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Commentary

Reclaiming direct-entry midwifery training in Brazil: context, challenges and perspectives

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Historical background

Since the 1980s, maternity care in Brazil has been the subject of much debate, with numerous attempts to revise maternity service policy and provision to enhance the safety and quality of care. Policies and new laws aimed at improving maternity care through targeting reductions in maternal and perinatal morbidity and mortality, and use of interventions such as caesarean section are examples of these. These drivers have informed a framework for social and feminist movements which, through calls for full sexual and reproductive rights, recognise the rights of women to choose the place of birth and to have an active involvement in decision-making at all stages of their pregnancy and birth.

Public and private maternity hospitals in Brazil have worked to revise models of maternity care, triggering organisational and structural change. The opening of birth centres as integrated, alongside or stand-alone units is one example of change recognised as essential to support the humanisation of birth informed by evidence-based practice. Drivers for change have also promoted nurse–midwife and/or midwifery-led care to utilise professional skills to promote improvement in the quality and safety of maternity care (Lansky et al., 2002; Costa et al., 2005; Di Mario et al., 2005; Calderon et al., 2006; Hatem et al., 2008).

However, changes to service organisation and delivery have yet to demonstrate an impact on the maternal mortality rate in Brazil, which was 74/100.000 live-births in 2007, or early neonatal mortality, which was 50.8/1.000 live-births in 2007. According to Rattner (2009), these statistics have remained static over recent years, due not only to factors related to socio-demographic, health and education conditions of Brazilian women, but also the quality of maternity care, as women continue to die from preventable causes such as bleeding and infection. Brazil had one of the highest caesarean section rates in Latin America in 2006; 40% of women giving birth in public health service hospitals had a caesarean birth, as did 85% of women giving birth in the private health sector. This mode of birth results in higher maternal and perinatal morbidity, and mortality and higher financial costs for the health-care provider. In recognition of this, the Brazilian Government issued another set of policies in 2008 to promote normal birth and reduce unnecessary caesarean births.

This situation shows how important it is to promote and increase the role of the midwife in Brazil. This typically requires an increase in midwifery numbers, with a focus on their interpersonal relationships and qualifications, to promote and protect maternal and infant health and well-being (Page, 2001; World Health Organization, 2001; Hongoro and McPake, 2004; United Nations Population Fund, 2007). Recognition of this need stimulated the resumption of the direct training of midwives as an alternative to the exclusive post-qualification midwifery training for nurses, whose curriculum is focused on a biomedical model of health care (Carvalho, 2000; Narchi, 2001). These were the main reasons for the decision to re-open the direct-entry course in midwifery at the School of Arts, Sciences and Humanities (EACH), University of São Paulo (USP). The model of training reflected a university model which existed in Brazil until 1970, and met the requirements for registration with the regulatory council of nurses of the country.

Re-opening of the midwifery programme was widely discussed within the Brazilian midwifery and nursing arena at events promoted by the Brazilian Association of Nursing Midwifery. The development of the curriculum was based on the midwifery course at USP which finally closed in 1971, on guidelines from USP and EACH for undergraduate programmes, and recommendations of the World Health Organization (2001, 2004; OPS, 2006) and International Confederation of Midwives (ICM). Sources that informed the philosophy, model of care, competencies and legal and ethical aspects of the programme included the ICM (International Confederation of Midwives, 2002, 2005a, 2005b) and the Brazilian Nursing Code of Ethics and the Brazilian Nursing Practice Law.

The context of training

USP is a public institution in the state of São Paulo, Brazil, founded in 1934 and recognised as one of the best universities in

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the world, renowned for its scientific and technological expertise. Undergraduate programmes include some 229 courses, attended by around 56,000 students. USP has several campuses in the city of São Paulo, as well as in other cities of the state of São Paulo. Due to its high level of excellence and because tuition fees are not required, the USP college entry examination for access to undergraduate courses is highly competitive. In 2005, USP established EACH as an isolated campus providing 10 courses, including the midwifery degree programme. EACH represents an innovative approach that uses interdisciplinary learning as a tool for building knowledge, created with a strong commitment to the community of the city of São Paulo East region to develop and provide community projects as well as education and research. The EACH educational model adheres to the following basic structure:

- All courses are four years long and part-time. Classes are held in the morning, afternoon or evening.
- All courses have a weekly class schedule of 20 hours and a schedule of self-directed learning to enable students to develop their own learning activities, for example in libraries, skills rooms in EACH or in the community.
- In the first year of all courses, students enrol in modules from a common basic cycle (BC), and also take subjects specific to each course.
- Lecturers and students on different programmes participate as members of elected committees to help establish and implement the academic, administrative and political guidelines of EACH.

The basic cycle was devised to promote academic initiation and interdisciplinary debate in the humanities, science and arts, and develop students' knowledge of Brazilian social, regional and local issues. The basic cycle principles and objectives are committed to training of scientific, social and political character which must allow for the differentiation of professionals trained by EACH. A problem-solving approach is one of the central points of the pedagogical strategy of the basic cycle, which uses the active role of the students in the building of knowledge as a principle. This problem-solving approach was inspired by international educational movements that have used problem-based learning principles, a method that consists of using real-life problems to stimulate critical thinking and learning concepts, relating them to a specific area of knowledge. According to Barret (2001) and Barrows (1996), problem-based learning is considered to be one of the most promising innovations in health-care education, due to the results it generates, and coherence between its principles and the main theories on adult learning.

Conceptual landmarks and curriculum organisation

The general aim of the EACH-USP midwifery course is to prepare and educate professionals with the skills and competencies to support safe motherhood. The midwifery curriculum, which has a total load of 3600 hours, is supported by theoretical critical reflexive references to support the building of knowledge based on dialogue. The principles of humanisation of health care run through the programme, particularly with respect to the pregnancy–puerperal cycle and recommendations of the World Health Organization (2004) that minimal intervention should take place in pregnancy, birth and the postnatal period, and the importance of evidence and respect for the rights of women to be involved in decision-making. The health-care model used is centred on women and based on the premise that pregnancy and childbirth are normal life events.

The four-year course is structured in the basic cycle in the first year, with subjects divided in three areas: biological basis of midwifery, psychosocial basis of the reproductive process and assisting/caring in the reproductive process. In the biological basis of midwifery, the basics of human biology are developed, emphasising the pregnancy–puerperal cycle. The content of this area seeks to stimulate scientific and critical reasoning, opening possibilities for an active, cooperative, integrated and interdisciplinary learning process, setting the basis for introducing specific knowledge in midwifery. In the psychosocial basis of the reproductive process, the biological reference of midwifery care is extended, incorporating psychosocial elements as fundamental to thinking and acting in midwifery practice. Assisting/caring in the reproductive process provides a practical and investigative context by means of fieldwork, where technical, expressive and interactive skills, as well as specific knowledge of midwifery, are promoted.

The 840 hours of clinical practice of the third knowledge area includes providing care to women before, during and after pregnancy. This includes necessary supervision, providing care and advice to pregnant, parturient and postnatal women; attending births and assisting newborn infants and postnatal women; detecting risk and abnormal clinical conditions and referring women when necessary; and undertaking emergency procedures with members of the multiprofessional team. This also includes providing advice and education on health to women, their families and the community.

The midwifery course currently has 19 professors, all with PhDs. Of these, 12 are nurse–midwives with appropriate qualifications in midwifery education and experience of teaching and clinical practice. These nurse–midwives are in charge of many subjects and clinical practice placements, assisted by five clinical preceptors who are also nurse – midwives with long experience in midwifery practice. Practical activities, which occur at a ratio of one clinical lecturer and/or preceptor to five students, are undertaken in the skills rooms of EACH, in the University Hospital of USP, clinics, birth centres and public hospital maternity units with whom USP has established agreements. It is important to note that services are chosen which offer the best possible conditions, so that students may put into practice a model of effective midwifery care, although unfortunately this is not yet a reality of Brazilian maternity practice. This is one of the main factors that limits more active and independent participation of our lecturers and students, as an overly interventionist medical model continues to predominate in maternity care in Brazil.

Resistance, challenges and perspectives

As this is a new programme which continues to face resistance from clinical colleagues, and promotes an unfamiliar and distinctive type of training in Brazil, the midwifery course has attracted an average of 7–14 candidates for each of its 60 vacancies in the USP entrance exam ination, a rate far lower than other courses at USP. All involved in the midwifery department have attempted to the best of their ability to constantly and effectively disclose the need to include midwives in maternal and perinatal health care. For these reasons, it is important to highlight that agreements and partnerships with local maternity services demand time and continuity of contact, on-going dialogue, preparation and awareness-raising among staff to develop midwives and support a midwifery model of care.

By 2009, our first two cohorts had graduated; the first with 45 midwives and the second with 40, who, throughout their training, followed-up an average of 30 pregnant women during activities in pregnancy, 40 women in labour and 40 postnatal women and their infants in various health-care settings. Since 2005, when the programme commenced, the curriculum has been constantly

evaluated with feedback and on-going evaluation from lecturers and students. Until now, major revisions related to the adaptation of the essential competencies of midwifery care in accordance with the ICM definitions (International Confederation of Midwives, 2002). Due to issues with identifying practice environments conducive to midwifery models of care, supervised clinical practice and the contribution of students to the care of women is below the recommended minimum of 50% of the programme (OPS, 2006). Changing this situation requires service provider support and the allocation of a larger number of clinical opportunities for lecturers and clinical mentors. Given the administrative conditions of EACH and USP, it will be challenging to achieve this in the short term, yet it should not hinder lecturers and students from working to achieve this objective.

We have also had to face opposition from nurse midwife and medical colleagues, concerned about the vulnerability of their established professional groups if a separate profession of midwifery is promoted and implemented. Many medical colleagues do not acknowledge the need for change in the current biomedical and interventionist Brazilian model of maternity care, and have an apparent reluctance to understand why a 'new' professional group is needed. They assume that 'obstetrics is strictly a medical specialty' as reported by medical students in a study of medical training and resistance to a humanised model of maternity care in Brazil (Hotimsky and Schraiber, 2005). Rattner (2009) concluded that the major resistance against implementing evidence into maternity care in Brazil lies within faculty. Professors of medicine from important universities continue to publish articles in the media disqualifying both the proposals for humanising obstetric services and the need to expand midwifery. These opinion-shapers promote traditional and professional points of view rather than care based on evidence of effectiveness, and support clinical training models devoid of humanistic values. Resistance to change and lack of support for the participation of other professionals in health care has resulted in Brazilian medical associations hindering the opening of birth centres, defending the caesarean section rate and attacking policies of the Health Department to promote the role of nurse–midwives and midwives in maternal and perinatal care.

Moreover, sectors originally expected to accept the new midwifery programme have also shown opposition, with obstacles imposed by the Nursing Council of São Paulo for the registration of midwives. Instead of implementing the necessary professional legislation as originally agreed with the Council, the organisation only agreed to register midwives following judicial review. In addition, the Council advised local health services not to employ midwives. Despite the pressing need to enhance maternal and perinatal health, less than 10% of our midwife undergraduates have succeeded in entering the Brazilian job market after obtaining their qualification.

The results of a study by Narchi (2010) illustrate the difficulties of implementing a health-care model centred on the needs of the woman/family and interventions based on evidence of effectiveness. It was observed that the majority of low-risk births were assisted by nurse – midwives, most of whom used routine practices that were not evidence based and which are potentially harmful to maternal and infant health. The clinical practice of some of our midwifery students takes place in these hospitals, where midwifery lecturers, midwifery students and women face impositions from clinicians which contradict practices discussed and recommended in our theoretical training.

As Brazil is a country of great socio-economic and cultural diversity, with regions where the health system is precarious and devoid of skilled maternity professionals, future plans are to involve midwifery students in outreach research projects to work with communities in which pregnancy and birth care occur outside the hospital environment. We are developing working relationships between students and traditional Brazilian birth attendants who are not recognised and are often disregarded by other health professionals. However, they perform practices essential in woman-centred care, such as emotional support, respect, facilitation of physiological processes through use of different positions for birth, and motivation in establishing breast feeding (Rattner, 2009; Rattner et al., 2009). Furthermore, to add to the exposure and quality of the environment of birth for our students, there are plans to create an independent birth centre to provide care to low-risk pregnant women during their entire pregnancy and postnatal period, including planned home births in accordance with the established model of training and without the authoritarian interference of doctors or nurses in the teaching-learning process which has been occurring. We are also building academic cooperation and exchange with international midwifery programmes with acclaimed standards of excellence, like those of the UK and Chile. These partnerships will help to develop joint projects and share information and experiences in order to expand and promote our midwifery course nationally and internationally.

Although it is understood that improving women's health care in Brazil faces on-going challenges, we anticipate that midwives will find their professional 'voice' to improve the current conditions of maternity care; they will contribute to the necessary reduction of our shameful maternal and perinatal morbidity and mortality rates; and will 'demedicalise' childbirth so that women receive appropriate care and can exercise their sexual and reproductive rights. Through shaping public opinion and a particular identity following the necessary regulation of the new midwifery profession in Brazil, the current situation may gradually be reversed. These are some of the main challenges facing those engaged in this true struggle of improving maternal and perinatal health in Brazil.

Exercising midwifery's essential competencies requires the strengthening of the professional identities of midwives and nurses. Midwives and nurse – midwives should not focus their attention on exclusivist and counterproductive disputes with each other, as this could further weaken efforts (Davis-Floyd, 1999). These two professions must work harmoniously in striving for their due recognition, for respect and consequently for the transformation of the sexual and reproductive health of Brazilian women, with the full support of all national and international institutions.

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