Collegian (2013) **20**, 7—9

Available online at www.sciencedirect.com

SciVerse ScienceDirect

journal homepage: www.elsevier.com/locate/coll

LETTER TO THE EDITOR

Response to editorial: Meeting the needs of rural and regional families: educating midwives

When a midwife is working as a midwife that is what she is. A midwife who is also a nurse is not working as a nurse when she cares for women with complex maternity care needs she is working as a midwife, an honour afforded to her by her midwifery education, registration and regulation.

We would like to respond to the Editorial published in the previous edition of the Collegian (2012) 19 '*Meeting the needs of rural and regional families: Educating midwives*' (pp. 187—188) and share some of our very positive experiences of Direct Entry Bachelor of Midwifery (BMid) Graduates working in some of Australia's most remote areas in the Northern Territory (NT).

A little bit about us: Rachael Lockey is a graduate of a BMid education. For the past 5 years she has worked in the NT, first for an Aboriginal Community Controlled Health Organisation, Congress Alukura, and then as NT Department of Health (DH) Co-Director of Maternity Services, an NT wide role with responsibility for midwifery workforce development. Currently she is employed as a Technical Midwifery Advisor for the International Confederation of Midwives.

Sue Kildea is a midwife and a nurse who has spent a large part of her career in rural and remote areas and has spent nine years as Vice President of CRANA*Plus* the remote health organisation. Most recently she holds a clinical chair position as the Professor of Midwifery which is a joint appointment with the Australian Catholic University (ACU) and Mater Health Service. In this role she was instrumental in developing the partnership with the NT DH and Congress Alukura to commence the first cohort of students in the ACU Away from Base BMid (Indigenous) course. Her previous position was a joint appointment between Charles Darwin University (CDU) and the NT DH.

The authors to whom we respond describe themselves as '*nurses, midwives and academics practising in regional Australia*' and challenge the notion that an undergraduate BMid degree '*alone*' will meet the health workforce needs of regional, rural and remote Australia. We agree with the authors on this point, no single profession can meet the workforce needs of regional, rural and remote Australia. However, midwives can go a long way to meet the maternity care needs of families in these areas.

Like the authors we also do not advocate that there should only be one pathway to midwifery education. However, the undergraduate BMid pathway is attracting those who have a vocational calling to become a midwife, it is heavily subscribed and growing in popularity. It is here to stay and we need to embrace it and think creatively about how this workforce can benefit regional, rural and remote Australia.

When thinking about health care workforce in regional, rural and remote areas of Australia it is critical to think about developing a local workforce. This can be challenging and requires services and education providers to think outside the box. In the NT and Queensland innovative steps have been taken to ensure access to midwifery education for people from regional, rural and remote areas as well as Aboriginal and Torres Strait Islander people, through the provision of BMid, Away from Base (AFB), blended learning education pathways. The ACU and Griffith University are most notable in this respect with CDU and others currently following suite. These BMid pathways have attracted a number of students from regional, rural and remote areas, who have a strong commitment to becoming a midwife. Many of these students have waited a considerable number of years for a local and/or accessible BMid education.

Furthermore one cannot consider regional, rural and remote areas in Australia without also considering the need of Aboriginal and Torres Strait Islander people, many of whom live in these areas. Currently it is estimated that there are only 60 Aboriginal and Torres Strait Islander midwives in Australia (personal communication Health Workforce Australia 2012). At the time of writing, in Alice Springs, there are currently no Aboriginal and Torres Strait Islander people educated and working as midwives. When funding became available through an Aboriginal Community Controlled Health Organisation, Congress Alukura, for two local Aboriginal and Torres Strait women to train as midwives the positions were advertised in the local paper attracting a considerable number of applicants of high quality. During interview all applicants expressed a strong desire to be a midwife, not a nurse also. The two students, along with others from their cohort, will graduate within the next year. This may seem like small steps, but this is what is required in remote settings.

The authors state that: 'the National Maternity Services Plan (2011) supports all women having access to high- quality, evidence-based, culturally competent maternity care

1322-7696/$ — see front matter
http://dx.doi.org/10.1016/j.colegn.2012.12.004

settings close to where they live (2011)' and then comment that 'in reality women may live several hundred kilometres from maternity and support services.' This is true and is the very issue that the National Maternity Services Plan (AHMAC, 2011) (The Plan) and a number of BMid pathways seek to address. The Plan is to be commended for its strong focus on rural and remote maternity care as well as giving high priority to Aboriginal and Torres Strait Islander families. A total of 55% of Australia's Aboriginal and Torres Strait Islander birthing women, those for whom maternal and perinatal outcomes continue to be some of the poorest in Australia, live in outer regional, rural and remote Australia compared to 9% of other birthing women in Australia (Kildea et al., 2010). The Plan recognises that, like all families in Australia, these families should have access to quality care close to home. Can we argue otherwise? Other Commonwealth funded initiatives such as the roll out of Telehealth and the Medical Specialist Outreach Assistance Program are also concerned with keeping clients near to home whilst increasing access to care. Utilised effectively by midwives working in regional, rural and remote areas these innovations can make considerable in-roads in providing high quality maternity care close to women's homes.

The authors go on to suggest that the BMid graduate is not well positioned to tackle the growing complexities and co-morbidities found in maternity clients in regional, rural and remote areas of Australia. Whilst we recognise that some women experience considerable health burdens we would also like to recognise that many women remain low risk obstetrically and that the prevalence of existing co-morbidities can be exaggerated. A recent audit of women in the Barkly region, a remote area in the NT, revealed that obstetric risk was not as high as it was commonly anecdotally quoted to be (Schultz & Lockey, in press). Furthermore, high levels of co-morbidities can be used as an excuse for not providing maternity care locally, however this does not address the social, psychological, cultural and financial risks of 'relocating' a women from her family and community for extended periods.

Our own experience is that those working with protected time in dedicated midwifery roles, whether they are direct entry midwives or nurses whom are also midwives, are well positioned to provide high-quality care to all maternity clients including those with complex care needs. Risks can arise when a midwife is not working as a midwife often enough, not given adequate protected time to fully address maternity care needs, not accessing relevant professional development and clinical placements in order to remain fully skilled as a midwife and not working as part of a wider maternity care team, whether it be virtual or not. Many nurse midwives feel ill prepared to provide maternity care in the remote setting and this was a significant driver for the development of the CRANA*Plus* Midwifery Up Skilling Course (https://crana.org.au/education/courses/midwifery-up-skilling-course/). In remote areas nurses commonly work as nurses, Health Centre managers and as midwives, having three or more hats. They consistently fed back that they had limited capacity to do anything other than the minimum antenatal care as the provision of acute care nursing services always takes priority. Health promotion and antenatal education are described as dreams and postnatal care can be a very poor cousin. This is evidenced through auditing in remote areas which shows that significant improvement in the care that is currently provided is essential (Bar-Zeev, Barclay, Farrington, & Kildea, 2012; Bar-Zeev et al., in press; Rumbold et al., 2011).

We would like to challenge the belief that the midwife educated through the BMid pathway is only able to care for low risk women because she is not a nurse. BMid students learn knowledge and skills required for providing care to all women, thus meeting the Australian Midwifery Competency Standard 6: Assesses, plans, provides and evaluates safe and effective midwifery care for the woman and/or baby with complex needs (ANMC, 2006). A BMid is 3 years of midwifery education and requires the student to meet the ANMAC essential minimum requirements to practise as a midwife (2006). Until recently the education pathway for nurses in Australia to become midwives was only one year and the competency assessment in some programmes resulted in some graduates being signed off as competent having attended less than five births (Australian Nursing and Midwifery Council, 2009). This has been addressed with the introduction of the new midwifery education standards (Australian Nursing and Midwifery Council, 2009) setting a benchmark for the registration of all midwives in Australia.

The authors go on to suggest that a particular skill set is required for working in the regional, rural and remote heath care context with which we agree. Whether a nurse, or not, a midwife who received her education in an urban setting can only learn this by being immersed in the regional, rural and remote setting accompanied by appropriate mentorship and access to professional development specific for this task. This is the same for all health professionals taking the leap from an urban setting to a regional, rural or remote one.

We also challenge the authors view that 'The reality of small regional, rural and remote healthcare facilities is that numbers of births will not support a health professional with midwifery skills only' stating that it would prove 'uneconomical'. We believe this is true for outdated models of care that try and ensure nurse midwives cover every shift, working primarily as a nurse but available to provide midwifery care if needed. The delivery of caseload midwifery care matches midwifery skills to midwifery workload and can be sustained in very small communities as is seen in New Zealand which supports a model of care that has caseload midwives and primary services across the country with 51 of the 58 primary units located in rural or remote settings, and 31 over an hour from tertiary services (Hunter et al., 2011). In New Zealand, in 2009, 31% of the practising midwives are BMid graduates (Professor Sally Pairman, Chair, NZ Midwifery Council, pers. commun., 2009).

In the NT we have seen maternity care reform through the development of Remote Area Midwives (RAM), Remote Outreach Midwives (ROM) and Midwifery Group Practices, providing continuity of care models for women from remote communities. The RAM and ROM roles were developed and implemented in response to research in the NT that highlighted the absence of designated midwives in communities, fragmented care pathways and a lack of communication and coordination between services resulted in serious risk to the safety of mothers and infants (Bar-Zeev et al., 2012, in press). These positions have proven to be extremely popular attracting both direct entry midwives and midwives who are also nurses, the common theme being they all want to work

as 'midwives'. The proven popularity of these positions is critical in areas where recruitment has traditionally been difficult. None of the RAMs are locums who fly in and out at great expense, they all live in the communities where they work. Where remote communities are small, such as in Central Australia with a handful of births per annum, RAMs work across a cluster of communities. In the Top End where communities are larger there is plenty of work for one midwife and in the largest communities, such as Wadeye and Maningrida, workload is such that there is a RAM supported by other midwives recruited to the primary health care team.

The RAM role includes:

- Providing comprehensive antenatal and postnatal care, attending labour and birth where necessary.
- Providing education and health promotion opportunities including issues relating to nutrition, smoking, alcohol and domestic violence.
- Liaising with referral maternity units for obstetric and birthing care.
- Working with Aboriginal and Torres Strait Islander colleagues such as Aboriginal Health Workers and Strong Women Workers to improve the cultural competence of care.
- Working alongside other partners and services such as schools, Families as First teachers, Nutrition and Child Health services.
- Contributing to regular audit of maternity care.

Needless to say RAMs are not sitting in remote communities twiddling their thumbs, comprehensive primary maternity care is much more than a few antenatal checks. A significant advantage of the RAMs being Direct Entry Midwives, means they cannot so easily be taken off the duty of providing quality primary maternity care and so maternity care continues to receive the attention it is due.

For too long regional, rural and remote maternity care has been put in the too hard basket. What has existed up until now has not worked; many women in regional, rural and remote areas have not been able to access high-quality maternity care by suitably educated maternity care providers and outcomes remain poorer for women and babies from rural and remote areas (Abdel-Latif et al., 2006; Roberts & Algert, 2000; Steenkamp, Rumbold, Barclay, & Kildea, 2012). The National Maternity Services Plan (2011) (AHMAC, 2011) recognises that families in regional, rural and remote areas, often those who already experience inequality and disadvantage, are getting a raw deal and that maternity services need to be closer to their homes. Midwives, both direct entry and nurse educated, have taken up the challenge and shown a strong desire to work in dedicated midwifery roles in remote areas and we welcome this.

References

Abdel-Latif, M., Bajuk, B., Oei, J., Vincent, T., Sutton, L., Lui, K., et al. (2006). Does rural or urban residence make a difference to neonatal outcome in premature birth? A regional study in Australia. *Archives of Disease in Childhood. Fetal and Neonatal Edition*, *91*(4), F251—F256.

AHMAC. (2011). *National Maternity Services Plan, 2011*. Canberra: Australian Health Ministers Advisory Council, Commonwealth of Australia.

ANMC. (2006). *National competency standards for the midwife*. Canberra: Australian Nursing and Midwifery Council.

Australian Nursing and Midwifery Council. (2009). *Standards and criteria for the accreditation of nursing and midwifery courses leading to registration, enrolment, endorsement and authorisation in Australia — With evidence guide*. Australian Nursing and Midwifery Council.

Bar-Zeev, S., Barclay, L., Farrington, C., & Kildea, S. (2012). From hospital to home: Assessing the quality and safety of a postnatal discharge system used by remote dwelling Aboriginal mothers and infants in the Top End of Australia. *Midwifery*, *28*(3), 366—373.

Bar-Zeev, S., Barclay, L., Kruske, S., Bar-Zeev, N., Yu, G., & Kildea, S. Use of maternal health services by remote dwelling Aboriginal women in northern Australia and their disease burden. *Birth: Issues in Perinatal Care*, in press.

Hunter, M., Pairman, S., Benn, C., Baddock, S., Davis, D., Herbison, P., et al. (2011). Do low risk women actually birth in their planned place of birth and does ethnicity influence women's choices of birthplace? *NZCOM Journal*, *44*, 5—11.

Kildea, S., Kruske, S., Barclay, L., & Tracy, S. (2010). 'Closing the Gap': How maternity services can contribute to reducing poor maternal infant health outcomes for Aboriginal and Torres Strait Islander women. *Rural and Remote Health*, *10*, 1383 (online)

Roberts, C., & Algert, C. (2000). The urban and rural divide for women giving birth in NSW, 1990—1997. *Australian and New Zealand Journal of Public Health*, *24*(3), 291—297.

Rumbold, A., Bailie, R., Si, D., Dowden, M., Kennedy, C., Cox, R., et al. (2011). Delivery of maternal health care in Indigenous primary care services: Baseline data for an ongoing quality improvement initiative. *BMC Pregnancy Childbirth*, *7*(11), 16.

Schultz, R., & Lockey, R. Birthing in the Barkly: Review of births to Barkly women in 2010. *Australian Journal of Rural Health*, in press.

Steenkamp, M., Rumbold, A., Barclay, L., & Kildea, S. (2012). A population-based investigation into inequalities amongst Indigenous mothers and newborns by place of residence in the Northern territory, Australia. *BMC Pregnancy and Childbirth*, *12*(1), 44.

Rachael Lockey*
International Confederation of Midwives, The Netherlands
Sue Kildea
Australian Catholic University and Mater Medical Research Institute, Australia

* *Corresponding author.*
E-mail addresses: rachael.lockey@hotmail.com (R. Lockey), suev.kildea@acu.edu.au (S. Kildea)