The shortage of midwives in Australia has been a concern to maternity units, women and the midwifery workforce for many years (National Nursing Review, 2002). Charles Sturt University (CSU) embarked on a novel approach to help address the shortage of midwives by engaging the area health services in the processes leading to the registration of registered nurses to be midwives. This case study describes the partnering of the University with many maternity units across Australia to theoretically and clinically prepare student midwives for registration as midwives. The complexities of developing long term sustainable partnerships between the tertiary and clinical sectors are described here. The development of the partnership and ongoing interaction between the partners in all facets of the midwifery course is shown to have very successful outcomes. Key components for maintaining the partnering relationship including agreements and liaison between CSU staff and the maternity units are considered. The value of ongoing support mechanisms for midwifery facilitators and midwives is described as well as acknowledging and addressing strengths and challenges will be shown to result in among the most prolific output of midwives from any one organisation in Australia. Evaluations by students and maternity unit staff will be shown to play an integral role in maintaining and developing the partnership. Continuous liaison by the University and a sense of ownership by the hospitals has led to an increase in the number of student midwives graduating. This has ultimately contributed to some maternity units remaining open and others offering other midwifery related services because of an increase in their midwifery workforce.
2009 AUCEA National Conference  8-10 July

Whyalla, South Australia

Midwifery Partnerships: it takes two to tango

Abstract

The shortage of midwives in Australia has been a concern to maternity units, women and the midwifery workforce for many years (National Nursing Review, 2002). Charles Sturt University (CSU) embarked on a novel approach to help address the shortage of midwives by engaging the area health services in the processes leading to the registration of registered nurses to be midwives. This case study describes the partnering of the University with many maternity units across Australia to theoretically and clinically prepare student midwives for registration as midwives.

The complexities of developing long term sustainable partnerships between the tertiary and clinical sectors are described here. The development of the partnership and ongoing interaction between the partners in all facets of the midwifery course is shown to have very successful outcomes. Key components for maintaining the partnering relationship including agreements and liaison between CSU staff and the maternity units are considered. The value of ongoing support mechanisms for midwifery facilitators and midwives is described as well as acknowledging and addressing strengths and challenges will be shown to result in among the most prolific output of midwives from any one organisation in Australia. Evaluations by students and maternity unit staff will be shown to play an integral role in maintaining and developing the partnership. Continuous liaison by the University and a sense of ownership by the hospitals has led to an increase in the number of student midwives graduating. This has ultimately contributed to some maternity units remaining open and others offering other midwifery related services because of an increase in their midwifery workforce.

Key words: midwifery, partnership, liaison
Midwifery partnerships: it takes two to tango!

Introduction

The increasing shortage of midwives in Australia has been a concern to women, families, maternity units and the departments of health throughout Australia for many years (National Nursing Review, 2002). According to the Australian Health Workforce Advisory Committee it was estimated there is a national shortage of 1850 midwives in 2005 and it was not expected that this dearth of midwives will improve in the near future (Weaver, Clarke & Vernon, 2005). While this critical shortage of midwives applies Australia wide, rural and remote areas are especially affected (Australian College of Midwives, 2007). To assist in addressing this shortage of midwives Charles Sturt University (CSU) developed an accredited midwifery course to offer to hospitals who wished to participate in midwifery education in 1990. Up until the early 1980s individual hospitals selected and trained their own midwives through what was known as the hospital system. After that the responsibility for midwifery training was transferred to the tertiary sector.

In 1991, a Director of Nursing (DON) at a base hospital in rural NSW had the foresight to realise that if rural hospitals did not once again participate in the responsibility for the training of midwives there would soon be few midwives left to provide midwifery cares to
women and their families in rural communities. The DON diverted bequeathed estate funds
towards supporting four student midwives and thus began CSUs new midwifery course.

The threat of a diminishing midwifery workforce in rural areas in particular was the
beginning of very successful midwifery training partnerships between CSU and now, 59
maternity units located in five states of Australia. The initial courage and commitment and
sense of need by one hospital’s manager has led to approximately 700 registered nurses
qualifying as registered midwives with 65 graduating this year. It is known that
approximately 80% of midwives who train in rural areas return there to work once qualified
(National Nursing Review, 2002).

Rationale for the Postgraduate Diploma of Midwifery course

Prior to preparation for course re-accreditation CSU conducted a needs analysis in
2006 to determine what women wanted in relation to maternity services, especially in rural
areas. The results clearly indicated that women wanted to give birth as close to their
families and communities as possible (CSU, 2006). At that time there were increasing fears
that the closure of maternity units would result in rural women having to travel further from
their homes to birth with 130 maternity units ceasing to provide maternity services since
1995 (Australian Rural Nurses and Midwives, 2007). The impact on women when they are
forced to birth away from their communities is enormous and includes: financial
disadvantage and family separation issues. It is also is culturally inappropriate for Indigenous women and denies midwives the right to practise the profession for which they are qualified in (Dietsch, Davies, Shackleton, Alston, and Mcleod, 2008).

A further stimulus for CSU to continue to develop and increase the number of midwifery partnerships is the gradual change in the direction of the midwifery profession. According to Pairman, Pincombe, Thorogood, and Tracey (2006) midwifery care is moving (albeit slowly) back to physiological care for women who are well, and away from the medical model of obstetrics that has dominated birthing in Australia for most of the twentieth century. Inherent in this new direction is the development of different midwifery models that includes continuity of care, independent midwifery practice and team midwifery all with a primary health care focus. These models of care encourage and support more flexibility in the preparation of midwives for registration to enable them to practise midwifery without the dominance of the medical model of obstetrics. This preparation can be undertaken in small and large maternity units and community settings where the student midwives can achieve the required standards to become a midwife. Evidence supports the notion that midwives who work in small maternity units provide equally high standards of maternity care as do the larger city maternity units (Hundley, Tucker, van Teijlingen, Kiger, Ireland, Harris, Farmer and Bryers (2007); Tracy, Sullivan, Dahlen, Wang and Tracy, 2006).
This is an important consideration because 70% of CSU’s partnering maternity units are located in rural communities where units are smaller. However these units have demonstrated the capacity to provide the birthing services that women require within the parameters of the model of care available at the unit.

The success of the CSU Postgraduate Diploma of Midwifery (PGDM) course depends on the partnership that it develops with each individual maternity unit to ensure the student achieves the standards needed to practise as a beginner midwife in any geographical location in Australia (The Australian Nursing and Midwifery Council, 2006). “It takes two to tango” describes this genuine and committed partnership whereby both the university and the maternity unit agree to liaise and take responsibilities during every step of the student’s journey in becoming a midwife. True collaboration between partners will benefit the university, maternity units and students alike (“University Partnerships”, 2009).

Martin, Smith and Phillips (2005) write that for courses to succeed they need to be coordinated, sustained, long-term projects targeted towards a specific community.

The midwifery partners need a sound understanding and appreciation of the components that bring together a course that will meet the needs of birthing women into the future. These components include: initial liaison between all stakeholders, accreditation of the midwifery course curriculum, clarification of roles, dissemination of course processes and procedures to midwives and students and course and maternity unit evaluations.
Partnerships – “open to interpretation”

Across Australia there is a variety of university courses that prepare student midwives for registration. In most cases the term “partnership” is not applicable, instead students are placed in a maternity unit for a period of time to meet their specific clinical learning objectives for that midwifery area, for example ante natal care. This model of midwifery education has been successful in preparing many students for graduation as safe, competent practitioners. Each State registering authority has clear guidelines about the content of midwifery courses and the manner of conducting the courses is dependent on the individual university’s choice of course delivery processes. In South Australia, student midwives are not usually paid when they undertake clinical placements in maternity units that their university has negotiated for them. In NSW there is a variety of training structures for example, the student might be paid by a maternity unit during the block clinical component of the course (about 6 months per year); or, there is no payment at all during the undergraduate year. In Victoria it is common for the students to attend the clinical area for 4 days per week (for example, for a period of 8 months) and they are paid for 2 days per week only.

There are several downfalls with the above systems: students need to find other work, for example, as an assistant in nursing, to survive financially. Often the students are
expected to be more self directed in their clinical learning which results in the midwives taking a less active role with the students’ learning. Many midwifery courses in Australia have a 50% attrition rate with most states only graduating 30-50 students per year. This does not replace the departure rate where midwives are retiring or changing professions (National Nursing Review, 2002; Midwifery Workforce, 2007).

CSUs partnering relationships are structured to ensure that the university and maternity units are accountable and responsible for ensuring that students meet the required registration standards. The hospital has more “ownership” of the students than for other models of midwifery education. The hospital selects their students through their usual employment processes and then pays them a full time or a .8 wage over the course duration. Partnering maternity units are informed from the start of the liaison process that they are responsible for paying the students a wage while CSU funds the travel costs that its academics incur for workshops and liaison visits. Martin et al (2005) believes that funding issues need to be defined clearly and early in the partnership.

The hospital often pays fees such as costs for attending residential schools and textbooks. As employees, the students’ professional indemnity insurance is paid by the hospital. The students have a sense of belonging when they have this “home hospital”. Often the students can stay in their home towns to study midwifery and complete their post
graduate period there. In a 2008 survey conducted by CSU it was found that 70% of the midwives working in the smaller maternity units were CSUs ex-student midwives (CSU Survey, 2008). The impact of this is that if it was not for the CSU midwifery course these smaller units would probably be closed.

Partnering with CSU

CSU employs midwifery academics who through a partnering relationship with midwives in the maternity units work together to provide theoretical and clinical learning experiences for the students throughout the 12 month duration of the course. “Cross-institutional provision: what institutions really need to know” (2005) write that it is vital the appropriate staff are engaged at all levels of the partnership. This is easier to achieve when shared goals are understood at both strategic and operational levels. The course aims to avoid a “theory-practice gap” (Jordan and Farley, 2009) and instead provide these future midwifery graduates with the skills, knowledge, confidence and competence to practice their profession (CSU, 2009).

There is no specific “formal agreement” between CSU and the partnering maternity units as the course curriculum, approved by the Nurses and Midwives Board, New South Wales (NMB, NSW), is accepted as the “agreement”. Neither CSU nor a maternity unit can alter any aspect of the curriculum without prior approval from the NMB, NSW. A quick
reference to any point in the curriculum by CSU academics, midwives and students will quickly resolve any query.

The responsibilities of CSU and the maternity unit staff are designed to complement the total midwifery practice experience for the student. CSU academics are responsible for:

1. Curriculum development; conducting residential schools on-campus where course requirements and theoretical components are presented; and

2. Introducing the often daunting information technology “need to know” course aspects. They also try to foster the development of often, life long friendships that occur between many students.

The partnering maternity unit is responsible for selecting their student midwives from the pool of registered nurses who demonstrate a desire to practise midwifery. The maternity unit also undertakes to select a suitably qualified midwife who will be the student’s facilitator. This experienced midwife will be the student’s advocate, confidante and accepts the responsibilities of organising rosters and clinical appraisals. The person who fulfils this vital role will be the contact person for CSU academics when the student’s progress is discussed and has the responsibility of apprising the hospital management of the student’s progress. The unit also nominates midwives who are suitable and willing to be preceptors for the students. Preceptor role-modelling is essential to provide students with
opportunities to learn and develop confidence and competence in the midwifery practice setting (Jordan and Farley, 2008). The partnering maternity units often state “we know if we are to keep them, we have to look after them”.

**Mechanisms for developing and maintaining the partnership**

**The orientation visit**

Hospitals considering accepting a student midwife, inform CSU of their interest. The CSU practice coordinator or course coordinator will make the first orientation visit to the unit and discuss the course curriculum with key stakeholders including hospital management, midwives, prospective students and sometimes interested medical officers. These meetings can be described with a variety of terms including stimulating, intimidating, fearful and mostly interesting. Midwives worry about their ability to teach students, others do not believe they should have to teach students because they “are here to deliver babies”. This is denying the ANMC (2006) Competency Standards for the Registered Midwife that clearly states that midwives “support students to meet their learning needs and objectives; contributes to mentoring, peer support and clinical supervision”.

This initial meeting is a great opportunity for all parties to discuss and clarify what is needed for the successful outcomes of graduate midwives to be achieved. The midwifery facilitator will complete the Maternity Unit Accreditation form which provides evidence to
CSU that the midwifery clinical experience requirements are able to be met. Some of the key components of the orientation visit include:

- assurances to facilitators and midwives of CSUs ongoing support to both students and themselves;
- discussion of the integration of theory/practice components; course structure and documentation;
- student study packages and workbooks;
- appraisals;
- the role of the facilitator in ensuring all NMB, NSW requirements are met;
- processes to be followed when students experience difficulties (CSU 2009).

This diagram shows the support that is given to the student:

- CSU Midwifery Academics
  - develop curriculum
  - facilitate theoretical development
  - residential schools
  - liaise with maternity units

- Midwifery Facilitator
  - rosters
  - confidante
  - support
  - appraisals
  - support in midwifery

- Student role is to achieve standards required to become a midwife

- Maternity Unit Managers, Midwives and other Students
  - support
  - share learning
  - facilitate opportunities
Continuing support mechanisms

Communication between partners is essential and will include "frequent, formal meetings" (Martin et al, 2005, p. 3). CSU and partnering maternity units have constant, ongoing dialogue to either address issues or just for “catching up” either in person or via electronic means. A member of the CSU midwifery academic team will make a follow-up visit within three months to any maternity unit that has accepted a student for the first time. From then on annual visits are made to each unit unless extenuating circumstances exist, such as if a student is having difficulty meeting the clinical midwifery requirements. Facilitators and midwives are offered facilitator and preceptor workshops to update them on course matters and to assist them to manage other student needs for example, academic writing. *Gravid Notes* is the newsletter that is circulated to students, managers, facilitators and midwives each quarter. This, along with the CSU forums and email system, provides avenues of two way communication between CSU and partnering maternity units on a continuous basis.

Evaluation process

The CSU/maternity unit partnership is evaluated at each annual visit to the participating hospital. Facilitators and students have the opportunity to attend a reciprocal
evaluation at each of the five clinical appraisals. Further evaluation of the partnership satisfaction is undertaken during course review. Since 1991 CSU has been proud of the success of the course and the willingness of those concerned to discuss issues and accept suggestions for change. This allows partnering units to see that it is their course too rather than gain a perception that the course is directed from the proverbial “ivory tower”.

**Mechanisms between CSU and maternity units to ensure student learning objectives and student assessment standards are met:** The clinical practice setting

The PGDM course bases its student clinical appraisals on the National Competency Standards for the Midwife (ANMC, 2006). The appraisal is used as a monitoring, reporting and teaching tool (CSU, 2009). When the facilitator informs the CSU teaching team that the student is under-performing in the clinical area, specific examples of concern are identified and learning objectives with a time frame for achievement are developed. This, together with added clinical support from designated midwives, usually assists the student to achieve the desired outcomes of midwifery competency. The appraisal also serves as a tool for documenting the student’s clinical hours completed in each of the four clinical areas (antenatal, birthing, post natal and special care nursery). If the submitted clinical appraisal show that the student is deficient in clinical experiences or hours in any particular area, the CSU
teaching team will liaise with the facilitator to alter the student’s roster. It may also be necessary for the student to access a different maternity unit to enable the achievement of the necessary experiences/hours.

A key component of the partnering relationship is that evidence of the student’s progress is transparent and available to all stakeholders. According to “Cross-institutional provision: what institutions really need to know” (2005) clear lines of communication are vital to all involved with the partnership and not just managers. Students are informed that if there are any aspects of their study that are a concern, either clinically or theoretically, the CSU midwifery team and maternity unit facilitator will work with the student to improve the situation. This process enables strategies to be prepared to assist the student to achieve the required outcomes. It also reassures maternity units that the person they are providing midwifery education to as well as supporting her or him with a wage and often fees, is progressing satisfactorily to becoming a midwife. If this open dialogue was not maintained, hospitals would probably feel less confident in participating in midwifery education.

**Concerns: The partnering maternity unit**

Usually the student, maternity unit facilitator and midwives are well informed of the course requirements. They are committed to assisting the student to access the best
possible learning environment whilst the student completes this very “full on” course. However, sometimes the “system” fails. The student might experience bullying from midwives and doctors or be expected to perform procedures /work for which they are not qualified as a student midwife, for example working in birthing suite unsupervised by a registered midwife. If the maternity unit is short-staffed, the student might also be expected to work alone and manage the care of many women on the post natal ward. This breaches the guidelines for the development of courses leading to registration as a midwife (NMB NSW, 2008). When partnering units fail to abide by any aspects of the course curriculum the CSU academic staff will liaise with the facilitator (and if necessary the hospital manager) to resolve the issue. If the situation does not improve to meet the curriculum requirements CSU will withdraw that unit from the course. Van Eyk and Baum (2002) have the view that for issues to be resolved there needs to be successful and strong, established relationships where resilient trust permits sustained action to be taken.

In conclusion, the tango for these partners will continue. This will occur because for the last 18 years the course has successfully prepared a significant number of midwives who work in hospitals like those in which they were trained. Currently there are two intakes per year for the course, producing more than 60 graduates annually. There are increasing numbers of maternity units accepting students (four already in 2009). The maternity unit
staff in most instances, are committed to preparing midwives for the future and CSU will continue to develop midwifery courses that reflect the needs of birthing women in Australia.

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Acknowledgement: Thankyou to Dr Doug Hill, Wagga Wagga, who kindly offered suggestions for the development and proof reading of this paper.