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Commentary

Strengthening midwifery in Brazil: Education, regulation and professional association of midwives

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ABSTRACT

This article describes Brazilian midwives' struggle to establish their professional field in the arena of maternal and child health in Brazil. Despite the obstacles, midwives continue trying to claim their social space, seeking to maintain and strengthen the profession, and legislative aspects of practice and regulation of their profession. They seek space in the job market, support from entities of civil society, representatives of judicial and political power, and from the movements organised for improvement and change in the birth care model in Brazil.

Introduction

Health indicators of the Brazilian population have improved since 1980s, thanks to advances in social determinants and the creation of a unified and public health system. However, for those issues affecting mothers and children in Brazil, serious problems persist. These include: high maternal mortality rates; elevated and growing prematurity rates and rates of elective caesarean sections; excessive medicalisation of labour and delivery; a lack of integration of antenatal, birth, and postnatal care, as well as low quality of antenatal care; a significant increase in congenital syphilis, teenage pregnancy, and vertical HIV transmission (Victora et al., 2011).

The oft-cited improvements do not fully meet the commitments made by Brazil in the Millennium Summit, a meeting held in 2000 by the United Nations where Millennium Development Goals (MDGs) were established according to the principal problems affecting the world. All the countries present committed to putting effective actions into place in order to achieve the stated goals by 2015, based on statistics from 1990. The fifth MDG calls for improvements in maternal health; Brazil's goal is to reduce by three quarters the maternal mortality rate by 2015. This would entail reducing mortality to 35 deaths of women for every 100,000 live births. Unfortunately, this objective will be difficult to achieve, as the number has stabilised at around 70 since 2000 (Brasil, 2010, 2012).

A Health Ministry bulletin (Brasil, 2010) concerning this problem reported that more than half of maternal and neonatal deaths occurred during the woman's hospitalisation for birth; almost 70% of the maternal deaths occurred as a direct result of obstetrical causes; around 15% of the deaths occurred from unsafe abortions; 51% of neonatal deaths occurred in the first week of life and are mostly related to problems in birth; two thirds of infant deaths occurred during the neonatal period. For each maternal death, it is estimated that another 30 women suffered consequences or chronic health problems from complications during pregnancy, birth, or post partum.

Another challenge to be faced is the recent 'epidemic' of premature births in the country. The proportion of premature babies being born has been growing since 2006. In 2010 the figure reached 7.8% of babies born by caesarean section, and 6.4% in normal births (Victora et al., 2011). It has been hypothesised that one reason may be that some births are planned before the 37th gestational week, so that the caesareans could be performed on women in a programmed way, without them going into labour (Brasil, 2012).

Regarding caesarean sections, the Brazilian health system has recorded a growing increase in surgery. In 2010, 52% of the almost

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three million births in the country were by caesarean section. A report from the Ministry of Health (Brasil, 2012) about this serious public health problem warns that this situation must urgently be reversed. The report suggests that more effective measures must be taken by the regulating health agencies of the public and private health systems, and that a larger number of normal birthing centres be created throughout the country.

The Brazilian National Survey on Demography and Health, performed in the country in 2006 (Brasil, 2009), underlines the persistence of the interventionist model of care which is evident in the low rate of accompanied women giving birth (around 16.3%), the high rate of episiotomies (71.6%), the low rate of pain control during normal births (30.4%), and the low breast-feeding rate within the first hour after birth (42.9%).

In terms of the work force in the area of maternity care in Brazil, in 2010, 98.9% of births occurred in hospitals, and were mostly (89%) attended by doctors. The number of nurse midwives or midwives working in this area is unknown, however it is known that only 9% of births occurring in hospitals are attended by these professionals (Victora et al., 2011).

The number of births at home or in birthing centres, attended by traditional birth attendants, nurse midwives, midwives, or doctors, is insignificant. This is despite a recent growth in the number of Brazilian women seeking this type of care, as they are unsatisfied with the biomedical and interventionist model that they perceive causes institutional violence and abuse of power in care relationships. A 2010 study illustrates this situation, showing that one in every four women suffer institutional violence during childbirth, from mean or joking comments to not being offered adequate care such as pain relief (Perseu Abramo Foundation, 2010).

In the context of this reality, the direct-entry midwifery programme was proposed, and the University of São Paulo (USP) implemented the programme and did not encounter difficulties within the educational sphere. The programme was fully recognised by the appropriate educational agencies.

The midwifery education provided by USP, along with Brazilian society's pressure on health services to promote changes in the care model, should have paved the way for the easy incorporation of midwives into the labour force. However, the midwives graduating from the direct-entry midwifery programme found themselves confronting a difficult set of obstacles related to their entry into the market and the regulation of their work. This prohibited them from truly being able to implement the midwifery model of care, especially in the public health system context.

This occurred principally because the organisations representing the Brazilian health workforce, specifically nurses and doctors, do not accept midwives, and have prevented them from being integrated into healthcare. Despite the recognised legal validity of the midwifery programme, the main points of opposition to the insertion of midwives into the job market are related to the following aspects. A lack of a description of this profession in Brazil, despite the existence of legislation regulating its practice; a lack of recognition of the regulation of this profession; the lack of recognition and advocacy on the part of USP for this health professional curriculum (midwifery), in which human and social sciences act as a supporting axis; the resistance of practicing health care professionals, who discount the education of this new professional, and do not recognise – or impede and undermine – their entry into the work place.

The objective of this text is to describe and discuss all of these aspects in the context of midwifery in Brazil.

The education of midwives

The first regular direct-entry programmes for midwife education were initiated in Brazil in 1832, first in the state of Rio de Janeiro, and later in Bahia, Rio Grande do Sul, São Paulo and Pará. These programmes were successively discontinued, and in 1971 the last remaining midwifery programme, that of the University of São Paulo (USP), was incorporated into the USP Nursing Program under the pretext of the university reform implemented in that era (Riesco and Tsunechiro, 2002).

This occasion was marked by a great expansion in the obstetrical medical major programme, which promoted hospital deliveries. At the time, there were very few midwives – neither enough to attend to the demands for care during birth, nor enough to resist pressures and conflicts with other professions. From that point onwards, prevailing opinion dictated that the creation of a specialisation for nursing and medical professionals would enable the training of a sufficient number of professionals to satisfy the demand for maternity care in Brazil (Riesco and Tsunechiro, 2002).

Henceforth, individuals interested in working in maternity care would have two options: complete four years of nursing school, and a specialisation in midwifery nursing, with a minimum duration of 360 hours; or, complete six years of medical school and two or three years of specialisation in residency in gynaecology and obstetrics (Narchi et al., 2012).

However, it is important to mention that midwifery nursing education also suffered discontinuation in the final decades of the last century, along with the Brazilian hiatus in midwifery education. It was only at the end of the 1990s that midwifery nursing gained new impetus, aided by government policies and social movements that stimulated change in the model of maternity care in the country (Rattner, 2009). This stimulus for change was related to the challenge of reversing the technocratic model for maternal health care, prevalent even now in the country (Davis-Floyd, 2007)

The return of direct midwife education occurred in 2005, with the creation of a four-year and a half programme and curricular plan (4200 hours) based on the essential competencies for midwifery practice of the International Confederation of Midwives (ICM, 2002) and the proposals of the World Health Organization (WHO, 2001, 2004, 2006) for the training of qualified professionals to promote the improvement of women's health care, changes in the care model, and safer motherhood. The importance of this type of midwifery education is underlined in the context of Brazilian reality. A large number of technically trained and prepared professionals are needed to implement woman-centred and evidence-based care in order to promote and advocate for women's sexual and reproductive rights. It is principally a transformation of the care model from technocratic to humanistic or humanised, the more commonly used term in Brazil. For Davis-Floyd (2001), the humanisation of birth translates to an attitude or posture towards the birthing event, something reaching beyond care models all the way to the essence of the relationship between caregivers and women, as well as their families and community. Humanising care is expressed in the way in which people position themselves towards life, care, and their understanding of women. Humanising care helps to translate, within the infinite complexity of a subjective and single event, what is happening in the intimacy of the woman's body.

Although USP has continued the direct-entry midwifery programme, the traditional professional health education system still resists their proposal. In the Brazilian higher education system, a 2008 university reform was passed that, amongst other measures, promoted the restructuring and expansion of universities. This allowed for the implementation of new majors that would be more compatible with the US university system and with the European Bologna model. As a result, as Victora et al. (2011) emphasise, the academic establishment, led by traditional teaching institutions, rallied against the rearranging of the higher educational ideological base, rejecting innovative course models

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such as midwifery. According to the authors, the prevailing educational system of human resources in health is ruled by market forces and oriented towards illness, centred around the hospital and directed towards the current specialisation of professional education. This model is contrary to a more socially active humanistic education, oriented towards health, and focusing on primary care: the proposal developed for midwifery education at USP.

Legislation related to the professional practice and regulation of midwives

In terms of legislation, the Brazilian National Constitution guarantees the free exercise of professions, and the Law of Professional Nursing Practice legalises the profession of midwife. This law, passed in 1986 and enforced in 1987, defines three different professions: nurses themselves, midwives, and nurse-midwives.

The aforementioned legislation was defined and approved in this way because all nursing professions needed to be encompassed, which includes midwives trained until the 1970s and, subsequently, those graduated from USP after 2008, the year in which the first class graduated.

Given that in Brazil, midwives always formed part of the nursing profession, they were also accepted by the Nursing Council, which also licensed midwives from other Latin American countries, and from around the world. Following the moment in which the first graduates from midwifery programme at USP sought official licensing from that professional council, they were met with serious resistance and discrimination: the council that represents and monitors nursing work in Brazil tried to thwart the licensing and the subsequent regulation of midwives.

Teachers, students, and graduates of the direct-entry midwifery programme at USP met the negative registration with bafflement. Firstly because midwifery as a profession is regulated by law. Secondly, because there are precedents for the licensing of midwives in Brazil – the Nursing Council covered and still covers midwives within the professions that are regularly described in it. Thirdly, because the São Paulo Nursing Council had fulfilled the commitment of licensing applicants, even before the midwifery programme started.

It is important to note that the main sources of occupational regulation in Brazil are the National Congress, which creates laws of professional practice and authorisation for the functioning of professional practice Monitoring Councils; the Labor Ministry, which defines the regulated occupations; the Ministry of Education, which regulates the aspects relating to curricula and general norms of the university system; and, the Monitoring Councils for professional practices, publically recognised and authorised by the State of Brazil. Without the existence of a professional council, an occupation cannot be fully recognised as a profession in the country (Girardi et al., 2000).

The opposition scenario created by the Nursing Council led the graduates of the direct-entry midwifery course to go to court to obtain what was rightfully theirs. Judges and the Federal Public Ministry have continued to confirm the midwives' rights to be fully licensed.

Despite this, the Council continues to place political pressure on those providing professional introduction and training, namely the health institutions. What is observed is a fight for the monopoly of authority to dictate the rules and distribute power within the field of women's health care. One example is an article published in the journal of the Regional Nursing Council of São Paulo (2009), in which the entity claim to provide clarification and a warning to nurses, writing that the Council would only give registration to graduates of the USP direct-entry midwifery programme when forced to by legal action. In this document, the council alerted nurses that: '*if the students or graduates of the Midwifery Program were to commit iatrogenesis, the patient will be able to seek legal and ethical recourse again them, as well as against the Health Institution which assumes the actions of the Nurse, also responsible for this situation, as well as the Head Nurse, who will also be involved ethically and legally.*'

This article tried to construct a public image of danger associated with the training of midwives, discounting the relevance as well as the competence of the academic programme. It also ignored the fact that unfortunately, iatrogenesis may be committed by any health professional, regardless of whether they are a nurse, doctor, or midwife.

In Brazil, regulated health occupations have relatively closed markets, and therefore the offering of these services is delineated by professional corporations that register and validate the necessary professional degrees for practice (Girardi et al., 2000). In this respect, the entry of midwives into the job market is limited by the type and scope of its difficult regulation, which ends up guaranteeing space for or even handing over exclusive property rights to nurses within the field of practice.

In this way, as Victora et al. (2011) state, the problems associated with professional interests – that is, corporatism – are a public health challenge in Brazil. Medical societies lobby against other health professionals (even those with university degrees) such as nurses, physical therapists, audiologists, and more recently, midwives. Doctors lobby against authorisation for nurse midwives (and midwives) to perform normal births; nurses oppose authorisation for health agents to apply injections; nurses and doctors oppose the entry of midwives into the job market.

For the programme's professors, graduates, and various social and academic institutions, it is important for Brazil that midwifery programmes constitute their own major. They stress the importance of maintaining and expanding professional midwifery education in higher educational courses – courses which follow the ICM recommendations and differentiate themselves from traditional human resource education in Brazilian healthcare. In this sense, Day-Stirk and Fauveau (2012) emphasise that in order to improve care and services for childbearing women, the status, education and regulation of midwives globally must be improved.

However, the pressures against midwives are very strong, involving legal action, the media, and prejudice towards the image of the profession. The USP midwifery programme is still the only course like it in Brazil; its professors, students, and graduates, together with important organisations of the civilian society, are fighting and mobilising to maintain and strengthen this profession, which stands to contribute in an important way to the quality of health care for Brazilian women.

There is a central message underlying all the documents and opinions emitted by the nursing council regarding the midwifery programme at USP: it is not a nursing programme, it does not educate nurses, and therefore its graduates cannot form part of its organisations. Indeed, midwifery is not nursing: it is another and similar profession that in Brazil has the historical interface of group work and partnership with nursing. The official monitoring and regulatory bodies should follow the laws establishing the profession of midwifery, thus enabling midwives to enter the job market.

The Federal Public Ministry (MPF), the agency defending social and individual rights as part of the legal branch of the Brazilian Democratic regime, considers it illegal to block the professional practice of midwifery. The MPF issued in June of 2011 a recommendation to the Nursing Council for it to fully comply with the law: that is, for it to license midwives. However, that entity, along with not complying with the MPF resolution, issued an appeal in

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which it once again questioned the profession. In acting in this way, the organisation did not even consider drafting a resolution regulating the inscription of midwives, which would have resolved the issue.

Given this, the only option left for graduates of the USP midwifery programme was to seek professional licensing through legal means. On their side, the representative medical and nursing organisations, realising that midwives were obtaining licensing and subsequently, legal authorisation to practice their profession (albeit through judicial means) has started to politically deconstruct the idea that Brazil needs midwives, causing direct repercussions in the job market. The market is unlikely to go up against those professional entities, as they are consolidated and highly respected, especially by Brazilian governmental agencies.

It is interesting to note that these professional organisations rally against the necessity of substantial improvements in maternal and perinatal health care: they go not only against the midwives, but against the improvements for the problems affecting Brazilian women.

It is important to recognise that the Labor and Health Ministries experience direct and constant pressures from medical and nursing organisations. In prohibiting the work of midwives, there is then a lack of official description and regulation of the profession. Regarding the function of the Health Ministry's participation in the regulation of professions, Girardi et al. (2000) state that this governmental agency plays this role unsystematically, and with a high degree of case-based reasoning, which, amongst other things, ends up favoring the professions that boast higher prestige, economic power, organising and political resources, that possess a greater capacity for following through with lawsuits, or for blocking countersuits. Thus, medicine is what wields power over all other professions that are supposed medical subsidiaries, and nursing then prohibits the midwifery profession from being established and duly regulated.

Because the Brazilian Ministry of Health, unlike in other Latin American countries, is not responsible for the registration and monitoring of health professions, and the Labor Ministry has not permitted the creation of new occupations in the health care realm, midwives cannot obtain a share of the job market.

In theory, workforce numbers should be determined by specific objectives set by policymakers for the health sector and by the demand for health services (Fritzen, 2007). As previously cited, this does not occur in Brazil, because the capacity for strategically planning the workforce in the health field is not effectively managed by the Ministry of Health.

As previously discussed, midwives educated by USP have obtained support from several governmental, and non-governmental agencies, as well as in the court of public opinion. In order to react, the graduates of the midwifery programme founded the Midwives Association in 2011. This organisation is slowly earning respect and achieving guaranteed participation of midwives in public job recruitment, opening up the possibility of work in the public health system as well.

The Midwives Association option of creating a professional council and own system of regulation, unattached from nursing, necessitates a greater number of midwives, complex political relationships, and a greater amount of time in the job market. This task is long-term, as the number of midwives graduated from USP is still very small: 166 in 2012, of which 70% left the profession due to the previously described obstacles.

In order for a specific midwifery regulatory system to exist in Brazil, midwives must demonstrate the indispensability of their occupation in health services, be recognised by the legal system, and obtain recognition and legitimacy within the court of public opinion. In order to carry out this process, the barriers imposed by the professional field must be overcome, which will certainly happen once the midwifery profession is no longer considered 'lesser,' has a larger number of practicing professionals, beats jurisdictional conflicts, and convinces by way of ability.

For the sake of mothers and newborns both 'scaling up' coverage and 'skilling up' quality of care are necessary (Fauveau et al., 2008). Without a strong political decision to empower non-clinician providers of midwifery care, Brazil will not fulfil the fifth MDG, nor will it improve the problems that Brazilian women face.

It must be emphasised that the education of midwives does not exclude nurse-midwives from care. Rather, it attempts to strengthen a care model that is not centred on the biomedical model, still so present in general nursing education, or restricted to labour and delivery care. Many nurse-midwives, who question their educational and thus working model, seek to transform their own practice and also offer this critique. During this process they also encounter many obstacles due to the still-limited market which is dominated by medical power, despite legislation and governmental incentives asserting and legitimising their autonomy to care for women (Carvalho, 2000; Narchi, 2001; Narchi et al., 2010).

Final considerations

The construction of the midwife's professional space has been permeated by disputes and conflicts in the search for recognition in childbirth care in Brazil. There is a lack of understanding of the innovative potential of this new profession, a hindrance for their incorporation into the job market. The disputes involve several actors; as a consequence, recently graduated midwives encounter several obstacles resulting from a market that is still limited to nurses who are specialised in midwifery, despite current legislation.

In spite of obstacles, midwives continue trying to claim their social space, seeking to maintain and strengthen the profession. They seek effective insertion in the job market, support from entities of civil society, representatives of judicial and political power, and from the movements organised for improvement and change in the birth care model in Brazil.

An important role is played by the Midwives Association, whose central axis is the work of keeping midwives involved and active in professional matters, as well as supporting continued change in the current birth culture in the country. Organisations are more effective as they become more organised; the better they are, the greater the possibilities of action for their professionals. Professionals and associations also play an important role in the formation of women's desires, based on information on the competencies of the different professions. The association has sought partnerships and support from politicians and governmental agencies, as well as with the media. The media is fundamental in building society's awareness of the role of midwives in the evolutionary process of health policies in the country.

When the desired professional space has been claimed, midwives will be able to continue to contribute to safer maternity, promoting improvements in maternal and perinatal epidemiological indexes, as proposed by the Brazilian government in the Millennium Declaration. For this, there must be qualified staff fulfilling the midwifery model of care, still lacking in the Brazilian care reality. Therefore, the country must implement policies and norms regulating midwifery work, distancing themselves from corporate influences focused on wielding power over the professional healthcare field. Midwives can strengthen midwifery by seeking out alternative areas for practice, such as maternity and paternity support groups.

It is important to note that midwives have sought continuing education and graduate courses in order to develop technically, scientifically and professionally. This supports the development of

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leadership in midwifery, as well as knowledge production based on the Brazilian reality.

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