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The full potential of midwives will only be realised when midwifery has professional autonomy☆

Women in childbirth have been attended for millennia by other women and it is from this tradition that the profession of midwifery was born. Midwifery has evolved differently in various countries. In many countries, midwifery was bound to nursing at some point in history in a move that has often limited the opportunities for midwifery as an autonomous and unique profession. In this coupling, midwifery became the addendum to nursing. In many countries in regulation there are "Boards of Nursing and Midwifery", in education, "Schools of Nursing and Midwifery"; in leadership "Directors of Nursing and Midwifery" in government, the "Chief Nurse and Midwife". It seems to be no accident that it is always "nursing and midwifery", rather than "midwifery and nursing". This arrangement both reflects and reinforces inequities in professional autonomy and as we argue in this Editorial, has significant implications for midwives, midwifery, maternity services and childbearing women.

Midwives have core essential competencies which span the perinatal period from pre-conception through to the postnatal period, ensuring sexual and reproductive rights for childbearing women [1,2]. Promotion and support for physiological birth and the recognition of deviations from the norm, and seeking medical and other care as needed are key components of midwifery care [2]. The power of midwifery care should not be underestimated. A study published in *The Lancet Global Health* estimated that 67% of maternal deaths, 64% neonatal deaths and 65% stillbirths in low- and middle-income countries could be averted if midwives educated to international standards, were integrated into health systems in the context of multidisciplinary teams. Significant gains would also be made in high income countries including a reduction of 51%, in maternal deaths, 47% in stillbirths and 44% in neonatal deaths [3].

The recent State of the World's Midwifery (SoWMy) report revealed that the world needs 900,000 more midwives and the scaling up of midwifery is now a global priority [4]. This was the first SoWMy report to include both high, middle and low income countries and stresses a need to invest in midwives and quality midwifery education, regulation, workforce development and leadership [4,5].

The pairing of midwifery and nursing began with midwifery education in many countries (the Netherlands and Denmark being notable exceptions) and the requirement for midwives to be nurses; a move that effectively subsumed midwifery into nursing. In Australia, this occurred with the professionalisation of nursing in the late 1800s in what has been described as a strategic grab for occupational territory by nurses, supported by doctors who wanted to eliminate vocational midwives who were not their subordinates [6]. In many countries midwifery education became an "add on" to nursing with nurses 'topping up their education' with this postgraduate qualification. While many excellent and passionate midwives were prepared in this way, this has been limiting for the profession of midwifery. Midwifery education has made great strides in more recent times with the introduction of educational pathways where nursing is not prerequisite (known as "direct entry") including midwifery degree programmes that are fully accredited in accordance with international standards. These programmes prepare midwives to deliver highly skilled, specialised care including the care of women and newborns with complex needs, working collaboratively within a multidisciplinary team as appropriate. Despite the establishment of direct entry programmes for midwifery, many institutions continue to offer abbreviated pathways for nurses to become midwives through postgraduate nursing awards. The Netherlands, Denmark and New Zealand are some exceptions here as the only pathway to midwifery is via a direct-entry Bachelor of Midwifery degree in these countries. Thus, we have a situation where in many countries a lot of midwives are also nurses and the two continue to be conflated not only in the minds of the public but also in policy. This leads to widespread lack of understanding and misinformation about the role of the midwife at all levels of policy, health services and funders [7].

The lack of professional autonomy in midwifery is evident in education, regulation, leadership, and policy. Midwifery education programmes, for example, are often situated within schools or faculty of nursing with heads of schools who are more often nurses than midwives. This means that midwifery may not have appropriate leadership within the institution and may not be well-represented in committees and other academic fora where important decisions affecting midwives are made. Too often, it is assumed that decisions that work well for nursing, will work well for midwifery. These decisions may relate for example to clinical practice arrangements, choice of or sequencing of units/subjects (some of which may be co-taught with nursing). Nursing programmes are often privileged due to their larger size and leadership, and this is to the detriment of midwifery.

We understand that there may be benefits to co-teaching subjects where similar knowledge and skills are required, including efficiencies and enhanced opportunities for interdisciplinary collaboration. Subjects such as research and physiology for example are relevant to a range of students being prepared for different healthcare professions such as dietetics, physiotherapy and medicine. Our argument is with the customary practice of adding midwifery to nursing whist privileging the needs of nursing students over midwifery. At this time in our history, it is important that midwifery strengthens its unique professional identify

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(separate from nursing) and educational pathways shared with nursing is less than optimal in this regard.

To scale up midwifery and build an appropriate midwifery workforce, midwifery education must be scaffolded and supported by existing healthcare structures. Midwifery students must have opportunities to work in or at least have exposure to the normal physiological processes in midwife-led settings, but they do not exist in some places. The profession needs to take ownership of their expertise to be successful in this drive to build the workforce and being the 'and' of nursing does not lend itself well to this.

Midwifery regulation is another sphere in which midwifery does not always have professional autonomy. Notable exceptions include New Zealand, the Netherlands, Cambodia, and Denmark who have bodies such as the Council of Midwives (New Zealand) who are responsible for the regulation of midwifery in those countries. Many others are regulated by nursing and midwifery organisations who are responsible for the regulation of both nursing and midwifery. This often means that standards for practice and education are set by boards or committees that may not be midwifery-led and may not reflect contemporary midwifery. Again, standards and systems that are developed for nursing are often imposed on midwifery with the assumption that they will be similarly fit for purpose. The current structure in many countries limits the capacity of midwifery to establish its own standards and to realise the aspirations and full potential of the profession of midwifery.

The potential of midwifery is further limited by clinical leadership that may not understand or value the role of midwives. Midwives who are not also nurses do not always have opportunities to fill leadership roles in clinical services or government organisations. Thus, we see Directors of Nursing and Midwifery (or similar senior clinical leadership roles) filled predominately by nurses and in government, Chief Nurse and Midwife Officers (or similar). Those holding these positions may have limited understanding of the midwifery philosophy, contemporary midwifery practice, current evidence for midwifery care, and they may not be fully engaged with the profession through membership of professional colleges and the like. In practice this means that systems that work for nursing but not necessarily for midwifery, may be imposed on midwifery (such as shift patterns and workflow) and that clinical services may not be utilising midwives to their full potential, and therefore not providing women the best standard of care. Our leaders in government may not be best placed to advocate for midwifery to ensure that maternity service and midwifery workforce policy are appropriate to the profession.

We have known for a long time that midwife-led, continuity of carer models of care is the gold standard [8] and that homebirth and birth centres better facilitate physiological birth, yet maternity services in many countries have been slow to respond to this evidence. This may reflect lack of leadership in senior positions in clinical and policy settings. In an Australian survey of maternity mangers for example, organisational support was one of the key factors associated with the implementation of continuity models of care [9]. It may be difficult for non-midwives to advocate for, or provide, such organisational support and hence, implementation of these models of care is hampered.

In the United Kingdom (UK), the recent Ockenden report [10] into failings of a maternity service identified a lack of leadership within the maternity governance structure as a contributing factor; an issue that appears to be widespread in the UK and other countries. This lack of effective and appropriate leadership impacts the quality of care provided to childbearing women and also midwives' job satisfaction. When midwives cannot work to their full capacity, when they cannot provide quality care and when they are not respected and valued for their considerable knowledge and expertise, they will leave the profession. We are seeing this scenario play out in many countries currently with significant midwifery staff shortages impacting maternity service provision in the UK and elsewhere.

There is no doubt that nursing as a profession is also oppressed within our social and health structures that largely privilege medicine over both nursing and midwifery. In line with Jugov and Ypi [11] we suggest that it is a responsibility of those who are both oppressors and oppressed to address structural injustices. There is much that the nursing profession can do to facilitate the professional autonomy of midwifery.

Midwifery's contribution to the health and welfare of childbearing women across the globe is unparalleled [1]. Experts are calling for the scaling up of midwifery to realise midwifery's full potential [7]. The sexual and reproductive health of women in our society is dependent on an array of complex factors and we don't presume that midwifery alone can resolve all the issues. The Lancet Series on Midwifery for example, cautions that scaling up is not enough to guarantee high quality care or improvements to maternal and newborn morbidity and mortality and that policies should address both midwifery coverage and quality [12]. We argue here that midwifery's full potential will not be realised until midwifery has full professional autonomy. Strong midwifery leadership at all levels from local, national to international, and full control over midwifery regulation, education and practice will help deliver much needed improvements to the quality of maternity care.

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