwifery in Jamaica

Midwifery became legally recognized in Jamaica with the first Midwives Act being instituted in the early 1900s when laws regulating the training, examination and practice of midwifery in Jamaica were first promulgated. The records show the Second Schedule, Section 25 of a Bill entitled "A Law relating to Midwives" that there was previously a series of midwifery acts such as Midwifery Law Cap.74 (n.d.) and there was also the Midwifery Amendment Law 1942 27/1942, the Midwifery Amendment Law 1948 20/1948 and the Midwifery Regulations 1948 (The Jamaica Gazette supplement dated 21.10.1948.)

Under the Bill entitled "A Law relating to midwives", it states "this Law may be cited as the Midwives Law". This was in the mid-1950s, and the exact date is unclear in the records reviewed. It appears to have come into force 3 years after the law to provide for Registration of Nurses for the Sick for the Registered Nurse. So as to be legislatively clear regarding midwifery under the Medical Act Chapter 241 August 12, 1908 states clearly that "medicine and surgery" do not include midwifery (p. 3992). Under this law a Board called the "Midwives Board" was established with responsibility for the duty of issuing, ……in pursuance of rules in that behalf made under the following provisions of this law certificates to women who comply with the rules" (p. 2). Although called the Midwives Board, this entity comprised of

only two midwives most of the members being medical doctors. Midwives were entered on "A Roll". This roll certified that these persons were midwives. Interestingly this initial midwifery law was also gender specific. It referred directly to a midwife as "woman" throughout its entirety. In fact it stipulated that "if a person being either a male person or a woman not a certified midwife attends a woman in childbirth ……. be liable on summary conviction before a Resident Magistrate".

The Bill was also specific with regard to who could supervise midwives; these persons included a medical officer (health), a public health nurse employed to the Board of Health or a registered nurse who was also a midwife. The Bill included the suspension of a midwife from practice "if it appears necessary in order to prevent the spread of infection" (Section 15 c p. 8). Deaths of midwives had to be reported to the Midwives Board. This Bill also gave the board the power to make provisions as it related to the uniform and badges to be worn by certified midwives. The Bill also excluded midwives from doing jury service.

Amendments to the Law are aligned to Government health policies and standards for maternal care. Barker posited "in 1973 a concerted effort was made by Governments of the Caribbean region to address the problem of high maternity and infant mortality and morbidity" (1988, p. 3). The author indicated that the Minister responsible for Health initiated a comprehensive strategy with recommendations, action and targets to improve maternal and child health services. The decision of Government to use the primary health-care approach and Health for All by 2000 expanded to the health of women during the reproductive years and child care from birth to adolescence (Barker 1988). There were other Acts that have impacted the service of midwives in Jamaica. For example, under the Hospitals Act 1984, the Hospital (Public) Fees (Amendment) Regulations 1984 Maternity Services allowed midwives to charge a fee of $40.00 flat for home deliveries. Skilled birth attendant deliveries moved from 39% in 1950 to 95% in 2001 and hospital births from 31% in 1960 to 91% in 2001 (McCaw-Binns 2005).

As one considers current models of care delivery with health policies that influence users' decision-making such as no user fees, new technological innovations and other health-seeking behaviours, there is likely to be continued reduction in the number of home deliveries by midwives in Jamaica. Traditional birth attendants usually known as nanas were a known part of the birthing landscape in Jamaica. Forbes et al. (1994, p. 18) in their study found the major factors for choice of nanas, namely, availability of nanas, affordability of nana services, confidence in nana's ability, tradition and unavailability of transport and midwives in the districts.

Act 35 of 1964 saw a turning point in the legislation of midwifery in Jamaica. This Act is cited as the Nurses and Midwives Act 1964. The Proclamations, Rules and Regulations of October 3, 1966 provide the detailed roles and responsibilities of the registered midwife.

In the 2005 amendments, the definition of a midwife is given: "Midwife means a person who having been admitted to a midwifery education programme authorized and duly recognized by the appropriate regulatory body, has successfully completed the prescribed programme of studies, has acquired the necessary qualifications and is registered and licensed to practice midwifery" (Amendment of Section 2 of the

Principal Act 2005). Under the law "midwife" is a protected title. In the 2005 Act to amend the Nurses and Midwives Act, new regulations were introduced. The main element of this amendment is the need for relicensure of midwives every 2 years; the regulations dictate the number of hours of continuing education stipulated for relicensure. Plans are in motion to amend the Nurses and Midwives Act; a recommendation is to have the Council renamed the Nursing and Midwifery Council.

9.3 The Education of Midwives in Jamaica

Midwifery education has progressed over the decades from an "apprenticeship" system, where on-the-job training was given, to a formal one where a structured curriculum was implemented in the 1970s. Currently, there are two categories of midwives post-registered nurses (post-RNs) and direct-entry midwives (DEMs) who are prepared at the certificate or the baccalaureate level. The programme has experienced changes in duration to satisfy the increasing demands of the maternal and child health landscape, varying from 6 months at the inception to a 2-year and 4-year programme for the direct entry and from 9 months to 1 year programme for the post-RN. Once the applicant meets the matriculation requirements stipulated by the NCJ, it is mandatory that the applicant undergoes a systematic process of selection as instituted by the schools of nursing/midwifery. For the direct-entry midwifery programme, this includes sitting an entrance test, being interviewed and undergoing a medical examination. Having met the criteria, the candidate is selected for the programme. The admission process varies slightly for the post-RN who is licensed by the NCJ to practice as a RN. Within the first 30 days of training, the requisite documents for indexing of all students must be submitted to the NCJ in order for them to be recognized as a legitimate participant in the programme.

The initial 4 months of the introductory period of training for the DEM students at the certificate level is focused on foundation courses, while those at the baccalaureate level complete 1 year of foundation courses. Post-RN students are credited for prior training. Various teaching learning methodologies are employed to help the process of imparting the knowledge, skills and attitude appropriate for a midwifery professional. Simulation exercises are done in the classroom and skills laboratory to enhance these exercises. During the introductory phase or the first year clinical, the DEM students are rotated on the medical and surgical wards to practice fundamental skills before being introduced to midwifery practice skills. Progress is monitored with the use of authentic assessment tools suitable for adult learners. The course is structured with a highly clinical component, where students are rotated through the morning, afternoon and night shifts. The students are assigned to maternity hospital or maternity units in approved hospital and the community services to gain clinical experience.

Formative and/or summative assessments follow current evaluative processes for adult learners. Both theoretical and clinical practice examinations are engaged during the student training. Students in the DEM programme at the certificate level are allowed one resit after failing an internal examination. Another failure may result in

discontinuation or demotion of the students. This decision is made based on the profile of the student and is determined by the evaluation committee comprising midwifery educators. Students in the baccalaureate programme are evaluated as per university policies and regulations. On completion of curriculum hours and the fulfilment of other requisite conditions, candidates are eligible to sit the NCJ's final oral and practical examinations. Both certificate and baccalaureate candidates sit the same qualifying examination, which is administered by the NCJ. Once the students have passed this examination, they are registered and licensed to practise as registered midwives in Jamaica. Students also have the opportunity to resit the NCJ examination twice. The student who achieves the highest overall score for the examination in the island is awarded the Grabham Prize in recognition of Dr. Michael Grabham, who was instrumental in promoting and extending maternity services at the Victoria Jubilee Hospital.

9.4 The Transition of Newly Qualified Midwives in the Workforce in Jamaica

The number of midwives for training was increased in 2001 as part of the national strategy to accelerate the reduction of the maternal and perinatal morbidity and mortality as well as to increase the cadre of midwives in Jamaica. Since then approximately 100 midwives are trained and are expected to graduate annually from the UHWI, Utech, Jamaica, and the Kingston School that has three campuses. Of these 100 graduates, 40 are DEMs and 60 are RNMs. The number of males over the years has been very sparse to non-existent. Approximately, three males have completed the midwifery programme over the past 10 years. Following the successful completion of the programme, all graduates are automatically registered and licensed with the Nursing Council of Jamaica.

Completing the midwifery programme is a great accomplishment for the RN in Jamaica since midwifery is a prerequisite in most instances for RNs to progress in nursing. Most of the newly qualified RNMs will be assigned to the maternity units in secondary care with some returning to their substantive post on the adult or paediatric units. When registered nurses complete their midwifery training, they automatically receive a financial incentive by being promoted to another level after their substantive post. An added incentive for these RNMs is that over time some will be recommended to pursue management education making them eligible to be promoted to charge nurses on the maternity units or across the secondary healthcare system.

There is a compulsory 6 weeks at a minimum orientation programme for RNMs led by the nurse educator from the nursing in-service departments in secondary care. The orientation programme consists of classroom and clinical practice. During the classroom sessions, the midwives are expected to review hospital policies as well as procedure manuals. The orientees are also rotated on all the maternity wards and outpatient clinics. Newly qualified RNMs who will be selected to work on the labour and delivery unit will have a longer rotation on that area during their

orientation. Each midwife is expected to complete tasks that are specific to the units/wards during their orientation under the supervision of the senior midwives. The midwives are also responsible for having their competence checklist booklet satisfactorily completed by the end of the 6-week period before their orientation is considered completed.

Direct-entry midwives on the other hand are mainly trained for primary health care where most of the Level II RM posts are, and they are referred to as district midwives. In the past RMs were assigned immediately to work in the community. However under the Ministry of Health (2005) Direct Entry Midwives Rotation Policy developed in 2005 aimed at allowing DEMs to hone their skills, DEMs are placed in a 1 year "internship" programme. The "internship" also provides an opportunity for the newly qualified midwives to better develop their competency as well as facilitating them with their transition from students to beginner midwives.

This "internship" occurs in two phases. The first phase takes place in hospitals and lasts for nine (9) months, and the second phase takes place in a primary health care and lasts for three (3) months. During the internship, the director of nursing or senior charge nurse and public health nurse will assess the midwives' performance. Following the completion of the rotation, the midwives will be deployed to work in the primary health-care setting depending on the needs of the public hospitals and vacancies in the health centres near to where they live.

Although there is still no structured support mentor or preceptor programme, RNMs as well as the RMs are not left alone to care for mothers by themselves, especially on the labour and delivery units during the orientation period. The new graduates are expected to work on all shifts including weekends during their orientation under the direct supervision of the senior midwives. They are also required to have pre- and postclinical conferences and ward rounds with their nurse educator or senior midwives. The senior midwives are also expected to sign off on the newly graduated midwives competency checklist before the orientation period is considered complete.

Upon completion of the "internship" and the employment of the newly hired midwives, immediate supervisors will ensure that the midwives gain additional skills and experiences that will strengthen their competences. The midwives also have responsibility for their own professional development and growth. In addition, the in-service departments under the leadership of nurse educators in the various employment agencies usually have structured programmes in place to facilitate and assist midwives in their growth and career development in the profession. Other entities and associations such as the Jamaica Midwives Association, the Nurses Association of Jamaica (NAJ), schools of nursing and medical schools that also have conferences, workshops and seminars that midwives access for their own continued growth and development. These programmes also provide continuing education hours that assist the midwives to meet the NCJ's requirements for biennial relicensing. All midwives are required to relicense biennially. The RNMs are required to complete 40 continuing education (CE) hours, 25 h for nursing, 10 h for midwifery and 5 h for non-nursing. All RMs are expected to complete 30 CE hours, 25 h for midwifery and 5 non-midwifery hours. The midwife could be deregistered

if she continues to practice without a current licence (The Nurses and Midwives (Amendment) Act 2005).

The Jamaican authority has always supported midwives with flexible scheduling, tuition support, study leave and partnerships with universities and in-service to facilitate ongoing educational achievements for midwives. However, it is much quicker for RNMs to get promoted more than RMs because there is shortage of nurses due to attrition. Attrition is at a slower pace for RMs compared to RNMs. District midwives enter the profession at RM Level I and are expected to be promoted to Level II upon their deployment to the community. Those who remain in secondary care continue as Level I RMs and have the potential to be promoted up to Level III in secondary care. The RM Level III is the highest level for the RMs which is the supervisory level. The typical RM would have to work for at least 5 years before she is selected or recommended to pursue the supervisory management required for promotion to Level III. Even then promotion is not guaranteed as this depends on the vacancies in primary or secondary health care. There are also a limited number of posts available in primary health care for the Level III RMs.

9.5 The Lived Experience of Newly Qualified Midwives in Their First Year as Registrants

Hughes and Fraser (2011) alluded to the experience of the transition from the classroom to clinical practice for newly qualified midwives as one in which the graduate can either "sink or swim". To some extent this was the lived experience of [1]Beth a RNM and (see footnote 1) Dacia a RM in their first year of clinical practice. These two newly qualified midwives were asked to describe their experience in their first year as hired midwives. Both reported that they were not overly anxious but were too happy to put theory into practice. Beth and Dacia were asked to describe their emotions reporting for duty on the first day. They both reported that they were overjoyed. They both said that pursuing midwifery was like a dream come true for them. Beth said, "Caring for women and babies is the penultimate for me as a nurse. I do not want to do anything else". Dacia who worked in the health system before pursuing midwifery voiced the same sentiments. They both felt that their transition from students into practice was easy. This they credited to their familiarity with the staff and the work environment both as staff and as students. "As a matter of fact, I would have attended to and cared for some of these same women or babies weeks before graduating", said Beth.

The midwives said although they did not have a mentor or preceptor assigned to them, they got support from senior midwives and the nurse educator responsible for their orientation. They are uncertain however whether their experience would have been different if they had been assigned a preceptor or mentor. Beth said that she modelled the senior midwives who she felt were professional and competent. One of the observations that Beth made was that the nurse educator in

[1] Names changed.

charge of orientation was not able to spend more time with her because she would have had other responsibilities and duties to other members of staff and the other orientees. Hughes and Fraser (2011) also share their opinion. The authors believe that this could occur as the orientees and nurse educator find it challenging to find time to meet as they are rostered on different shifts, and very often it is the same nurse educator who has responsibility for each midwife's orientation in the institution.

Nevertheless, Dacia thinks that her internship could have been better. She was asked to state some of the mechanisms that were put in place by her employer to assist her to transit from a student to a professional midwife. She laughed as she described her orientation as a "joke". "I was given some papers to read and a co-worker introduced me to the staff", she recalled. She is still uncertain whether or not her orientation has completed. She is of the view that her orientation was for 2 months. This is contrary to the mandatory 1 year "internship" stipulated by the Ministry of Health for RMs. "I believe I assume duty from day one", said Dacia. She was asked if she has completed her competence checklist booklet. She said that she is not aware of such booklet. Although she was not asked, she reported that she did not get any incentives during those 2 months. Dacia voiced concern that some of her fellow graduates have not gained employment. She said she could not understand why they have not been employed as they have met all the requirements for the programme, and there are vacancies in the community.

The midwives were asked, "what do you think are the greatest challenges that midwifery graduates face in the first year of employment?" Both Beth and Dacia reported the lack of resources such as staff shortage coupled with the lack of some vital equipment and material. These they believe are too common and could challenge how effective the midwives perform their duties each day. Beth believes that the time has come for midwives to use more technology in their practice. "It seems as if we are behind in the world", she said. They were asked, "what are some of the skills you think you need to improve your practice as a midwives?" Both Beth and Dacia recalled how they were uncertain in doing vaginal examinations at first. Today, they are both comfortable in conducting vaginal examinations and assisting junior staff to do the same. Both observed that the institutions to which they are employed conduct teaching session by midwives and medical doctors. However, they believe that the midwives could benefit more if the sessions include demonstration of skills and not just lecture/discussions.

Dacia reported that she has been working for the past year and a half and believes it is time that she be reassigned to the community. She said she has not been able to put all her theories into practice in secondary care. She has not been given any leadership roles as she said she is considered to be a "junior staff" member. She feels trapped and wants to be more autonomous when giving care to the mother and baby. She is of the view that the real midwives are in the community as they are more independent. She is not yet a member of the JMA but hoping to do so soon as she is assigned to the community as she believe that the Association should give her legal support if the need arises. Dacia has no immediate plans on studying right now due

to family commitments. However, she would want to complete the post-BSc midwifery programme when it begins. Beth on the other hand is hoping to migrate in the near future.

9.6 The Future of Midwifery in Jamaica

One of the most recent exciting prospects for midwifery in Jamaica is starting the journey to have scholarly midwives. We believe this will help to raise the status of midwives in Jamaica, empower mothers and support normalcy as midwives continue to play their part in assisting with the many national strategies to achieve local and international maternal health goals. This chapter lacks the documented evidence of the role midwives played over the years in response to the rapid changes and sometimes unexpected demands in health care caused by the socio-economic as well as political changes in Jamaica.

Nevertheless, this chapter has presented an opportunity for midwives to further document more of their contributions to society over the years and develop new thoughts through research and storytelling. What is also needed is for midwives to embrace their identity and become more visible as they move away from what seems like under the shadow of nurses and nursing. This can be achieved by regaining professional control of midwifery practice and taking responsibility for evaluating the standards for which they are accountable (Dawson 1993). Reinforcing their identity would see midwives becoming more autonomous and placing themselves at the centre of sexual and reproductive health in Jamaica. So who will be tomorrow's midwives? Where will they work? How will they differ from today's midwives?

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Embracing Life as a Midwife in Aotearoa/ New Zealand: Transitioning from Student to Midwifery Practitioner

10

Lesley Dixon and Jacqui Anderson

10.1 Introduction

An unfamiliar environment, a new set of relationships and the differing expectations of a new role are some of the challenges graduate midwives face as they transition from undergraduate student to confident midwifery practitioner. The graduate midwife needs to adapt to a new role and responsibilities, continue to learn and deepen her understanding of clinical practice and navigate professional networks, referral pathways and environmental culture. These challenges can be mitigated by transition programmes which are focused on providing ongoing education to support learning, strong mentoring support and positive feedback which values the individual.

The New Zealand midwifery profession set up a national transition programme which is designed to meet the needs of each graduate midwife, wherever she works. This programme is fully funded by the government and is considered an important mechanism for retaining graduates within the profession by providing individualised support during the first year of practice.

The programme incorporates support for clinical practice, ongoing education and a professional development plan along with one-to-one mentoring support from an experienced midwife throughout the first year of practice. The programme is completed by a Midwifery Standards Review where the graduate is required to reflect on her first year of practice and identify an individualised professional development plan going into the future. Important principles of the programme are choice, partnership and autonomy. Although the programme is a compulsory requirement following graduation, the graduates can choose where they work (hospital or community), identify a mentor that suits them and attend education that meets their own professional needs. All professional relationships are modelled on

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autonomy and partnership—whether the relationship is with women, the mentor, other midwives or other health professionals. It is important that the graduate is welcomed into existing professional maternity networks and understands the roles and referral mechanisms for the wider maternity context—other maternity clinicians, the multidisciplinary team and community primary health care groups. All of which are important if the graduate is to be able to work confidently within the New Zealand maternity environment.

This chapter explains the system of maternity care in New Zealand, the undergraduate preparation for practice and the structures that support practising midwives as the background context of New Zealand maternity care. It provides an explanation of the Midwifery First Year of Practice programme with each element of the programme important for supporting the graduate. Evaluation of the MFYP programme demonstrates that it is flexible, meets the needs of the NZ graduate and helps improve confidence as the graduate transitions to confident health professional. Quotes from participants from research into the programme have been used throughout the chapter and identify the new graduates' experience of the programme (Dixon et al. 2014).

10.2 New Zealand

New Zealand is situated in the southwest Pacific Ocean and is comprised of two main islands—descriptively named by the early Europeans as the North Island and the South Island. Māori, the indigenous people of New Zealand, named the country Aotearoa with Te Ika-a-Māui (North Island) and Te Waipounamu (the South Island).

There are approximately 4.5 million people living in New Zealand with approximately 60,000 babies born each year and approximately 3000 practising midwives. Most people are of New Zealand European (74.6%) ethnicity with 15.6% Māori, 12.2% Asian, 7.8% Pacific peoples and 1.2% Middle Eastern/Latin American/African (MELA) (Ministry of Health, 2017; Midwifery Council of New Zealand, 2018).

10.2.1 The New Zealand Maternity System

New Zealand (NZ) has universal health coverage, so maternity care is free for women who are NZ citizens or meet the "eligibility" criteria (https://www.health.govt.nz/new-zealand-health-system/publicly-funded-health-and-disability-services/pregnancy-services).

When a woman finds out she is pregnant, she chooses a health care professional to provide and coordinate her maternity care, and this may be a midwife, a general practitioner or an obstetrician. The majority of women choose a midwife (93%) to be their health professional—also known as the Lead Maternity Carer (LMC) (Ministry of Health 2017).

The LMC midwife is contracted and funded by the Ministry of Health to provide all primary (community) maternity care to the woman—this includes

antenatal care, intrapartum care for normal labour and birth and post-natal care in the community for up to 6 weeks (Ministry of Health 2007). Obstetrician LMCs charge a copayment from their clients when they provide care and will subcontract to the hospital for intrapartum and post-natal midwifery services. General practitioners have gradually withdrawn from providing maternity care so that now only 0.3% of LMCs are general practitioners (Ministry of Health 2017). Continuity of maternity care through this LMC model is the foundation of maternity care within New Zealand.

Midwives in New Zealand can choose to work in the community providing continuity of care to a caseload of women as the Lead Maternity Carer, or they can choose to work in a hospital setting and work rotating shifts (to cover 24 h) providing midwifery care to women in a maternity hospital. This may be a midwifery-led unit or a secondary or tertiary level unit.

Working in a hospital environment is an equally important and vital role for the graduate midwife within the maternity system. Women need midwives who have the necessary knowledge and expertise to provide care when they have a complex pregnancy, labour, birth and/or postpartum. Midwives who work in the secondary/tertiary maternity facilities develop and deepen their knowledge and expertise of complex pregnancies. They learn to develop supportive relationships with the woman and her family often at a time of stress for that family. They also become a locus of support, knowledge and expertise for other midwives and health professionals. They are the key to ensuring continuity of maternity service and a high quality maternity care within the hospital environment.

10.3 Undergraduate Preparation for Practice

Since 1992, preregistration midwifery education has been provided through a 3-year Bachelor of Midwifery programme. The development of the standards for midwifery education and the design of the curricula were a collaborative process between consumers, the profession (the NZ College of Midwives), the regulatory body and the educational institutions. All of the programmes continue to have consumers and the midwifery profession represented as advisors. The programmes' focus on educating midwives for autonomous midwifery practice where midwifery relationships are underpinned by partnership and continuity of care is the expectation (Pairman 2010).

The Midwifery Council of New Zealand sets the requirements and standards for preregistration midwifery undergraduate education and approves and accredits each programme and teaching institution. The programme curriculum continues to be written and reviewed in consultation with midwifery teachers, midwives in practice, the New Zealand College of Midwives, maternity consumer organisations and Tāngata Whenua (Māori) (Midwifery Council of New Zealand 2015). The midwifery education programme is required to prepare graduates for practice across the Midwifery Scope of Practice (Midwifery Council of New Zealand 2015). This degree and a pass in the Midwifery Council's National Midwifery Examination

enable applicants for registration to demonstrate that they meet the Midwifery Council's Competencies for entry to the register.

Preregistration midwifery education in New Zealand combines academic and apprenticeship learning. Women and practicing midwives are seen as important teachers in this model alongside the programme midwifery educators (Gilkison et al. 2016). The curriculum reflects the Midwifery Council's Midwifery scope of practice, code of conduct and statement on cultural competence for midwives. The New Zealand College of Midwives' midwifery philosophy, code of ethics and standards for practice have an equally significant role in the curriculum.

Each approved programme must provide a minimum of 2400 midwifery practice hours, more than 1920 theory hours with a total of 4800 h or more on completion of the programme (Midwifery Council of New Zealand 2015). The total hours equate to 4 academic years, but the programme is delivered over 3 calendar years, with midwives undertaking clinical practice experience in either a maternity hospital or in the community during the academic holidays as well as during the academic year. Thus the students are able to gain the requisite practice and academic hours throughout the whole year (Gilkison et al. 2016).

Midwifery theory and practice experiences are designed to promote women-centred care. This encompasses holistic and integrated assessment, respectful and evidence-informed care, professional autonomy, accountability and self-responsibility. Along with professional collaboration, referral if required, recognition of ethical and legal responsibilites, contextual understanding, quality assurance and reflective practice (Pairman 2010). There is a significant bioscience component and strong research focus. The programme is underpinned by the impetus for evidence-informed practice and supports the development of critical thinking and reflection skills.

Midwifery practice hours are gained in the care of women and babies at any stage of the childbirth experience (pregnancy, labour, birth, post-natal period) and in any maternity setting including home, community, clinic, primary birthing units, secondary/tertiary maternity facility and neonatal intensive care (Midwifery Council of New Zealand 2015).

The majority of practice experiences are gained through continuity of care settings. This is usually achieved through practice placements with LMC midwives in the community. This may be an individual midwife or sometimes with a group of midwives who work together in a group practice. Group practices generally involve six or eight midwives who work together and organise their work so that they can cover each other's caseload to support time off. This enables the student to experience the provision and benefits of continuity of care for both the women and the midwives. The student works with women who have agreed to have a student involved in their care. Students also gain experience in birthing units and hospital settings as part of the hospital team but also follow women into these settings when they are in labour. The student will support the women wherever the women plan to birth.

In the final year of the programme, students must undertake at least 80% of that year in practice placements including within complex care settings and in rural practice. This is, in essence, an apprenticeship year. The student is placed in

practices from 4 weeks up to 14 weeks at a time to enable them to immerse themselves in practice and the realities of life as a midwife.

10.3.1 Registration and Regulation

Prior to 2003 midwives were regulated by the Nursing Council of New Zealand. From 2003 with the advent of the Health Practitioners Competence Assurance Act 2003 (HPCAA), the Midwifery Council of New Zealand was established as the regulatory authority for midwives. The creation of the Midwifery Council provided final acknowledgement that midwifery is a profession in its own right. The Council is responsible for protecting the health and safety of the public through ensuring that midwives are competent to practice. In order to do this, the HPCAA requires that midwives must be registered by the Midwifery Council. To be registered applicants must complete the prescribed preregistration qualification which demonstrates they meet the required competencies for entry to the midwifery register and meet other requirements based around character and health.

Following registration and in order to practice, midwives must hold an annual practising certificate (APC) which has to be applied for at the start of each year. The Council stipulates that midwives must also maintain their competence to practise though engagement in the Council's prescribed recertification programme and demonstrate they work across the midwifery scope of practice. The recertification programme is a 3-year cycle where midwives are required to undertake prescribed compulsory education and identify relevant elective education and professional activities they participate in to maintain practice currency and competence. The recertification programme also requires midwives to participate in the New Zealand College of Midwives' Midwifery Standards Review process where they review their practice in relation to the New Zealand College of Midwives Standards for Practice. This is an educative, supportive and comprehensive review of practice encompassing self-reflection and assists midwives to develop insight into their practice. The process incorporates consumer feedback and results in a professional development plan (PDP) to assist midwives to continue to explore and develop their practice. There are a number of frameworks that guide midwives in their day to day practice. These are identified in Table 10.1.

10.4 The Midwifery First Year of Practice programme

The transition from undergraduate student to fully confident midwifery practitioner can be challenging due to the need to adapt to new environments, new relationships and the differing expectations of the new role. The main areas that can cause challenges include the increased responsibility for client care; the need to become familiar with health systems, hospital policies, administration, etc.; as well as role changes. These changes can trigger feelings of uncertainty and fear and can be highly stressful due to the increased levels of responsibility and individual

Table 10.1 Frameworks that guide midwifery practice

There are a variety of professional and legislative frameworks that support and guide midwifery practice in New Zealand. The focus and philosophy within each of these frameworks are continuity of midwifery care, working in partnership with the woman, informed decision-making and evidence-informed practice
Frameworks include: • Midwives handbook for practice identifies the competencies and standards of practice for midwives—wherever they work (New Zealand College of Midwives 2015). • New Zealand College of Midwives consensus statements provide the midwifery professions' position on various aspects of maternity care. • Code of conduct provides the minimum expectation of midwives as they engage in their professional activities (Midwifery Council of New Zealand 2010). • National Guidelines for practice—provide agreed multidisciplinary guide for practice for certain conditions.
For midwives working as a Lead Maternity Carer: • Section 88 Primary Maternity Services Notice which details the contractual expectations of LMC practitioners (Ministry of Health 2007) • The referral guidelines which set out referral processes for consultation, transfer or emergencies and guidance on what to do if a woman declines any of these options (Ministry of Health 2012) • Access agreement which provides the LMC with access to the maternity facility and is part of section 88
For midwives working within maternity hospitals: • Secondary/tertiary maternity specifications—detail the contractual expectations of the DHB maternity services (Ministry of Health and DHBNZ 2011, Ministry of Health 2013) Midwifery staffing standards for maternity facilities—which identify optimal staffing levels within maternity facilities to support high-quality, safe midwifery care (MERAS 2014)

accountability. Supporting a positive transition is important to ensuring increased confidence and the retention of graduates in the profession (Dixon et al. 2015).

The Midwifery First Year of Practice programme was established in 2007 following a midwifery forum (held in 2005) in which leaders of the profession identified the need to set up a programme of support for graduates (Pairman 2010). It was considered an important strategy which would combat midwifery shortages by supporting the retention of midwives once they entered the profession. The strategy was supported by the Ministry of Health with formal funding provided for a pilot programme in 2006. An expert advisory group designed and developed the pilot programme based on existing evidence and the identified need to provide mentor support as well as support for clinical practice, reflection and ongoing professional education (Pairman 2010).

The Midwifery First Year of Practice programme (MFYPP) vision is that:

> New Zealand midwifery graduates enthusiastically commence their careers in New Zealand: well-supported, safe, skilled and confident in their practice; meeting the needs of maternity-service consumers, providers and communities; and building a sustainable base for the New Zealand registered midwives workforce into the future. (Clinical Training Agency 2006)

Essentially the programme has several different intersecting elements which involve clinical practice experience, continuing education, professional mentoring and preparation for the Midwifery Standards Review at the end of the first year of practice (Fig. 10.1). Each of these elements is funded by the Ministry of Health for New

Fig. 10.1 The elements of the Midwifery First Year of Practice programme (Source: New Zealand College of Midwives)

Zealand graduates, meaning neither the graduate nor their employer (i.e. hospital facility) is required to fund the activities. Graduates are required by the Midwifery Council to participate in the MFYP programme in their first year of practice.

10.4.1 Midwifery Practice: Support in Clinical Practice

Clinical practice support is important for the graduate midwife to enhance and consolidate her undergraduate knowledge and experience. It is often only when the graduate starts to practice as a midwife that she comprehends the gaps in her existing knowledge and experience and fully understands the responsibility that comes with working as an autonomous practitioner. The programme recognises that it is through the integration of practice and education that midwives continue to expand their knowledge and experience to develop confidence in their role.

> My clinical skills were sound. It was just management of births that were no longer straight forward. I could run what I was thinking by other midwives at the hospital, core midwives, other LMC's or my mentor, most were willing to help. (Kensington et al. 2016)

Clinical practice support is provided for the graduate from the midwifery community in which they work—this is from the hospital midwives, the Lead Maternity Carer (LMC) midwives and other practice colleagues.

The programme also provides some midwifery practice support (MPS). With funding support for a midwifery clinician (generally the mentor) to work alongside the midwife if/when the graduate needs extra clinical support. This tends to be for the graduates "firsts"—the first birth, suturing, homebirth, induction, etc.

10.4.2 Professional One-to-One Mentoring

Professional one-to-one mentoring is provided by an experienced midwife mentor chosen by the graduate. Mentoring is defined as "a formal relationship with another midwifery colleague for a defined period of time for the purposes of support and

guidance as the midwife colleague adjusts to a different practice context or to practice as a new practitioner" (Midwifery Council 2005).

The graduate herself identifies who she would like to be her mentor. Mentoring involves face-to-face meetings and telephone support between meetings as needed. The meetings are designed to support the graduate to critically reflect on her practice. At the start of the year, the graduate works with her mentor to identify individual learning goals and set up an individualised professional development plan. During the meetings, the mentors discuss and update this plan as well as discuss clinical practice and where necessary challenge the graduate midwife to critically reflect on her practice.

> An amazing relationship vital for my transition from competence to confidence (Dixon et al. 2014)

Only experienced midwives can become mentors. In preparation to become a mentor, the midwife is required to undertake a mentoring workshop and receives ongoing education and support when they are mentoring.

10.4.3 Continuing Education and Professional Development Activities

The graduate's professional development plan is linked to education with the graduate required to undertake ongoing education throughout the first year. The education consists of both compulsory and elective education. Compulsory education requirements are set by the Midwifery Council (regulatory body) and are a requirement of all practising midwives. An example of compulsory education is the emergency maternity skills workshop which covers situations such as shoulder dystocia and maternal and newborn resuscitation.

Elective education involves workshops that the graduate identifies as being helpful for her to increase her knowledge and understanding and to consolidate her learning. Examples include intravenous cannulation and suturing the perineum (Dixon et al. 2014).

> I felt I was adding pegs onto my basic framework of knowledge, from which I could build and expand in different directions. (Dixon et al. 2014)

10.4.4 MFYP Midwifery Standards Review

All midwives in New Zealand participate in Midwifery Standards Review (MSR). The MSR provides midwives with an opportunity to reflect on their midwifery practice in a formal manner with the assistance of specially educated reviewers (one a midwife and one a consumer). It is considered a key quality framework and requires the midwife to reflect on the following:

- A written reflection on how she works using the standards of practice and Turanga Kaupapa as a guide.

- Feedback from the woman she has provided midwifery care to and feedback from colleagues she works alongside.
- Statistical and clinical outcome data—either from her caseload or from the facility she works in.
- Identification of professional education needs.

Graduate midwives are required to participate in MSR at the end of their first year of practice.

> My review was very empowering for me, the learning and the confidence gained over that first year were not fully clear to me until I had my review. (Dixon et al. 2014)

10.5 Evaluation of the Programme

Formal research to identify whether the programme supported retention and fit the needs of the graduates was undertaken by Dixon et al. (2014), using the MFYP database of participants between the years of 2007 and 2010. The research had two aims: the first was to identify if graduates who had participated in the programme were retained in the profession, and the second was to identify which elements of the programme were considered as most supportive.

The authors ascertained retention by analyzing whether graduates who had participated in the programme were still on the Midwifery Council register and had practicing certificates in 2012. They found an 86.3% retention rate overall. To identify which elements of the programme were supportive, the authors surveyed the programme participants. There was a 43.4% response rate with overwhelming support for the programme and participants reporting that each element of the programme was important to their transition. The MFYP programme was found to be supportive, flexible and met the needs of each individual wherever they worked (Pairman et al. 2016). The graduates described how they received reassurance and encouragement from their midwifery colleagues with a wide network of support available to the graduate. This involved support from the midwives they worked alongside—whether hospital midwives or LMC midwives, their mentors, and from the hospital managers and other maternity clinicians. The graduates commented on the value of being able to discuss assessments and care planning with their midwifery colleagues and gain positive feedback that supported their evaluation of the situation. Being able to choose their own mentor was identified as a vital component of the programme with comments such as:

> She had to be someone that I completely trusted to maintain confidentiality; someone to whom I could reveal all my doubts and insecurities safely, also someone whose clinical philosophies aligned with my own, and carried a demographically similar caseload. (Page 36, Dixon et al. 2014)

The researchers concluded that the programme provided wrap-around support from the whole profession for graduates during their first year of practice (Kensington et al. 2016). They found that the programme appears to have fostered a culture of nurturing the graduate midwife amongst the wider profession.

A more recent evaluation has been undertaken by independent contractors on behalf of the Ministry of Health (Clarke, 2018). The aim of this evaluation was to assess and determine the effectiveness and value of the programme and identify issues, challenges and areas for improvement as a means of providing guidance for future direction. The evaluators undertook interviews with key stakeholders, an online survey of the graduates and mentors, a case study interview with eight graduate midwives and five mentors, two workshops with the expert advisory group and an online survey of midwifery consumers.

In their report the evaluators identified that the MFYP is a successful programme which meets its intended aims. They found the programme was:

- Good at being responsive to the graduate midwives' needs with most graduates reporting that the programme was successfully adapted to meet their learning needs and consolidate learning
- Excellent at building confidence with graduates providing clear and consistent demonstrations of how the programme contributed to becoming a confident practitioner
- Good to excellent at supporting the graduate's ability to adapt to multiple settings, environments and colleagues
- Good to excellent at supporting positive attitudes and realistic expectations about midwifery practice in New Zealand

They conclude the MFYP programme is a successful, valuable and valued part of the graduate midwife's transition to confident practitioner over the course of their first year.

> I think the programme is invaluable in promoting a safe and exciting environment in which the new midwife can develop and grow in terms of actual knowledge, and also networking and confidence in practice. A mentor can bring out the best in you, whilst acting as a small buffer as you step forward into your life as a midwife. (Dixon et al. 2014)

10.6 Conclusion

The MFYP programme was specifically designed by midwives and the New Zealand midwifery profession to meet the needs of its midwifery graduates. It has four intersecting elements that are funded and adaptable for each individual graduate. Being able to choose their clinical practice environment, their mentor and their education was important and supported autonomy for the graduate. A principle of the programme is flexibility which is necessary to meet the differing needs of the graduate depending on her work environment and her own individual transition needs. The programme is fully funded and compulsory for midwifery graduates to support them in their transition to confident practitioner. Since its inception in 2007, the MFYP programme has received consistent positive feedback. Formal evaluation has indicated that the programme is meeting the transition needs of midwifery

graduates, is flexible and adaptable, supports retention of graduates within the profession and increases the confidence of the graduate midwife. The programme is considered important by the midwifery profession and has fostered a culture of support and understanding for the graduate midwife in New Zealand.

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Transition to Practice for Newly Qualified Midwives in the Netherlands

11

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Abstract

In the Netherlands newly qualified midwives (NQM) have to work in practice, without formal mentorship and support. Midwives are fully qualified, autonomous medical professionals when they complete their bachelor's degree. Dutch NQM depends on informal support systems, mostly provided by colleagues and peers. NQMs seem to initiate informal support by themselves. For primary care NQMs, colleagues are sometimes employers and therefore not always safe for deliberating their questions.

Keywords

Dutch NQMs · Midwifery-led care · Legislation · Autonomy · Informal support · Colleagues · Peers

11.1 Introduction

In the Netherlands, midwifery is integrated in a remarkable healthcare and educational system. Dutch newly graduated midwives have to function as autonomous medical professionals within this health system. In this chapter about midwifery in

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the Netherlands, we start off with a brief summary of the history of midwifery, followed by a description of the midwifery educational system and a section providing information about the registration and regulation of new midwives. Finally, mentorship and support for newly qualified midwives will be discussed.

11.2 History and Context of Midwifery Practice in the Netherlands

11.2.1 Legislation of Midwifery, the Birth of an Autonomous Medical Professional

In the Netherlands, legislative developments in 1865 laid the foundation of modern midwifery practice. By law it was determined that midwives were only to attend such deliveries that were the work of nature or which could be done by hand (van Lieburg and Marland 1989). This meant that this law forbade midwives to attend "abnormal" deliveries. If complications arose during a birth, the midwife was to summon a physician. Because of this law, training for midwives was also regulated resulting in the establishment of two midwifery academies, respectively, in Amsterdam (1865) and Rotterdam (1882). The result was the formation of a professional group secured by legislation, licensing, and training facilities. On the other hand, it was also the beginning of a more rigid definition of the role of midwives during birth. All difficult cases were to be transferred to or supervised by a (usually male) medical attendant (van Lieburg and Marland 1989).

As the nineteenth century progressed, midwives established their own professional organization and journal (van Lieburg and Marland 1989). In the twentieth century, tasks and responsibilities of midwives were extended leading to the authorization of providing prenatal care that started from 30 weeks on (1932) (Schultz 2013). In 1951 midwives' responsibilities expanded even more; legislation was modified to extend responsibilities to include the provision of care during the whole pregnancy and during birth including the suturing of perineal tears (Drenth 1998). Before 1951, if a woman needed suturing, midwives had to call a general practitioner. Nowadays, midwives have the responsibility for women in the reproductive age including prepregnancy, prenatal, intranatal, and postnatal care. However, the scope of midwifery within perinatal healthcare is still related to the definition of the law of 1865.

11.2.2 Place of Birth

Up to the 1960s, Dutch women preferred to give birth at home (Schultz 2013). The main reason for the high rates of home birth during this period was the lack of hospital facilities for maternity care and birth (van Lieburg and Marland 1989). After this period, so-called polyclinic deliveries were introduced. Polyclinic deliveries are deliveries in which women give birth accompanied by their primary care midwife.

This also leaded to the increase of hospital births from 22% in 1953 to 71% in 2008 (CBS 2009). Up until now women have to pay a fee if they decide to have their baby in the hospital (in 2018 €342) (i.e., when there is no medical reason to deliver in the hospital). The tradition of giving birth at home is fading away resulting in the declining home birth rates from 70% in 1970 to 13% in 2016 (Kenens et al. 2017; Perined 2018). Social-cultural explanations given for the declining rates of home birthing are the changing economy, immigration, and increased interaction with other cultures via media and travel, which have altered ideas about birth, healthcare, family, and roles of women (De Vries et al. 2013).

11.2.3 Birth of the Hospital Midwife

As mentioned above, in the early 1970s, women began to prefer to deliver their babies in a hospital. The number of polyclinic births increased as well as medically indicated births. At that time, hospitals also employed midwives in a clinical hospital setting in order to maintain physiology in a setting where many medical interventions were used. Midwives liked working in hospitals because of the better work environment as compared to the work they did in home birth settings. A new midwife was born, the hospital midwife (Kenens et al. 2017; van Lieburg and Marland 1989; Schultz 2013). Hospital midwives are primarily involved with relatively uncomplicated medically indicated births (Wiegers and Hukkelhoven 2010). The proportion of hospital midwives in the Netherlands has increased to 28% in 2016 (Kenens et al. 2017).

11.2.4 Organization of Midwifery Practices and Maternity Care

Until the late 1980s of the last century, most of the midwives worked in solo practices (67.6%) taking care of 165 caseloads a year. In 2016, only 5% of all midwives worked solo—with a caseload of 105 (Kenens et al. 2017). Nowadays, the majority of primary care midwives (80.4%) work in group practices of three or more midwives (Kenens et al. 2017). This move to group practice has been a strategy for primary care midwives who wanted to create a more balanced private life (Warmelink 2017). Midwifery practices have a specified working area to guard timely care. They offer prenatal consults during the week and have a midwife on call 24/7 (KNOV).

Dutch maternity care has been split into primary, secondary, and tertiary care, similar to the overall organization of the Dutch healthcare system (Feijen-de Jong 2015). Primary maternity care is provided by primary care midwives and by some general practitioners for normal physiological pregnancies (low-risk pregnancies). Midwives and general practitioners attend and supervise a large proportion of births, falling from 60% in 1910 to 30.5% in 2012. In 2012, 85.4% of all pregnant women started maternal care in primary care (0.4% with the GP). These women received the care of a total of 2692 midwives (Feijen-de Jong 2015). Secondary/tertiary

maternity care is provided by obstetricians or residents and secondary care midwives working under the responsibility of obstetricians (high-risk pregnancies). The costs of secondary care are reimbursed by healthcare insurance companies exclusively for medical reasons. An Obstetric and Midwifery Manual—which is acknowledged by all primary and secondary care providers—is used to optimize risk selection and referrals from primary to secondary care (De Geus 2012).

11.3 Midwifery Education: Preparation for Practice

In the Netherlands, the Ministry of Education, Culture and Science is in general responsible for the financing of the education system, defining the general education policy, and specifying the admission requirements, structure, and objectives of the education system (Nuffic 2015). Higher education in the Netherlands has a binary system, different from many other countries in Europe. A distinction is made between research-oriented education (academic level) and higher professional education (applied science). Both types of education have different objectives and have their own admission requirements, program duration, and titles.

Midwifery education falls in the higher professional education (applied) category, a 4-year bachelor program. Midwives are fully qualified professionals when they complete the bachelor's degree. After taking the Hippocratic Oath, newly graduates have to register themselves at the BIG-register. The BIG-register arises from the BIG Act (in Dutch: 'Wet op de beroepen in de individuele gezondheidszorg'; Individual Healthcare Professions Act) (Ministry of Health, Welfare and Sport). From then on, they are legislated to work as a midwife in the Netherlands.

The academies in the Netherlands are strictly bound by the government by the amount of students they permit to enter the midwifery education. The inflow and outflow of midwives in the Dutch workforce are measured every 2 years (Kenens et al. 2017). Every year about 200 students are selected to enter Bachelor of Midwifery.

After the bachelor program, midwives can enter a Master of Midwifery program. These Master of Midwifery programs exist on two levels: professional higher education (Master Physician Assistant) and on academic level (Master Midwifery Science, European Master Midwifery Science).

11.3.1 Midwifery Education in the Netherlands

Since 1818, the education of midwives consisted of at least 1 year of education in the theory of midwifery. Following the theoretical underpinnings, the midwifery student would undertake an apprenticeship with a licensed midwife. Up until 1913, there were two regional schools and one city school for midwifery in the Netherlands: regional schools in Amsterdam, since 1861, and in Rotterdam, since 1882, and a city school in Groningen, which closed in 1912. In 1913 the Roman Catholic College of Motherhood founded a program in the south of the Netherlands (Heerlen)

with a 2-year training course for midwifery (van Lieburg and Marland 1989). Finally, in 2001, the Midwifery Academy of Amsterdam decided to start a new academy in Groningen, 90 years after the closure of city school.

From 1994, midwifery education became a 4-year Bachelor's degree program. Students did not have a degree in nursing, which means that the program was (and still is) direct entry (https://www.verloskunde-academie.nl/geschiedenis/).

Midwifery education in the Netherlands was, until 2008, one of the last educational programs embedded in the Ministry of (VWS) Health, Welfare and Sport. In 2008, midwifery education was brought under the Higher Education and Scientific Research Act (WHW). With this change in 2008, the four academies of midwifery in the Netherlands, previously autonomous organizations, had to become part of the Universities of Applied Sciences. All academies chose for an additional alliance or close cooperation with a full University in order to develop research program in midwifery science.

To maintain the strong autonomous position of Dutch midwives and the high level of care for low-risk women, the academies as well as the Royal Dutch Organization of Midwives declare the importance of empowering midwives by training them academically to a high standard. When the Ministry of Health, Welfare and Sport rejected this request in August 2011, the AVAG Midwifery Academy (Academy Midwifery Amsterdam and Groningen) looked at various ways of implementing midwifery training within the framework of research-oriented higher education.

The legal framework for midwifery education is represented in different pieces of legislation: the Individual Healthcare Professions Act (known in Dutch as the BIG Act) (Department of Justice 1993) November 11, 1993; the Higher Education and Research Act (WHW) (Department of Education 1992; Department of Justice 1993) October 8, 1992; and the Order in Council passed by the Ministry of Health, Welfare and Sport in 2008 as part of the BIG Act. The professional and educational framework trace back to international standards of the profession, as defined by the ICM (International Confederation of Midwives 2011). The educational framework is also based on the profile for integrated midwifery care approved by the Global Standards for Midwifery Education, the Royal Dutch Organization of Midwives (KNOV), and the national training profile approved by the Association of Dutch Midwifery Schools (SOV). The educational program is based on the core qualifications for Dutch higher professional education (Nuffic 2015) and the Dublin descriptors in the Framework for Qualifications of the European Higher Education Area (Bologna working group 2005), which are requirements for all educational programs within higher education.

11.3.2 Competencies of a Midwife in the Educational System

The three midwifery programs (Maastricht, Rotterdam, and Amsterdam/Groningen), through the SOV (Collaborative Education Midwifery), have developed a national profile for midwifery education. This profile is congruent with the national occupational profile developed by the Royal Netherlands Organization of Midwives (KNOV) (Aitink et al. 2014). The national profile for midwifery describes the requirements, the professional qualifications, which one has to

master to exercise the profession for which the student is trained. A national training profile sets out the common learning outcomes for the Netherlands, with skills that the student has to acquire during the program, enabling her to become an independent, skilled professional in practicing midwifery. The competency level of newly graduated midwives differs from other graduated healthcare professional on higher education level. There are higher levels required in terms of independent occupational practice and the evidence base of the profession: the practice of midwifery in the field of reproductive care and the competencies to practice this in an evidence-based manner. Regarding the organizational competencies such as administration and entrepreneurship, NQMs work at a starting level of the profession, which is similar with other professions on the higher professional education level.

In accordance with the Royal Degree Training Requirements (Nederlandse Overheid 2008), the program of 240 European Credits (EC) includes 100 EC of internship in the professional practice, of which 60 EC are in community practice: known as primary midwifery care. In addition, in order to graduate, a required number of specific "obstetric procedures" have to be performed. For instance, to graduate, a student must have supervised a total of 60 deliveries, of which 30 occur in primary midwifery care. Some of these "obstetric procedures" are restricted, designated as such in the BIG Act (Department of Justice 1993) November 11, 1993, for instance, performing episiotomies or suturing perineal repair.

In the formulation of the national profile of midwifery education, the statutory guidelines for the European Union (EU) are included in the level of traineeships and the number of performances. These EU directives therefore indirectly form part of the legal framework used by the courses (Council Directive 2005/36/EC on the mutual recognition of diplomas, certificates, and other evidence of formal qualifications in midwifery).

In conjunction with the national occupational profile (Aitink et al. 2014), the national educational profile consists of four domains in which the midwife exercises the various roles—namely, the role of medical expert and the other six roles associated with the seven CanMEDS roles in medical education (The Royal College of Physicians and Surgeons of Canada 2015). Each role has a number of competencies. The four domains a midwife is working in consist of (1) reproductive care in social, demographic, and cultural context of maternal and newborn care, prepregnancy care, and family planning, care during pregnancy, care during labor and birth, care for women during the postpartum period, care of the newborn, and facilitation of abortion-related care, (2) organization of midwifery care, (3) scientific basis of the profession, and (4) professionalization of the profession.

11.3.3 An Example of a Dutch Midwifery Curriculum

The curriculum of the midwifery academy Amsterdam Groningen (AVAG) 2014 is a newly developed educational program, sparked by the changes in the maternity

care system in the Netherlands. It builds on the changes in the organization of care involving integration of primary and secondary care that can contribute to improved collaboration. All those involved in this process also believe that integration of the various levels will improve the quality of care. Furthermore, AVAG has added its own ambitions for their educational program: learning high-level academic skills and a feasible, attractive curriculum at both locations.

Competencies, as derived from the national profile, are formulated in 16 different qualifying tasks. These tasks require proficiency in multiple competencies and qualify for entrusted professional autonomy. If a student meets these qualifying tasks, she is ready to work in practice. The performance of the tasks laid down in the final qualification tasks shows that a student has all the competencies demanded by the professional profile. The curriculum is constructed along five vertical leaning tracks, to ensure consistency in the program.

Parts of the educational program are internships, in primary and secondary midwifery care as well as in research and public health. Internships allow students to take the knowledge and skills they have acquired and incorporate these into their professional conduct. Workplace learning predominates in the second half of the program. Students learn on the job training—or, in more formal term, they develop competencies that become an integral part of their professional activity.

The Bachelor's degree in higher professional education consists of a major (210 EC) and a minor (30 EC). A minor is a period of study in another area of education. For the AVAG this can be a period of study within a research university. The minor period gives students the opportunity to study certain topics related to the field of midwifery in greater depth. Students have the opportunity to choose a minor as proposed by AVAG (offered are research, health science, health communication, ethics, and policy) or to draw up a plan for a minor of their own choice, in the Netherlands or abroad.

11.4 Registration and Regulation of Midwives

Midwives, graduated in the Netherlands as well as graduated midwives from other EU countries, are legislated by the Individual Healthcare Professions Act (BIG Act) (Department of Justice 1993) November 11, 1993. This act regulates the qualification of healthcare professionals wanting to practice in the individual healthcare sector. The BIG Act imposes rules for healthcare professions and protects patients against incompetent and negligent acts. The BIG-register includes physicians, dentists, pharmacists, health psychologists, psychotherapists, physiotherapists, midwives, and nurses. In order to be registered in the relevant register, the possession of a certificate stating that the person concerned meets the training requirements set for this purpose is required. Midwives may practice in midwifery and undertake other actions aimed to promote and monitor the normal course of pregnancy, childbirth, and the early postnatal period. Next to that, preventing maternal and perinatal complications by assessing the woman during pregnancy, childbirth, and first week postpartum, assessing the obstetric risk in obstetric policy, and the provision of advice and assistance as well as to consult or refer to a physician when necessary.

Apart from the legislation via the BIG Act, the Dutch Royal Organization of Midwives (KNOV) has its own quality register for midwives. The aim of this register is to show whether a midwife practices in accordance with the professional standards and invests in expertise. A midwife must demonstrate the following as per the criteria for registration: 10 h a week practicing as a midwife in every 5-year period, ability to demonstrate that she works according to the midwifery standards, participating in a complaint scheme that complies with the Quality, Complaints and Disputes Care Act (CHP), and participating in (accredited) lifelong learning activities (200 h/5 years). Registration is not compulsory, but around 80% of all midwives have registered so far.

The KNOV has also initiated a register for midwives who have advanced training and experience in external cephalic version (ECV) of the fetus (Register Verloskundigen Basis Echoscopie). Nearly 100 midwives have registered so far. To maintain her registration, a midwife has to perform a minimum of ten ECVs each year.

For hospital midwives, the Royal Dutch Organization of Midwives has conducted a supplementary profile. A steering committee with members of the KNOV and the Dutch association of obstetricians and gynecologists (NVOG) has been formed to formalize the position of the clinical midwife in legislation. Moreover, they want to determine the role and position of the clinical midwife; therefore, a specialist's register is required. Only midwives who have completed a professional Master's education will be able to register in this specialist's register.

11.5 Newly Qualified Midwives

As mentioned in the previous paragraph, newly graduated midwives (NQMs) are trained to work as a competent practitioner from the point of graduation. Before graduation, they always work under supervision of a qualified and experienced midwife. All midwives, including those newly graduated, work autonomously in primary midwifery care. They have the responsibility for women in the reproductive age including prepregnancy, prenatal, intranatal, and postnatal care. After graduation, no further mentorship is formally required.

In the Netherlands, over the years, changes in employment and working place have been visible. For instance, in 2015, 74% of new graduates were working as a locum in primary midwifery care (Kenens et al. 2017). This is very different to 1987, when zero percent of the NQMs worked as a locum. From 2007 on, there is a clear trend for new graduates that they work as locum midwife (from 6 to 74%), as explained in Textbox 11.1 (Kenens et al. 2017).

Textbox 11.1 Explanation of Working as Locum in Midwifery in the Netherlands

Locum midwives are self-employed. For the government and taxes, they are so-called self-employed without personnel (ZZP). Midwives working as replacement for a midwife in primary midwifery care are called locum midwives in the Netherlands.

Primary care midwives, working in a practice in the community, hire a locum for their holidays or when they are ill. To employ a locum, there are no hierarchic relationship whatsoever and no need for long-term employment.

NQMs working in a hospital setting varies from 7% (2015) to 28% (2010) (Kenens et al. 2017).

11.5.1 Support for Newly Qualified Midwives

After graduation, NQMs tend to work autonomously as (locum) midwife in practice. Formal support systems for these new graduates do not exist in the Netherlands. NQMs are educated to work autonomously and are fully accountable for their actions and decision-making in practice. NQMs usually have to rely on informal support, mostly by colleagues and peers.

As illustrated in the textboxes below, NQMs experienced the first months as tough and highly demanding. Support is depending on the goodwill of their colleagues or the arrangements they made by themselves. Stories about support NQMs' experience in the first period of practice are derived from interviews with NQMs in the Netherlands (Kool et al. 2018).

The NQM in the textbox is telling about the kind of support she experienced with colleagues and peers.

> With colleagues, so to say, I could mention: this is what I did, so I could check her point of view. This was more colleague like deliberation instead of her telling me what to do. But anyway, when I came home I was thinking: did I do the right thing? And then I made a call to my friend (also a NQM), and we talked, and then I could let it go and go on with my life. Nevertheless, I think it was nice to work on my own. Although, this first period in practice was very stressful. I could describe it as a turbulent period. Different emotions came up. Physically, I became aware that I have to learn to take care of myself as a midwife. Because if you do not, than it will go wrong, that you can face your own pitfalls. And mentally, at work I felt all right, but when I came home, I collapsed. Then the emotions came up. When I was at home, I cried a lot. Afterwards, when then tears were gone, I felt relieved. And the next day, I felt all right, and I felt that I could do my job. And my shift went well and when I came home, I cried again. At home, for my boyfriend it was a year with a river of tears.

For NQMs, colleagues, peers, and family seem important informal sources of support. Family members at home are important for sharing emotions, food, and sleep. For locum-working NQMs, peers are experienced as safe and trustworthy sources of support.

> A friend of mine who graduated as a midwife a year previously was also working as a locum midwife. I have contacted her very often, by phone or WhatsApp, and asked her: can I discuss something with you? That helped me a lot. In hindsight, I should have asked more support from colleagues. But I

did not do that. I wanted to prove myself. I was thinking: "I am graduated and I will not contact my colleagues on daily basis with minor issues." Then I contacted my friend. She did not mind my questions. She recognized the need for support and the feelings of insecurity about decisions. That helped me a lot. For me she was a kind of buddy.

Colleagues in primary midwifery care seem to be a very important source of support; however if these colleagues are employer as well, it is less safe for NQMs.

When I just started working as a midwife in practice, we arranged a colleague available for questions, for the first 1 or 2 months. That I always had someone to be able to call during my shift, to talk through something. A kind of help line, which was very reassuring for me. I only used it twice, but knowing that you could phone someone to chat it through. Even that is already very pleasant, I think. I had really learned to solve things for myself. So what I now tell a graduate, for example, a locum that I work with now, I say: Hey, phone me. It does not matter if you cannot work something out by yourself, because I know that it is nice if someone is backing you up. That there is someone who you can contact with upcoming questions. Even if you need the support a few times, it is pleasant knowing it is available. And even if I did not have that kind of support. I learned a lot very quickly, because I just had to do it all myself, but that was a tough process. It was a kind of: you do your job and you are on your own if you manage, you never hear whether you do it right.

In a hospital setting, NQMs seem to have other informal support. The urge for support from peers seems less as compared to primary care NQMs. Hospital midwives work in a team setting. Next to that, they mention the difference in care they deliver with their peers, which are most of the time working in primary midwifery care. NQMs working in a hospital setting are working in a team. Deliberating care seems more common in a hospital setting. Informal support is most of the time available at the workplace. As one NQM in the textbox below stated:

For me as a midwife, the hospital (place) is a nice work setting. I like having a lot of contact with colleagues and that I can consult them if necessary. When I started at the hospital, I felt very welcome. In the hospital setting (secondary midwifery care), you have a lot of contact with colleagues. In primary midwifery care, you often work alone, when you are on the road and when you are taking care of clients at their home.

Colleagues brought me a lot of knowledge. They supported me with decision-making. They said: "What would you do if you have a client with

these problems. Or what do you think of this if this is the result from the laboratory?" And if I did not knew the answer, they told me that I just have to learn from situations on that subject. They knew that I was just starting as a midwife, and they really liked teaching me, even when I just did not know how to act. They had a lot of patience with me and told me that this was just a normal phase of getting to know the procedures and routines in practice.

Colleagues supported me. If I ran into something or I could consult them or I could deliberate my decisions of situations I met. And it was nice that we sometimes could laugh too when we had a night shift: having a bit of fun. They (my colleagues) also helped me to further develop myself.

In the hospital where I worked, fortunately the gynecologist was always available 24/7 h a day. You actually discuss every patient at different times during the shift. And it just gives the opportunity to make decisions together. When I worked in primary midwifery care, I felt more alone making decisions.

Organizing support from colleague midwives requires sometimes a proactive behavior. In the textbox below, a NQM is telling a story about how to organize feedback from colleagues.

When I was working in a hospital setting, I just missed my colleague midwives. The first months, I did not know them. And I was not able to get to know them, because we did not work together at the same shifts. I never saw them at work, except for one colleague who supported me the first weeks on the ward. I had expected that I could learn from colleague midwives when working together, but that was not the point. I knew their names and did recognize their faces, but I did not know who they were as individuals. There were some issues going on at work. Issues I had not met previously, for example, patients asking for care outside the regular care standards. I was taking care of patients with special expectations, and I did not know how to deal with this kind of expectations. So these were situations I wanted to deliberate with colleagues. For that reason I asked several colleagues, who were in my opinion open to questions, to meet on monthly basis for a kind of consult meetings. In these meetings, we can discuss situations with clients/patients, and we can deliberate how to cope with specific needs of clients. And if you want to discuss your own questions or situations, I would like that. I need some feedback from colleague midwives, because I do not meet them at work and I actually do not see them performing. And they are willing to meet on a regular basis. We had scheduled different meetings, and I did like these meetings very much.

11.6 Current Research on NQMs

Up until 2017 no research has been performed regarding the transition of midwifery students into practice. However, in 2017, a research team started to study the job demands, job resources, and personal resources perceived by NQMs at the workplace and their well-being the first years after graduation. In 2018, the first results regarding the work characteristics perceived by NQMs in primary and secondary midwifery care are expected to be published. In addition, the well-being of NQMs in the Netherlands will be explored (results expected in 2019). Finally, an intervention for Dutch NQMs will be developed and evaluated. This intervention will aim at facilitating the well-being of NQMs during the transition period (expected in 2021). The ultimate aim of this research project is to improve maternal and perinatal outcomes and to prevent attrition from the midwifery workforce.

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The United Kingdom

12

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Abstract

Midwifery education and practice across the four countries of the United Kingdom (UK) (England, Wales, Scotland and Northern Ireland) is diverse and complex when considering the healthcare system as a whole. The Nursing and Midwifery Council regulates midwifery as a profession across the UK. Regulation and, hence, standards are undergoing change in light of legislative change due to the report of system failures within sections of the health service. These changes are occurring alongside the UK's adjustment in allegiance with the European Union through 'Brexit'. For many, this means uncertainty for the immediate and long-term future nationally. This will have an effect upon the delivery of healthcare regulation for all areas of health, financial security workforce provision and the delivery of education to future midwifery students. Whilst some may perceive this to be an anxious time for the newly qualified midwife, others seek out the opportunities that a period of change and uncertainty bring. This is the time for newly qualified midwives to carve the future of the profession and for themselves in terms of career aspirations and development.

Keywords

Midwives · Midwifery practice · Transition to practice · New graduates · Initial registration · Professional socialisation · Fit for first post · Preceptorship

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Birth of a midwife: The transitional journey from student to practitioner

12.1 The Context of Midwifery Practice: National Policy/ England, Ireland, Scotland and Wales Policy on Supporting New Graduate Midwives Onto Practice

The United Kingdom (UK) comprises four countries that of England, Scotland, Wales and Northern Ireland, and regions within each of these four countries are responsible for their health and social care provision. To aggregate all aspects of maternity service provision including workforce would be incongruous due to health policy differences within each country (Department of Health (DH) 2010) and advances within the political structures (with their own devolved political responsibilities) therefore, where appropriate statistical inference are separated. Congruence across the four countries is maintained due the regulatory role of the Nursing and Midwifery Council (NMC) (https://www.nmc.org.uk).

Since its inception in 1949 (Rivett 2015), the National Health System (NHS) remains free at point of entry for the entire population due to 98% of health care being funded by general UK taxes (The Kings Fund 2018). UK residents do not pay for the majority of their medical treatments, however; there is an expectation that prescriptions and dental work are remunerated. The NHS Constitution (DH 2012) (and updated in 2015) articulates a contract and pledges between the NHS, its employees and users of the services. Through a set of principles, it states, 'The NHS aspires to the highest standards of excellence and professionalism' (Principle 3). Pledges to staff include a positive, supportive working environment for staff to undertake their roles effectively, having clear roles and responsibilities that contribute to making a difference for patients and for contemporary continuous professional development, which is additional to the minimum legal requirements expected for individuals to perform at their best.

Health care in the UK is a complex system (The Kings Fund 2018) that coalesces predominantly the NHS, private health care, health and social services and charitable organisations. The health system underwent a major review and restructure in 2010 with the assembly of the then government, leading to a radical change in the commissioning and governance of all health-related services (DH 2010a). The focus of modernising care provision, was to put the patient at the centre of their care (DH 2010; The Kings Fund 2018), and to make the whole health care system easier to navigate, monitor and deliver at local level in an efficient cost-effective way (RCM 2009b). Funding was made available at local levels rather than being centrally distributed, and local areas were provided with the authority to commission health care. Putting the commissioning of services at the heart of communities overseen by community doctors (General Practitioner (GP)) through clinical commissioning groups (CCGs) anticipated that services met the needs of that community group.

Data from 2015 to 2016 indicates that the NHS received its annual budget of £136.7 billion and employed approximately 1.6 million people. The NHS remains

the biggest employing organisation nationally and the fifth largest employer in the world (Nuffield Trust 2017). In 2012 the world united through the London Olympics where a celebration of the NHS was presented as 'the institution which more than any other unites our nation' (The Kings Fund 2018). The NHS is not, however, without its critics, and there are ongoing and changing political, economic and workforce complexities that continue to challenge the delivery of high-quality care for all (Leng et al. 2014).

On 1 November 1993, the European Union was formed and the Maastricht Treaty came into force. England and the rest of the UK joined at this time (Trueman 2015). The benefits of joining the EU were to diminish the economic decline and to ensure trade was maintained with the rest of Europe. Joining meant that there was a need for compliance across its member states to ensure good and appropriate practices were maintained. The UK Central Council for Nursing and Midwifery (UKCC) was the regulator of the professions until it was replaced by the NMC in 2004, both of whom adhere(d) to EU requirements enshrined in law under 'The Order 2001' (NMC 2002). On 23 June 2016, the UK voted in a referendum to leave the European Union (EU), and in March 2017, the Conservative government invoked *Article 50* (The Lisbon Treaty 2008) to commit to what has been termed internationally as Brexit. This implies a period of uncertainty for the long-term future of the UK political structure and also to the nursing and midwifery professions where EU legislation currently is the foundation of the regulations as practised. Consequently, there have been implications for health care and UK-based midwives where there is a reliance on EU staff meeting deficits in workforce requirements (Royal College of Midwives (RCM) 2015). It is postulated that through Brexit, staffing levels will be affected as up to 11% of registered nurses, midwives and doctors from the EU leave the UK to return to their home nations. Overwhelmingly, 60% are considering leaving the NHS altogether (RCM 2016, 2017). This will undoubtedly affect the general health and wellbeing of staff remaining within an already stretched NHS where quality care free at the point of entry remains paramount.

Staffing and skill mix remain a significant challenge to maternity services impacting on increased responsibility for newly qualified midwives whilst they are in the process of transition and making the adjustment to the increasing accountability and responsibility of their role (Kitson-Reynolds 2010). Skill mix is key to any workforce planning, to ensure that an appropriate level of competence and experience is available to ensure the safety of mother and infant (and family) remains paramount at all times (NMC 2015). Skill mix is fundamental in risk management for all aspects of high- and low-risk midwifery care provision and to ensure that newly qualified midwives have the support from experienced senior colleagues to consolidate and develop their practice and levels of competence (Griffiths et al. 2017).

The Care Quality Commission (CQC) was established on 1 April 2009 to monitor and assure high-quality and safe care was delivered to all. This is regardless of the environment in which the care is taking place and includes NHS institutions, care homes, GP services and dentistry (CQC 2017). The CQC publish national performance benchmarking reports on its website so that anyone can review the

outcome of visits, see how organisations perform against established criteria as well as be able to identify the enhancements that are required. The CQC ranks each health and social care provider as either inadequate, requires improvement, good or outstanding. Staffing levels have been prevalent in services that have been highlighted as 'least well performing' along with mobility and mix of the population. For issues of maternal and fetal safety, the priority area within the maternity services remains intrapartum care and to ensure that women remain safe (O'Neill, 2008; Kirkup, 2015; Francis, 2013; DH, 2017). Midwives need to be flexible and fluid in their roles during the birthing experiences. Services and midwives need to therefore remain adaptable and responsive. This can impact upon the resilience (Edmonstone 2013; Brennan 2017; Hunter and Warren 2013) of staff, especially if less prioritised workloads accumulate over time. It is noted that there could also be an impact of midwives' ability to support learners due to reduced time for mentoring, coaching and preceptorship (Alred and Garvey 2010). Birthrate Plus (Ball and Washbrook 1996) is a national tool that is used to identify safe staffing levels. This tool is dependent upon calculations based on a 'snap shot' of current workloads and service planned. Midwifery 2020 (DH 2010) also documents a standard ratio of 1:28 midwife/woman.

12.2 Demographics

In 2009, the general UK population was 61.7 million, and in 2010, it was predicted to reach 66.5 million by the year 2020 (DH 2010, p. 5). There are changing demographics for women accessing maternity services. Women are choosing to become pregnant later in life due to wanting to build a sustainable career, changes in societal expectations (Peyman et al. 2017) and wanting to experience travelling and new experiences. Having children later in life may lead to an increase in the NHS care required due to the complexities associated with age (RCM 2016). The Office for National Statistics (ONS) (2017) identified in 2016 that the average age for women increased to 30.4 years compared to 30.3 years in 2015. In England 1.1 births per 1000 women aged 45 and over were noted as well as 0.7 births/1000 women. No statistics were recorded for Scotland or Northern Ireland. The RCM (2016) identified that there have been fewer births to women less than 30 years of age since 2010. It is because of this data there is a call for greater investment in maternity care services to meet the needs of these changes highlighted above. Rates of obesity within the general population are increasing, and with this come other health implications such as cardiac-related, reduced mobility and thrombosis-related incidences, poor nutrition, etc. (Quinn (2015) and Banfield and Roberts (2015)), all of which add to the demand on the NHS demands. The RCM (2016) report obesity rates in England at 21% and Scotland at 22% with an overall ratio of more than one in five pregnant women being considered as obese. There are increasing numbers of childbearing-aged women with congenital conditions who are now living long enough to have children of their own. Midwives need to have training to adapt to the different skills required to care for women in these situations as Renfrew et al. state (2014) 'poor

quality maternal and newborn care is a major factor for mortality rates globally and enhancing quality care reduces morbidity' (p. 1129). There is clear evidence of improved outcomes for midwives who are educated and regulated.

The number of live births in England and Wales in 2016 decreased by 0.2% compared to 2015 and stands at 696,271 (ONS 2017). Scotland reports their stats separately (Scottish Government 2017), and for quarter 3 July to September 2017, the birth rate is reported as 13,847, 2.9% fewer than the same time in 2016. Northern Ireland (NISRA 2017) reported 24,076 births in 2016. Scotland reports that this is the lowest birth rate since 2004 which corresponds to a trend in reduced birth rate across the UK. This means that interpretation or policy predicting birth rates, workloads and staffing resource in 2020 back in 2010 will require amendments and readjustment going forward. Just because the birth rate is reducing, however, the number of women accessing the service with co-morbidities and health complexities due to existing health conditions is increasing. This means the type of midwifery care is shifting to more complex skills and management of women (Knight et al. 2017) with a direct impact on the allocation of resources. Due to these issues, newly qualified midwives often misjudge the time required to manage their daily workloads which is an added strain to the transition period. Handling these professional challenges impacts upon both professional and personal lives where individuals often work well past their allocated shift time, feel overwhelmed by the workload and may feel that they are unable to provide the care that they feel they should (Kitson-Reynolds 2010).

12.3 Models of Care

Midwifery models of care typically involve a high-risk and low-risk divide. Much is verbalised as normalising birth (RCM 2018) regardless of risk status the woman and the pregnancy may be deemed to have. There are currently two tiers of service; the mainstream services are typically offered through the NHS. Options include hospital, community (caseload-held practice as well as standard team provision of care), integrated (both hospital and community cover), core (hospital only), home, co-located birth centre or stand-alone birth centre. Private services may include the above but delivered through private hospital services or through an independent midwife. Both independent and mainstream services cover antenatal, intrapartum and postpartum care. Both systems offer caseload-held practices by a midwife working in a small team or independently. Mainstream services may not be able to guarantee that a midwife already known to the woman and her family will be present for the birth or all of the care episodes, and caseload-held practice may be available only to women who fulfil a predetermined criterion such as age and perceived vulnerability. Private or independent practicing midwives may be able to guarantee continuity of carer with women who may be considered to be vulnerable and/or with no criteria other than journeying through maternity services.

The Changing Childbirth report (DH 1993) is a seminal 5-year plan and was perceived to be a powerful report at its conception. Its aim was to instigate a positive change for many women by implementing and affirming *the three Cs*: choice,

control and continuity. The reality is that after 25 years, the aim of the Changing Childbirth report has not completely been achieved. Better Births (NHS England 2016) a more contemporary report has taken and modernised key concepts from the original report. Changes in maternity services due to policy influence have positively informed professional working practices between midwife and women such as having a named midwife and/or a small team of midwives providing care, carrying personal handheld antenatal records and having some degree of autonomy and empowerment over choices of care provision. Financial constraints within NHS Trusts mean that realistically not all models of maternity care can be delivered in a way that public safety remains paramount (NMC 2015) and therefore a realistic 'menu' of choice is offered to women for birth choice (Birth Choices UK 2010). Newly qualified midwives passionately aspire to achieving the goal of providing continuity of carer during both the antenatal and postnatal periods and for there to be one-to-one care in labour as set out in 'The Changing Childbirth Report' (DH 1993). Commissioned maternity reports are yet to deliver what they recommended within the time scales promised.

Midwifery students are taught to use current evidence and policy (NMC 2015, 2009) and lead as change agents for the future (DH 2010b, NMC 2008). Implementing new ideas for practice or a new piece of evidence, however, may mean midwifery students either feel constrained by the service or chastised by their peers leaving them too exhausted to try to assert change which leads to disillusionment (Kramer 1974; Kitson-Reynolds 2010; Kitson-Reynolds et al. 2014). Some newly qualified midwives experience a practice-policy divide which may lead to uncertainty or confusion within their own interpretation of practice; however, they are adept in challenging processes in support of women and their choices.

12.4 Maternity Services and the Role of the Midwife Within the Health Services Structure

The term 'midwife' and its role are enshrined in law and are currently protected by EU legislation (World Health Organization (WHO) 2000; NMC 2002) and regulated by the NMC. Over 90 member states have registered midwifery practice with the International Confederation of Midwives (ICM) who define midwifery with a key purpose of working in 'partnership with women to promote self-care and the health of mothers, infants, and families' (ICM 2017). Midwifery practiced within the UK is regulated by the NMC as set out in the Nursing and Midwifery Order, 2001 (NMC 2002), and also takes into consideration the ICMs key recommendations and educational requirements. With impending Brexit, some UK midwives report trepidation for what the future holds in terms of professional protection (RCM 2016). Others seek out modernisation and opportunity to advance professional practice for the benefit of women and their families. This is a time for creativity and innovation, to embrace advancing technological developments and to set out the plan for the future generation(s) of midwives beyond the year 2030. Midwives need to develop the knowledge and skills to ensure they remain fit for purpose for

the changing health needs of the future population (Willis 2015). For longer-serving midwives, this can be a period of uncertainty which has the potential to be unnerving, and whilst focus has been attributed to what the future midwife of 2030 will look like, there needs to be a support mechanism in place for existing midwives. Supporting existing midwives to meet the demands of service provision going forward must be central to the development and sustainability of services and of course to assure women and their families remain central to all changes.

Current preregistration education standards state that the newly qualified midwife is an expert in 'normality' at the point of registration and working towards competence at high risk (NMC 2009, p. 17). The word 'normality' is ambiguous especially in the current healthcare climate as what was once considered to be extraordinary is now typical or normal practice. For many years, the role of the midwife in the UK has adapted and expanded to cover both high- and low-risk midwifery care provisions, and normality has been interpreted to cover women at low risk of complications throughout their antenatal, intrapartum and postpartum periods. Midwives have the opportunity to develop specialist roles in areas of interest or consultancy and/or education, predominantly due to the changes in work parameters of the obstetric doctors; what was once considered to be a midwifery extended role has become the standard role.

Midwives may work clinically and flexibly within hospital units, within caseload or community settings and within birth centres (NMC 2017a; Walsh 2008) where they provide holistic care throughout pregnancy and birth continuum. Midwifery students mimic this within their undergraduate education programmes. This means that midwives are to be adaptive to their environments, becoming able to meet the needs of women at a time when it is most needed. Flexibility promotes woman centredness (NHS England 2016), and for the newly qualified midwife, it means having to manage consolidating skills in all aspects of care, all at once. Some hospitals provide a more traditional rotational post where midwives spend a given number of months in each of the main areas in the hospital, i.e. antenatal ward, postnatal ward and delivery suite; however, this appears to be less prevalent. This could limit the likelihood of continuity of care and carer due to the focus being the ward rather than following the women through her care episode (Biro et al. 2003). This may compound a dissatisfaction of care for both woman and midwife.

Integrated and/or community team midwives (the terminology is dependent upon culture of the organisation) work autonomously providing care through the pregnancy and birth continuum. This typically occurs within the community and hospital/birth centre settings. Teams of midwives also are expected to provide care for high-risk women in partnership with the obstetric team. The option of a home birth has been greatly reduced due to cost and resources. Caseloads per midwife within mainstream services (more than 40 women per year dependant on how the workloads are distributed) are much higher than those for caseload-held midwives (typically 30–40 women per year) working in smaller team. Unlike caseload-held midwives, integrated team midwives cover the whole maternity services as priority dictates. The birth places project (Barber et al. 2014) has been key in supporting midwives and women in achieving the birth place of their choice

whilst maintaining safety. Maintaining a range of birth place options not only supports women's choices; it minimises newly qualified midwives' overall loss of clinical skills.

Effective partnership working across universities, commissioning groups, practice partners and experts by experience/users of services enhances the quality of education design and delivered ensuring that it meets current and future demands of maternity services. This is a cyclical monitoring activity that reviews the types of maternity care/service provision so that it remains fit for purpose and fit for women. The current national policy drives forward change, i.e. the public health agenda, support and educate women and their family, that women remain active in shared decision-making when considering their birth wishes and that feedback from families when things go wrong is heard and acted upon to ensure lessons are learned (NHS), for example, when a baby dies.

12.5 Registrant Demography

On 30 September 2008, there were 25,664 (19,639 whole time equivalent) midwives registered on the NMC professional register, and for the year 2009/2010, 39,945 midwives were registered with the NMC (DH 2010). The professional register is available for any member of the general public, employer and registrant to check the status of any practitioner claiming to be an 'active' nurse or midwife. There are a set criteria for registrants to achieve to enter and maintain registration status. Midwifery students must achieve a satisfactory outcome from either a 156-week validated university preregistration midwifery programme, meet the declaration of good health and character and pay their subscription to enter the register at the point of qualification. Registrants must achieve revalidation every 3 years which encompasses practising a minimum of 450 h for each part of the register they wish to maintain, undertake five reflections, receive five pieces of related feedback, complete a professional discussion with a registrant and complete a minimum of 35 h of related continuous professional development of which 20 h must be in a group environment, and this must then be overseen and signed as a true account by a confirmer who is also a registrant. The registrant pays a fee to maintain registration every 3 years and an annual retaining fee. It is the responsibility of the registrant to maintain this, not the employer; however the employer has a duty to ensure that registration is current and maintained.

The Royal College of Midwives is a professional organisation and trade union for the 'whole midwifery team' across the four countries of the UK (RCM 2018) providing advice, support, clinical and professional guidance and teaching and learning opportunities through online resources and annual national conferences for students and qualified midwives. The mission statement includes excellence in care for women and their families nationally and internationally through enhancing the confidence and practises of midwifery students and qualified midwives. The three words that encompass the RCMs philosophy are promoting, supporting and influencing.

According to the Royal College of Midwives (2016), 96% of midwives in the UK work within the NHS. They also calculated the shortage of midwives between September 2015 and September 2016 to be approximately 3500 full-time equivalents meaning that despite all the political hyperbole, there was only a real increase of 104 midwives. In reality this means that in England 'for every 25 people entering their midwifery training in England, the net result is a workforce that grows by just one midwife' (RCM 2016, p. 3). This is a very expensive commodity for limited output.

Registrant demography has been a cause for concern over the previous 10–15 years with the Midwifery 2020 report (DH 2010) and RCM (2016, 2016a, b, RCMc) highlighting an aging workforce. It was first identified back in 2004 (Hu et al. 2004) and mooted again in 2010 (DH 2010), in the MINT[1] report (NMC 2010) and by the RCM (2016), that a significant part of the work force (40–45%) was between 40 and 45 years of age (average age of midwives was 42–43 years in 2010) and would be due to retire by 2020. Since the publication of these reports there have been significant changes to pension age for women and pension contributions fuelled by the period of austerity meaning that women will need to work longer before they can receive their state pensions and therefore this may impact on previous forecasts. According to the RCM workforce statistics (2016, p. 3), the number of midwives working in the NHS in England has increased by approximately 1500 since 2010, but the age profile of midwives less than 50 years old fell. One in three (33%) midwives in England currently is between 50 and 60 years old; one in three (35%) in Wales is between 50 and 60 years of age; two in five (40%) in Northern Ireland and in Scotland (41%) are 50 years plus; however, this figure represents both midwives and maternity support workers combined. This loss of experience and expertise of lifelong career midwives compounded by the fact that there are increasing work pressures, aligned with a reduction in experienced midwives, may make the transition from midwifery student to registered midwife more challenging (Kitson-Reynolds 2010; NMC 2017d). Not only is the newly qualified midwife undergoing a period of transition and possible increased anxiety at entering their first position (Avis et al. 2013), they are also needing to adjust to the change in experienced workforce due to retirement, midwives leaving for other reasons and midwives choosing to work reduced and/or flexible hours (RCM 2016). In the UK, 57% of midwives work part-time. This is broadly comprising 62% in Scotland and 66% in Northern Ireland. More midwives need to be educated now for them to gain valuable experience from midwives qualified longer than 2 years rather than from midwives who themselves are still undergoing a period of preceptorship (Kitson-Reynolds 2010). NHS Trusts invest time in the education and training of the students affiliated to them and actively want them to remain for their first posts. The skill mix is currently in favour of newly qualified midwives with as

[1]The MINT report considers 'Midwives in Teaching' and the 'evaluation of whether midwife teachers bring a unique contribution particularly in the context of outcomes for women and their families'.

much as 80% of the workforce being qualified less than a year compared to 20% of experienced midwives. Many NHS Trusts are working collaboratively to address these national concerns.

Back in 2010, it was reported that a substantial number of midwives leave the NHS and profession within 5 years of starting their careers (DH 2010). This has led to implications on the NHS providing appropriate skill mix in clinical environments daily, with the newly qualified midwives making up a significant part of the midwifery workforce currently (RCM 2016b, c). The Mind the Gap report (Jones et al. 2015, p. 3) identifies employers concern about recruitment and retention of midwives (and others) and reiterates the need to address the current issues of transition from the third year as a midwifery student to the end of the first year as a newly qualified midwife (Kitson-Reynolds et al. 2014). Hamshire et al. (2014) and Kitson-Reynolds (2010) consider that the issue of retention of staff stems from studenthood. This is compounded by the generation stereotypes as set out by Jones et al. (2015), whereby early attrition of students can be due to unrealistic expectations of the role of a midwife and working clinically (Kramer 1974), personal situations such as financial, wellbeing, family, caring for the young or elderly challenges even the most resilient of individuals (Brennan 2017). Hamshire et al. (2014) consider the 'collaboration between academic institutions, students, placement providers, and commissioners' has the opportunity to develop more effective ways of working.

Commissioners within Health Education England (HEE) are no longer commissioning and funding education places for midwifery students who commence their education after 1 August 2017. HEE, Health Education Wales, Health Education Scotland and Northern Ireland Health Education are education and training bodies within the four countries of the UK and came into fruition within the modernised NHS from 2011. Each body supports the delivery of 'excellent healthcare and health improvement to the patient… by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place' (HEE 2018). There has been a societal shift with more tolerance afforded to part-time, flexible working for both men and women at any age. It may be that to reduce attrition, the future considers a part-time route into the profession especially given the rising numbers of part-time qualified midwives practising currently (RCM 2016). Many students come to midwifery education from already established careers outside of health, and this is an opportunity to embrace the diverse range of skills that individuals bring to the profession.

12.6 Preparation for Clinical Practice/Midwifery Education: Changes to the University Funding and the Consequences to Midwifery Education

Midwifery education in the UK has undergone numerous changes to ensure that preparation of future generations of midwives is fit for purpose with the skills, knowledge, values and behaviours required for the ever-evolving role and

expectations of society (Lauder et al. 2008). Historically, midwifery education has been via a direct entry route. After the Second World War, a significant number of midwives attained registered general nurse status prior to their midwifery training (Cowell and Wainright 1981). Traditionally, entry to the profession was via an 18-month midwifery programme within hospital training schools for these registered nurses (Fraser 1996) who were employed as part of the workforce with a salary for the duration of their training. More recently, the first diploma and degree courses for preregistration students began in 1989 (Fraser et al. 1998). Fraser et al. (1998) were key in further developing midwifery education, and during 1990 the first of the modern 3-year preregistration programmes commenced at 14 pilot sites. Prior to these programmes being fully evaluated, other institutions began to validate curricula to provide similar programmes of education. At that time Fraser et al. (1998) published an outcome evaluation of the effectiveness of their preregistration midwifery education programmes to ascertain if the students were appropriately assessed for competence and to provide women with emotional, psychological, spiritual and cultural holistic care. This research and related publications (Fraser 1996, 1999a, b, 2000a, b, c, 2006, Fraser et al. 1998) considered whether newly qualified midwives were fit for purpose after completion of what was deemed then as an effective midwifery education programme. The outcomes were favourable.

All midwifery students commencing training from September 2008 have been educated to a minimum of degree level through validated curricula (RCM 2009a) and monitored for quality assurance via the NMC; prior to this date, some institutions offered diploma-level entry programmes. They compete a disclosure and barring service declaration which checks that each midwifery student has no record of convictions (a legal requirement for ensuring public safeguarding) and an occupational health check to ensure they are of good health and appropriately inoculated to ensure protection of the public whilst working clinically. The degree was developed to prepare the midwifery student for the transition to a confident and qualified practitioner (NMC 2009) with appropriate skills to apply evidence base to practice and to inform practice. The NMC (2009, p. 15) currently states that direct midwifery training 'should be no less than 3 years' or 156 weeks equivalent for a full-time commitment. The practice to theory ratio is stated as being no less than 50% of clinical practice with a minimum of 40% theory. Education must be provided via university institutions (NMC 2009, p. 18), but with the political restructuring of healthcare student bursaries for training from 2017 to 2018, changes to commissioning of training places and the opening up of competition for healthcare training institutions (Skills for Health 2017), education and training are potentially reverting back to pre-1990 provision.

As there is a clinical component to all midwifery preregistration programmes, the NMC has provided standards to support learning in practice (NMC 2008). Currently midwifery students are required to be mentored by a trained and competent midwifery mentor who has a 'sign-off' status as recorded on a Trust-held mentorship database. The NMC audit mentorship standards at times of programme (re) validation and quality monitoring events. Midwifery students are currently assigned a 'sign-off' mentor who they work with for 40% of their clinical placement and who

takes responsibility for ensuring the student has met the required level of knowledge and understanding to practise safely. The 'sign-off' mentor take responsibility for assessing that the midwifery student meets the required level to pass practice as set out in the NMC preregistration education midwifery standards (NMC 2009). To ensure midwives are able to achieve 'sign-off' status, organisations may adopt a buddy mentorship approach to support students and develop competence of more junior mentors. New NMC (2018) standards for student supervision and assessment are to take effect from 2019 whereby Sign off mentors will be referred to as assessors and mentors will be supervisors.

At the point of course completion and professional registration, students complete a declaration of good health and character, and a Lead Midwife for Education takes professional responsibility for ensuring that each midwifery student has achieved the minimum standards of education as set out by the NMC (2009) before they can be considered for entry to the professional register. The University sends evidence of each midwifery student completing the course and NMC requirements to the NMC who match the corresponding completed documentation from each midwifery student once payment has been received.

A key quandary remains as to how new practitioners are educated to the realities of the role of the midwife and how they attain the full range of skills and knowledge as well as resilience to cope with the expectations and rising demands placed on all services in the current NHS climate (Kitson-Reynolds et al. 2014; van der Putten 2008). Equally it is anticipated that there will be increasing expectations of those students in both the academic and clinical environment. The realities of health service provision do not always meet the expectations of aspiring healthcare professionals who enter training programmes with what they perceive women will be offered and what they themselves want and expect their professional roles to be (Kitson-Reynolds 2010).

The move to the development of apprenticeship across the entire UK workforce has begun to increase from the start of April 2017. In the NHS apprenticeships are currently being developed and promoted (Skills for Health 2017). This can be for existing staff who are already employed within the NHS and who are looking to develop in their area of work or for new recruits. This relates to non-clinical and clinical roles. Clinical apprenticeships are currently in their infancy in terms of development. Nursing standards through an apprenticeship are already developed and approved by the NMC, and work is in progress to develop the standards required for other professions, for example, Physiotherapy and Operating Department Practitioners (ODPs). Skills for Health notes that the midwifery apprenticeship to degree level is currently 'being explored' and waiting on finalisation of the NMC standards of proficiency.

Some programmes, validated by the NMC, provide mastery-level academic work, whilst clinically they are assessed at the same level as undergraduate midwifes. These programmes remain few due to current funding arrangements for second degrees (HEPI and Unite Students 2017). It remains that those prospective students currently on the 'Nurses part' of the professional register, full-time courses must undertake a programme not less than 18 months or equivalent to 78 weeks in length. The same boundaries apply as to 156-week programmes (NMC 2009);

however, few universities continued to offer 78-week preregistration shortened programmes for qualified nurses with regional commissioning rendering these programmes redundant. Shortened programmes are beginning to look attractive to NHS organisations again due to the speed of output on a much-needed increase in workforce (Health and Social Care Information Centre 2014; Health Education England 2015). This means that practising midwives currently possess certificate level training or above; they may be dual registrants or direct entry registered. The NMC is reviewing its preparation of nursing standards with midwifery standards to follow in the next few months. This is a timely activity in a period of immense change with advancing technology, advancing science, political uncertainty and societal expectations to ensure and prepare the next generation of midwives for 2030 and beyond.

The Lancet series (Renfrew et al. 2014) articulates the importance that the contribution of midwifery provision can make to the quality of care of women and infants globally. The NMC under the leadership of Professor Renfrew is reviewing the midwifery education standards. The standards from 2009 (NMC 2009) are being modernised to address complex high-risk health concerns that may include co-morbidities. It is a complex world of change that the future workforce is embarking. These new education standards are due to be published in 2018–2019 and are expected to be implemented by 2020. The standards will be informed by findings from UK maternity reviews such as MBRRACE (Knight et al. 2017) and coroner's court findings and recommendations. The NMC (2017a) reviewed three key topics to enhance care which are fetal heart monitoring, escalating concerns and perinatal mental health which will have an important place in the new standards.

12.7 New Graduate Midwives' Experiences of the Current Graduate Programmes?

Barker (2014) proposes that the final year midwifery student employ reflexive practice by reflecting on their strengths and limitations and then seeking out opportunities to develop as a practitioner. For students, this skill of reflection begins with their undergraduate education with emphasis on looking at plans to develop during clinical placements. Students are aware of the lifelong learning commitment that is linked with the changes to revalidation as introduced in 2017 by the NMC. Historically there has been a plethora of texts related to nursing and the transition from student to newly qualified practitioner (Maben 1995; Maben et al. 2006; Maben and Macleod-Clark 1996, 1998; Macleod-Clarke et al. 1997) and more latterly within the midwifery arena (Kitson-Reynolds 2010; Kitson-Reynolds et al. 2014; Begley 1999; Van der Putten 2008). This has recently been presented through work undertaken by Jones et al. (2015, p. 6) looking to what newly qualified midwives have said was important to them. Below is Kate's reflection as to being at the point of registration following a 3-year Master of Midwifery Programme. It outlines her anxieties and preparation to fulfil her ambition to be a practising midwife in the UK.

During my first year of training, I was at least two steps behind my mentors—both literally and metaphorically. I spent a lot of my time attempting to decipher the secret code of midwifery: primip, anti D, Klehiauer, GTT, LFT, MSU. The list was endless, and I was left bamboozled.

By the middle of the second year, I was surprised to find that I was beginning to keep up: I understood the language and felt enlightened. I was participating in ward rounds and conversations, albeit tentatively. I stood shoulder to shoulder with my mentors, and I started to feel as though I belonged.

At the start of my third year, I could see that expectations had changed: midwives and mentors stood at least two steps behind me, and I was beginning to lead care. I am now weeks away from qualification, and midwives are preparing me to fly the nest, but they are still there in case I stumble. Mentors have facilitated my transition from terrified first-year quaking in her sensible leather work shoes, to competent third-year who knows her limitations and is not afraid to speak up. I am involved in decision-making, I lead care, I make referrals, I document, I love the women I care for, I initiate conversations, I know what I am doing a lot of the time.

My final practice placement has certainly consolidated my knowledge, improved my confidence, and reiterated the fact that I am more than happy to hold my hands up and ask for help when I need it. More importantly, perhaps, it has shown me the love and generosity of my future work colleagues. I am no longer simply trying to keep my head above water, but rather I am attempting to swim, and that means I can take in the view. I can see the love, compassion, patience, pride that midwives have, not only for the women they care for, but also for the students they mentor, teach, support. This year has been a learning curve for myself and the midwives with whom I have worked since my first year: we have had to renegotiate our working relationship as I take a more prominent role and they let go of the reins.

Qualifying fills me with excitement and trepidation in equal measures. The thought of being in a room caring for a woman for the first time without a mentor by my side terrifies me, although I am lucky enough to be starting my first post in the Trust in which I have trained. I know the midwives, I know how well newly-qualified midwives are supported, I know that people are rooting for me, even when I am not rooting for myself.

I am prepared for the fact that my journey as a newly-qualified midwife will mimic my journey as a student: there will be times when I cry all the way home, when I do not feel listened to, when I wonder what I contributed to the shift, and times when I want to shout from the rooftops about how incredible my job is, how privileged I am. At the end of my second year of training, I was given an incredible midwife as my mentor and she could clearly see I was struggling. She asked me why I was putting myself through this gruelling training. My response was instant: because I love women. Her reply: and that is your greatest strength. Whenever I wonder why I am doing this, why I get

up and put myself through the tough days, I always think back to that conversation and it gives me strength and courage. The same will be true in a couple of months' time when I will have replaced my student uniform with that of a qualified midwife, when I am feeling excited and petrified. Whenever my fears around qualifying surface, I console myself by remembering that some amazing midwives, mentors and lecturers have told me that I am going to be OK. In the not too distant future, I am going to have to take a leap of faith and trust that they are right: I will be OK.

12.8 Changes to Include the Introduction of Associate Professionals and the Potential Impact on the Newly Qualified Midwife

As outlined previously, the NHS has a recognised staffing crisis, coupled with the reality of nurses and midwives leaving the professions (RCM 2016) and that educating and training the future workforce is expensive. Some of these costs are now being met through students funding their programme fees, but generally midwives are a costly resource if they do not remain in the profession. There have been creative ways to address these deficits in workforce in other healthcare professions. Nursing has introduced levels of responsibilities through the inception of Nursing Associate (NA) role (NMC 2017b). There has been much discussion as to how this mimics historic roles such as the Enrolled Nurse (EN) and Assistant Practitioners. The NA role requires staff, who are working in a nursing healthcare support role, to undertake and complete a Foundation Degree in Health and Social Care (academic level 4 and 5) whilst also meeting the competencies required to meet the role description. The role will be NMC registered.

Midwifery to some extent has this with NVQ-trained maternity care assistants or maternity support workers, nursery nurses and registered adult nurses who support the role of the midwife by providing women-centred care which in turns supports midwives to undertake the roles that are currently protected in regulation. This would include midwives supporting women with their birth experiences. Midwives are technically managers of care, and for the newly qualified midwife, they are learning to take responsibility for the work carried out on behalf of them. This is something that is challenging to learn as a student.

12.9 Preceptorship and Developing Competence/Extended Roles

It has long been recognised that healthcare practitioners that have the best effective start in their careers will provide safe and effective care to patients (DH 2010; Murphy 2014; NHS Education for Scotland 2017). The DH *framework for preceptorship* (DH 2010b, p. 14) claims that a preceptorship programme will enable the

newly qualified midwife to feel 'valued and respected', thus improving retention. With the 60th anniversary of the NHS in 2008, Lord Darzi's (2008) NHS report espoused 'high-quality care for all' with an aspiration to valuing the work undertaken by NHS employees (p8) by providing a 'threefold increase in investment in nurse and midwife preceptorship with a view to offering protected time for all newly qualified nurses and midwives to learn from their more senior colleagues during their first year'. No direct details were provided allowing for individual organisations to consider how best to enhance the quality of their service provision. Darzi (2008) was influential in the development of practices, and hence, the NMC (2008) recommended a period of preceptorship of no less than 4 months within a circular 21/2006, but this was always an area of contention with academics stating that 4–6 months should be the minimum time for development and transition (Maben and MacLeod Clark 1996). The NMC and DH (2010b) advocate that preceptees should have learning time protected in their first year and have access to a preceptorship programme with facilitated action learning sets and/or reflective sessions. Whilst this is deemed to be best practice, there appears to be flexibility to interpretation and application remaining ad hoc due to workforce limitations and understanding. Newly qualified midwives actively seek out employment where they perceive they will be supported during their first year qualified, and hence preceptorship packages are keys in ensuring effective and adaptive workforce.

Preceptor programmes include a period of supernumerary status, but the length of time for each programme varies from trust to trust with the programme lasting between 4 and 12 months. Commonly newly qualified midwives are presented with a competencies workbook at the start of their first post to work towards their next-level pay banding by the end of year one as a newly registered practitioner (Mason and Davies 2013). Novel ideas that include a transition passport for third year students through to the end of their first year of preceptorship (Kitson-Reynolds et al. 2015) are becoming popular. Kitson-Reynolds et al. (2014) report newly qualified midwives difficult journey through the preceptorship programmes due to their feeling that the expectations and reality of clinical practice were unmatched. With the recent understanding of the different generations' view of the world (Jones et al. 2015), it is clear that better understanding of the newly qualified midwife's expectations, strengths and limitations, levels of resilience and technology acumen is needed. It is clear that a new, fresh, innovative vision of preceptorship delivery is needed to ensure retention to the profession. The world of midwifery needs to think differently and courageously. Fenwick et al. (2012) and Wain (2017) call for personalised preceptorships that are supportive which may prove to be cost-effective in the long term and timely in view of changing legislation and standards linking to the revalidation process (NMC 2017c).

12.10 Developing a Career Plan

Following a period of consolidation and preceptorship, the qualified midwife should have more confidence in their ability to perform their role and have developed competence to provide safe effective high-quality care for women and their families.

Newly qualified midwives may decide to practise in other countries. Most countries require the midwife to provide evidence of education and practice and currency of registration. The midwife may also be required to sit an exam as part of the country's entry criteria.

Registrants are required to demonstrate currency in practice by continued professional and personal development (CPPD). This CPPD can take the form of self-directed and shared learning, practising a set number of hours for each part of the professional register they hold and receiving feedback from service users (NHS England, 2017). This CPPD approach enables practitioners to reflect and further develop their practice and undertake a peer-related discussion about practice before being 'confirmed' throughout the revalidation process (NMC 2017c). Changes to the revalidation process offer registrants the opportunity to enhance their personal and professional responsibilities. Both students and newly qualified midwives are encouraged to consider what their career trajectories and aspirations are with a view to developing their knowledge and skills base to provide them with self-actualisation, purpose and meaning to best deliver care for women and their families.

The Midwifery 2020 report (DH 2010) considers career pathways for enhancing maternity services generally. Many new innovative career pathways are in existence such as clinical academic midwives who undertake both a research and clinical role (Kitson-Reynolds 2018), advanced practitioner routes (Health Education England—Wessex Advanced Practice Network 2016) and consultant midwife training. All routes drive forward quality and women- and family-centred care. Equally, there are midwives that want to focus on what is the most important reason for joining the profession, and that is being there to care for the women and their families, to provide best practice and to enhance the experiences for all involved. It is passion that drives midwives in their career desires (NHS Leadership Academy n.d), and it has been clear that midwives have left the profession due to not being able to sustain role and good care.

12.11 The Lived Experience of Newly Qualified Midwives During Their First Year as Registrants

As already alluded to, due to a 10-year period of austerity, there have been national alterations to recent working environments resulting in changes to health service delivery. NHS Trust financial deficits are reported almost weekly in the UK media. The reality for employers and employees surrounds cost-saving exercises leading to recruitment freezes, changes to pensions, potential high sickness levels due to burnout, maternity leave and demographic and social demands, all of which can prove stressful for any practitioner. Professional responsibility changes upon qualification/registration. For the newly qualified midwife, adapting to a change in mindset towards coping with increasing service demands, limited staffing and reduced 'protected' preceptorship time may exacerbate potential stress (Maben and Macleod-Clark 1996) all at a time where they are gaining confidence and competence with the uncertainty that their new profession brings (Kitson-Reynolds 2010).

Prior to the year 2000, midwifery education was provided fully within the NHS, and students did not have a degree of protection from being a full-time university student; they were employed and were immersed in a culture of employment with the same parameters of any contracted employee. Society and professionals have high expectations of healthcare provision and of professional conduct (Jones et al. 2015; Emmerson et al. 2000). This directly impacts on the working life of a newly qualified midwife which has provoked practitioners and managers to question whether individuals should be 'protected' from the realities of being qualified whilst in their student role (Clark and Holmes 2007), thus making transition to 'midwife-hood' (Kitson-Reynolds 2010) much harder.

Findings within Kitson-Reynolds' (2010) phenomenological study eliciting the lived experience of newly qualified midwives highlighted that confidence and the fear of litigation affected their experiences and satisfaction in their first posts. The undergraduate midwifery student is supported and developed as an individual so that they are confident, reflective and safe in their practice upon qualification (Davis et al. 2012; Mason and Davies 2013). However, newly qualified midwives noted their pursuit of reassurance from more senior midwives as so that they did not begin to display dependent behaviours, such as seeking constant affirmation of the decisions they had made belonging (Kitson-Reynolds 2010). This was interpreted as defensive practice (Andrews 2009) and not true autonomy as they had expected to have once qualified. Hobbs (2012) considered the culture of midwifery and how midwives fitted into the organisational culture (Robbins and Judge 2014) whilst determining what type of midwife they envisioned themselves to be. Themes of 'reality shock' (Kramer 1974) and 'lack of support' resonate across nations and were reported to be common place (Van der Putten 2008; Hughes and Fraser 2011; Fenwick et al. 2012; Kitson-Reynolds et al. 2014; Wain 2017).

Whilst much of the evidence is from the early 2000s, it is disappointing to see that 'being part of the club'/belongingness and professional socialisation remain key when eliciting why midwives stay or leave the profession (Rush et al. 2013; Kitson-Reynolds 2010; Jones et al. 2015; RCM 2016; DH 2010). Retention of newly qualified midwives remains a concern (Phillips 2014), and as previously suggested preceptorship programmes act positively to attain staff (Hamshire et al. 2014), but the reality is current workload means that positive actions often become subsumed. Jones et al.'s (2015, p. 15) study has shown that 'Generation Y' people are generally a more mobile group of workers than their older peers (Gaia Insights 2015). If their employer does not meet their needs, they will move on (Gaia Insights 2015) and may even leave the profession. This is potentially the cause of the attrition rates reported by the RCM (2016b) and within the media. There is emphasis on resilience training (Jones et al. 2015, p. 21) and the need of midwives to feel they have a sense of purpose through being part of a team with a true sense of community and team working.

Whilst transition of roles from student to qualified midwife appears to be stressful and challenging, once through this first year midwives are ready for their next adventure. The midwife is ready to take on the development of their junior peers and other midwifery students, and they are ready for promotion and further career

development (NHS Leadership Academy, n.d). Jules is a midwife who has been qualified for 2 years. She is embarking on developing an area of expertise that she can craft and further develop to meet the needs of the women. Below she presents a reflection on her journey from student to midwife.

I remember putting on my uniform for the first time, walking into the hospital full of nerves and uncertainty, feeling like a fraud. I felt like a little girl playing dress up, yet here I was a mature woman and a fully qualified midwife to boot.

Working on my own was initially exhilarating and yet daunting, but I soon fell into my pace, trusting what I had been taught and knowing it was ok to ask for help and support. The team at the hospital all welcomed me and supported me, encouraging me to trust my instinct and professional judgement. I found out I knew more than I thought.

In hindsight, I can see I probably learnt more in my first 6 months qualified than I did in my 3 years studying. Making decisions and care plans forced me to read more than I ever did whilst studying to ensure that my practice really was evidence based and current. I also learnt the weight of my professional registration. I learnt that the conclusions I came to from vaginal examinations, for example, had to be correct to avoid unnecessary intervention for the woman and to ensure that the care plans I made were appropriate. I discovered how important it was to be thorough and careful.

It is hard to see how far you have come until the new group of newly qualified midwives start working and you realise just how much you have grown in confidence, knowledge and experiences. The hardest thing I found in my transition was the lack of feedback you get once qualified. As a student, you debrief regularly and reflect on your practice continually with your mentor. In addition, as part of that is the receiving of feedback on your practice. Once qualified that stops completely, you are working independently, and there is no one to give you feedback. Initially this meant I sought reassurance from senior midwives that I was doing ok, but as time has gone on, I have learnt to accept that aspect of practising as a qualified midwife.

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