Midwifery education in New Zealand: Education, practice and autonomy

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Abstract

New Zealand’s midwifery education model is intertwined with a practice model which is underpinned by autonomy and partnership. The curriculum prepares students for practice across the scope of midwifery on their own responsibility. While students have formal learning opportunities within educational institutions they spend at least half of their programme learning through authentic work experiences alongside midwives and women. Midwifery educators partner with practising midwives to support students to develop the knowledge, skills and attitudes required to practise midwifery in the New Zealand context. This paper provides an overview of New Zealand’s midwifery education model and identifies how it is integrated with New Zealand’s unique midwifery service.

Background

Midwifery education in New Zealand has always closely reflected midwifery practice. Midwifery registration and formal midwifery training commenced in 1904. Initially midwives practised autonomously caring for women at home, in community-based midwife-run maternity homes and in State-funded midwife-led maternity facilities. Midwifery students (both direct entry and registered nurses) were trained ‘on the job’ with some formal classes. Students worked in all settings under the supervision and teaching of practising midwives and were educationally prepared for autonomous practice.

As in many Western countries, New Zealand midwives gradually lost their professional autonomy as a result of decreasing home birth and increasing rates of obstetric intervention (Donley, 1986). A law change in 1971 redefined midwifery as obstetric nursing and required midwives to practise under the supervision of a doctor. This loss of midwifery autonomy also led to a loss of direct-entry midwifery training and the integration of midwifery within an advanced nursing qualification, available only to registered nurses. In turn this led to a decrease in the numbers of midwives trained in New Zealand and the maternity services began to rely heavily on overseas midwives (Pairman, 2005, 2006; Guilliland and Pairman, 2010; Gilkison et al., 2013).

Women objected to the medicalization of childbirth and loss of control over what they saw as a normal life event. Establishing action groups such as ‘Parents Centre’, the Home Birth Association and ‘Save the Midwives’ in 1953, 1978 and 1983 respectively, women advocated for the return of midwifery autonomy trusting that midwives would enable them to take back control of
childbirth. Midwives too began to advocate for midwifery autonomy and the return of their professional identity. Through combined political action during the 1980s women and midwives called for the reinstatement of midwifery autonomy and the separation of midwifery education from nursing. This grassroots political campaign of women and midwives in partnership succeeded in 1990 with a law change that reinstated midwifery autonomy and paved the way for direct entry midwifery education (Pairman, 2010). The political partnership of women and midwives also laid the foundation for New Zealand’s model of Midwifery Partnership (Guilliland and Pairman, 2010).

Direct entry midwifery

Following the 1990 legislative changes midwives initially continued to be regulated by the Nursing Council of New Zealand and it was not until 2003 that the Midwifery Council of New Zealand (the Council) was established as the regulatory authority for midwives. Between 1990 and 2003 the New Zealand College of Midwives (the College), midwives professional organisation, worked closely with the Nursing Council to ensure that appropriate standards for midwifery education were set. The College understood how midwifery education could influence midwifery practice and how important it was to ensure that midwives were educationally prepared to provide autonomous and women-centred midwifery care that reflected the way in which New Zealand was developing its maternity and midwifery services (Pairman, 2010).

Three year direct entry midwifery bachelor’s programmes commenced in 1992 to prepare midwives for autonomous midwifery practice and the first graduates were registered in 1994.

A midwife-led and woman-centred maternity service

In the years since midwifery autonomy was reinstated in 1990 New Zealand has developed a unique maternity model. Maternity services integrate primary, secondary and tertiary services and aim to meet the individual needs of each woman and her family through a woman-centred and midwife-led model. Women choose care from a Lead Maternity Carer (LMC), 92% of which are midwives, with the rest being obstetricians or general practitioners (Ministry of Health, 2015). Midwife LMCs provide care at home or in a community clinic from early pregnancy through to six weeks after the birth of the baby. Women may choose to birth at home, in a birthing unit or in a hospital and all care is free. Postnatal care commences with daily visits, including in hospital, and continues for four to six weeks when the woman and her baby are transferred to well child and well woman services. Women requiring specialist care can access this freely and the midwife and the obstetrician work together to ensure a seamless service for each woman.

Midwives may also choose to work in maternity facilities (known as core midwives), caring for women admitted with complex care needs and partnering with LMC midwives whose clients have chosen to birth in the facilities. All midwives practise on their own authority and are accountable for this practice to women, to the profession and to the public through the Midwifery Council.

The Council sets the Midwifery Scope of Practice, the competencies for entry to the Register of Midwives and education standards as the requirements for pre-registration midwifery education programmes (Midwifery Council of New Zealand, 2015). In their first year of registered practice midwives must undertake a Midwifery First Year of Practice (MFYP) programme, run by the College. MFYP is a funded, structured and individualised programme of one-to-one formal mentoring, education and professional development designed to support new midwives as they gain confidence as autonomous practitioners (Lennox and Foureur, 2012; Dixon et al., 2014). All practising midwives are also required to demonstrate continuing competence through participation in the Council’s Recertification programme.

New Zealand’s midwifery education model

New Zealand midwives are educated through bachelor’s degrees that combine the best of academic and apprenticeship approaches to education. The Midwifery Council sets the framework (via standards) requiring 4800 total hours, flexible delivery approaches and specific theory and practice components including at least 2400 practice hours, 1920 theory hours, minimum 40 facilitated births, and 100 each of antenatal, postnatal and newborn assessments. The total hours equate to four academic years but the degrees are delivered over three calendar years so that students can maximise experiential learning opportunities across the whole year. The programmes must prepare students to meet the competencies for registration as a midwife. They focus on developing the knowledge and skills required for autonomous practice as a ‘specialist’ in normal childbirth, the development of critical thinking skills, professional judgement and a professional framework for practice. Students work alongside a number of practising midwives in the community and in hospitals so they can experience midwife-led continuity of care across the scope of practice in all settings. Practice experiences increase across the programmes to 80% of the final year and provide important opportunities for students to apply knowledge to practice. Both midwives and women participate in teaching and assessing students and the partnership between practising midwives, midwifery educators and women is recognised as fundamental to New Zealand’s midwifery education model (Pairman, 2006).

Accessing midwifery education

New Zealand’s geography means that the population is spread across five main urban areas, with many provincial and rural communities. The four midwifery schools are based in main urban centres but each provides a flexible distance option which enables access to midwifery education from all communities and ensures a sustainable midwifery workforce across urban, provincial and rural settings.

Each school provides a blend of face-to-face, online and practice-based learning using a variety of pedagogical approaches (Gilkison, 2013; Patterson et al., 2015). Each school employs midwifery educators in the distance localities who teach practice skills, run tutorials, assess students, support students and midwives during practice placements and provide students with pastoral support.

How well does model work?

The success of the model is seen in the quality of the midwifery graduates and the services provided to women and their families. New graduate midwives work as community-based LMC midwives or as facility-based core midwives. Each new graduate is assessed against the midwifery standards and competencies at completion of the MFYP programme through a formal quality assurance review process known as Midwifery Standards Review (MSR) that includes examination of feedback from women and colleagues and
review of practice and birth outcome data (Lennox and Foureur, 2012; Dixon et al., 2014). Maternity outcomes in New Zealand for mothers and babies are comparable to or better than countries such as the UK and Australia, and maternity consumers continue to report high satisfaction with midwifery care (Ministry of Health, 2015; Perinatal Maternal Morality Review Committee, 2015). The Midwifery Council's recertification requirements ensure that midwives engage in continuing education, professional activities, midwifery practice across the scope and regular review of standards by women and midwifery colleagues, thereby ensuring high standards of midwifery care to women, their babies and families in New Zealand.

Challenges

Educating midwifery students to be competent midwives able to practice across the scope on their own responsibility relies on quality midwifery practice placements where students can gain the skills they require. In a context of increasing technology, and intervention in birth and where fear of birth is a more prevalent societal attitude it is challenging for students to be grounded in normal physiological birth and to gain the trust in normal birth needed for practice. To develop critical thinking and decision making skills students need to work alongside midwives who role model how to promote normal birth. Students also need support to develop effective communication and emotional intelligence skills to negotiate the range of relationships they must engage in as midwifery practitioners. The ‘on call’ aspects of the midwifery practice placements require students to juggle all aspects of study and home life.

The relationships with colleagues and the women they care for, sustain students and midwives within their daily work (James, 2013; McAra-Couper et al., 2014). All midwifery schools offer preceptorship training to midwives working with students and have established support mechanisms in recognition of the important teaching role that practicing midwives provide.

Conclusion

New Zealand's successful midwifery model is underpinned by the three pillars of education, practice and autonomy. The midwifery education model combines academic and apprenticeship learning and produces competent, confident midwives able to work across the scope of practice on their own responsibility. Midwifery students are immersed in the midwifery culture throughout their programme and women and midwives are important teaching partners alongside their midwifery teachers. The blended delivery model has increased access for midwifery students and is growing the midwifery workforce in the rural and provincial regions. It is a cost-effective model able to be replicated in any country where midwifery is community based.

References


