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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