TE TATAU O TE WHARE KAHU
MIDWIFERY COUNCIL

SCOPE OF PRACTICE

FEEDBACK ON DRAFT

MAY 2022

CONTENTS

Introduction and Background 3

Method 3

Findings 3

- Positive feedback 4
- Concerns 5
  - Clarity of Scope 6
  - Workload / Resourcing impacts 7
  - Te Tiriti O Waitangi 7
  - Te Reo use 7
  - Kahu Pōkai 8
  - Absence of reference to Women/Wāhine 8
  - Infant 9
  - Whānau 9
  - Autonomy 9
  - Setting 10
  - Partnership 10
  - Physiological birth 10
  - Sexual Health and Preconception care 10
  - Other areas noted 10
- Suggestions for change 11
- organisations Providing feedback 11
- Development of Scope and Consultation Process – Midwifery Council 11
- Limitations 12

INTRODUCTION AND BACKGROUND

The Aotearoa Midwifery Project group developed a Draft Scope of Practice which was released by Te Tatau o te Whare Kahu | Midwifery Council on 17 February via email notification to all midwives with an Annual Practising Certificate. Relevant organisations were also sent the document for comment. Feedback was received via a Survey Monkey link and email from individuals, and organisations in both New Zealand and overseas. In response to requests for further time for feedback and provision of webinars the deadline was extended twice, closing on the 26th April at 5pm.

This report summarises the feedback received by the above means, within the timeframe specified. The findings have been grouped into those that were positive and those identifying concerns. Organisations also provided feedback and suggestions for rewording.

METHOD

The responses were collated into an excel spreadsheet as they were received by Midwifery Council. A person, external to Council was contracted to analyse the responses. The responses were categorised as Positive, Positive with Concerns / Comments and Concerns only. Responses were categorised as positive when there were no suggestions for change.

An initial review of the feedback identified common areas that were considered positive or were of concern. Each feedback entry was then coded as to whether the area was present, and a description of the positive comment or concern entered. An 'other' category was used to add new areas not present in the initial identification of areas. The comments under each area were then reviewed again, and a summary of the feedback for each area developed and presented within this report.

The original plan had been to provide feedback under each of the statements in the Scope, however most people made comments that related across the Scope. Some of the organisations did provide detailed comments under each section with suggestions for change.

FINDINGS

There was a total of 224 submissions providing feedback on the draft Scope (Table 1). There were 44 (20%) of responses that provided comments that were only positive. A larger group of 66 (30%) had a mix of positive comments and concerns. The largest group 110 (49%) provided concerns only. In summary 50% of responses provided positive feedback, and 79% provided concerns.

Table 1: Feedback respondents

Type of feedback	No.
Individual* or midwifery practice group	198
Organisations - Midwifery	14
Organisations – Non-Midwifery	12
TOTAL	**224**

* Most individuals did not state whether they were midwives so this group may include non-midwifery respondents. However, from the way the responses were written it appears most were midwives.

Table 2: Type of response - Broad summary

Type of response	Individual	Organisation (Midwifery)	Organisation (non Midwifery)	Total
Positive	39	1	4	44 (20%)
Positive with concerns/comments	49	11	6	66 (30%)
Concerned/changes suggested	106	2	2	110 (49%)
Unknown	4	0	0	4 (1%)
Total	**198**	**14**	**12**	

POSITIVE FEEDBACK

Many respondents acknowledged the work of the Aotearoa Project Reference Group in moving the profession to using a Te Tiriti o Waitangi framework and cultural safety. The submissions containing only positive comments tended to be short. The positive comments expressed in the responses that also raised concerns have been included in this section. The largest proportion of respondents provided their concerns without any positive statements about the draft Scope. This does not rule out that they did not consider some of the changes as positive, merely that none were not stated.

The areas that were complimented include the following:

- Te Tiriti framework
    - Provides opportunity to move midwifery into 21st Century
    - Honours Te Tiriti o Waitangi
    - Appropriate interlinking of cultural knowledge and practice
    - Step towards decolonising midwifery
    - Inclusion of Matauranga Māori
    - Needed to provide safe care in Aotearoa
    - "Thank you for sharing the revised Midwifery Whānuitanga o Te Mahi | Scope of Practice statement with …. The statement is a powerful example of partnership between Indigenous and non-Indigenous midwives. The principles and tools are powerful reflections for midwives around the world"
    - Refreshing to hear tau iwi as being good Tiriti partners

- Inclusive
    - Inclusive of Māori
    - Gender neutral
    - Inclusive of disabled
    - Respect and acknowledgement of all people
    - Focusing on small group rather than individual
    - Use of Whānau
    - More holistic
    - Midwifery autonomy & other ways of knowing honoured / promoted

- Partnership
    - Model needed updating
    - Encompasses Tikanga of Partnership
- Represents current practice
    - Represents midwifery
    - Already practice in this way in rural setting
- Scope
    - Expanded Scope
    - Very loose
    - Room for challenge and innovation
    - See swift changes occurring in our society and this Scope makes space for the changes in expectation which our birthing people will have for us as a profession
    - Makes a statement about the kind of midwifery future want to be part of
    - Future proofs the profession
- General
    - Fantastic
    - Beautiful piece of work
    - Amazing
    - Goosebumps reading
    - Excited
    - Commend the team
    - Ka kawe. Tears as read all our Te Reo words.
    - Innovative and well considered
    - Liked Kahu Pōkai term

CONCERNS

This section includes all concerns raised in the feedback. The areas of most concern have been quantified in the following table (Table 3). Many areas overlap. For example, some expressed concern over the clarity of the Scope in general terms, while other stated their concern about clarity in relation to not knowing what 'whānau' encompassed.

There were several comments suggesting that the draft Scope was providing a philosophical statement or a set of standards, and that something different was required to describe the Scope.

Table 3: Concerns raised in submissions

Area of concern	Individual (N=198)	Organisation (N=26)	Total
Clarity of Scope	91	17	108
Workload / Resourcing	39	11	50
Changes			
Use of whanau	63	17	80
Use of infant	52	16	68
Kahu Pōkai	12	2	14

References to the following being removed			
Autonomy	35	8	43
Setting	13	12	25
Partnership	15	6	21
Women/wāhine	51	11	62
Te Reo use	15	0	15
Te Tiriti o Waitangi	8	2	10
Physiological birth	5	4	9
Sexual health	14	7	21
Preconception care	11	5	16

CLARITY OF SCOPE

The most common concern related to the clarity of the draft Scope. This concern overlapped with the concerns around the use of whānau and infant. Within this section the focus is on the general comments relating to the clarity, with the more specific concerns included under the respective headings of infant and whanau. There was a repeated fear that the role of midwifery was being undermined and veered towards nursing.

- Lose focus of area of expertise
- Ambiguous, vague, non-specific, ill-defined
- Broad, no boundaries
- No sense of what midwifery is
- Open to interpretation/misinterpretation
- Extended timeframes that are not clearly defined
- Clinical responsibility unclear
- Unable to understand without competencies alongside
- Clear definitions missing
- Confuses what midwives 'do' with the 'how'
- Needs to ensure midwives and public know what midwives authorised to do
- Draft Scope overlaps with other domains and could apply to other professions (suggestions provided in different submissions were social work, wellness provider, nursing, nurse practitioner, practice nurses GP, Plunket, public health nurse)
- The Scope did not describe the role of the midwife or their clinical responsibilities and therefore did not meet the requirements of the HPCAA (2003)

In providing feedback one person acknowledged the long journey the Reference Group had been on, something the rest of the profession had not been privy to, *"If it takes a process such as the reference group have been through to understand the notion of the national scope, then it is not fit for purpose".*

The lack of clarity was perceived to pose the following risks:

- Nursing alignment
- Risk losing autonomy
- Risk of exploitation
- Erosion of midwifery
- Difficult for MC to regulate

WORKLOAD / RESOURCING IMPACTS

Concerns were raised about the increased workload for midwives and the potential deployment of employed midwives to other areas. The extra workload was raised in the following ways:

- Expanded Scope
- Reduce quality of midwifery care
- Not trained for the extended role
- Extended boundaries risk midwives and the public
- Deployment to other areas within DHB, Scope is written for Service Managers, Duty Managers and HR also
- Risk of burnout
- Greater expectations of midwives
- Workforce already struggling
- Midwives may choose to specialise in specific areas
- Scope needs to stay tight to protect the workforce
- Midwives will need renumeration for the additional work

TE TIRITI O WAITANGI

Most responses that mentioned Te Tiriti were positive. There were a small number of concerns relating to the following:

- Intent of incorporating Te Tiriti, but not considered to have been achieved.
- Positive to include but should still be open to robust critique
- Need to acknowledge many sources of tauranga, wisdom & research, not only Tikanga Māori
- Concern whether Te Tiriti principles alone can regulate and monitor midwifery Scope
- Potential to put Māori midwives in a culturally unsafe position and enforces a Māori world view
- "Although this process followed a Te Tiriti framework, our professional organisations do not provide honourable kāwanatanga (article 1) or leave space for tino rangatiratanga (article 2) and in order to honour such gifts of input from tangata whenua, we should actively be seeking the means by which we hand power and resources to Māori so they can manage their own midwifery workforce
- Marginalisation of Māori midwives
- Enormous gap in midwifery education
- Needs to be inclusive of other cultures

TE REO USE

There was no negative feedback in relation to providing a translation of the Scope in Te Reo Māori. Thirteen of the fifteen comments related to the use of Te Reo in the English version, which was thought to reduce clarity. It was also noted that a deeper understanding of the Te Reo version was required with a translation of Dr Hope Tupara's korero.

There were concerns relating to Māori concepts used:

- Use the term mātauranga in such a broad context is misleading and identifies the enormous gap in midwifery education for the developing midwifery student.
- There was concern that it was stated in the webinar that providing a translation of the Te Reo version was considered to demean the mana of Te Reo Māori.

KAHU PŌKAI

- Previously known te reo for midwife, kaiwhakawhānau, and that used by NZCOM. Small profession so need consistency
- May not be accepted by all hapū, contestable
- Highly political
- Risk of misinterpretation and years of breaches as occurred with Te Tiriti o Waitangi
- New term that is not known or understood in its entirety
- Request for video of tohunga who gifted kupu and its whakapapa

- Concern about its translation
    - Literal translation appears to exclude both women and midwife and could be applied to any caregiving workforce
    - Kahu means chiefly and should only be used in relation to women, patriarchal
    - Stated to cover pregnancy to birth, should cover more
    - Advised to seek the professional support of translators' interpreters' licence for Te Reo Māori services
    - Pokai is an insult in Cantonese.

- Concern about consultation process for new kupu
    - No evidence of extensive consultation across Aotearoa
    - Created without consultation with Māori midwives. Would have liked to have been involved in the discussion around the name change

ABSENCE OF REFERENCE TO WOMEN/WĀHINE

The concerns relating to the removal of women focused on two main areas: the status of women based on the history and the loss of the woman as the centre of care. The common suggestion was the inclusion of women/wāhine as well as whānau, and also the inclusion of pregnant person (English & Te Reo).

- Status of women
    - Dangerous to women and their status, based on history
    - Insulting to women, gender removed
    - Disrespectful to replace woman and baby with whānau
    - Women have become invisible
    - Out of line with other countries where women's right achieved
    - Undervalues work happening internationally
- Women as the centre of care
    - Ethos of midwifery care, midwifery partnership foundational in Aotearoa
    - How midwives have been trained
    - Focus needs to return to women
    - No longer able to guide her own care
    - Shift to exclude relationship with women
    - Midwifery is woman's business
- Risks to women's wellbeing e.g. if abusive relationships
- Responsibilities including confidentiality not clear
- Hard to understand without being involved in the process

INFANT

There was concern about the use of Infant due to the interpretation that it was up to 12 months. The following implications of this were raised:

- Increases scope
- Not educated to extend care beyond 6 weeks
- Takes away from the key focus of midwifery (i.e. newborn to 6 weeks)
- Do not have the time to provide this additional scope
- Rationale of ability to provide care beyond 6 weeks in rural areas / cover gaps is not a good reason
- Workforce already stretched.
- Question was raised as to whether this is already covered by Wellchild Provider.
- Sets a precedent for other midwives if someone chooses to provide.

WHĀNAU

The use of the term whānau, without an associated definition (within the Scope) created concern, particularly in relation to statement 8 of the Scope, "…meet the varied needs of whānau." There was some acceptance that some areas beyond the wāhine/women/person was reasonable such as prescribing for issues relating to the partners sexual health infections, smoking cessation. There was mention of the webinar where whānau was described as being inclusive of the pregnant person, however there were still many comments saying this needed to explicitly stated within the Scope. Concerns related to the following:

- "Whānau is a concept specific to Māori ways of knowing and being. Knowing what the kupu means for Māori does not automatically indicate Pākehā and Tauiwi have the ability to apply contextual Māori thinking to kupu Māori"
- Loses focus on woman/person at the centre of the whanau
- Women do not always have the power in the family to make choices
- Needs to be inclusive (gender, culture), but not caring for whole family
- Takes away from the key role of midwifery
- Although inclusive of women, it also has a wider use in Aotearoa, and therefore could be legally challenged
- The need to be educated to provide care to men
- Could imply provide care to all whānau members, including issues unrelated to childbearing
- Risk of working outside accepted boundaries of care that are accountable for
- Public and other health professionals may not understand the midwives' role within the whānau
- May provide emotional/spiritual support to wider family but not physical care.
- Interpretation may differ between midwives, varied expectations of public
- Increased workload
- Too similar to nursing

AUTONOMY

There was fear that the autonomy gained could be lost and there was a request to safeguard or future proof the profession. The thought that this was no longer needed did not recognise the history of midwifery and again the concern was raised that the profession could be consumed by nursing. It was also thought to be necessary to make it clear for other professions and the public, with some people still thinking midwives worked under doctors.

SETTING

Autonomy, as raised in the previous section, was also linked to the ability to practice in any setting. The main concern with removing the settings where a midwife could practice related to the ability to provide homebirth and choice for the pregnant person.

PARTNERSHIP

Comments relating to the need to keep the reference to partnership included:

- Partnership is what was fought for
- Foundation of our current model and needs to be explicitly stated
- Represents how midwives practice
- Removal changes the feel
- Leads to a grey area when there is complexity
- Emphasis on birthing person lost in attempt to be culturally inclusive
- Linked to better outcomes

PHYSIOLOGICAL BIRTH

- Work with physiological processes rather than facilitate physiological birth
- No mention of when birth not normal
- Complicated should also be included, ability to recognise the abnormal
- Risk of further medicalisation if midwife not involved in all areas

SEXUAL HEALTH AND PRECONCEPTION CARE

Feedback was coded into this area if sexual health or preconception care were mentioned. Many respondents made general comments about the need for clarity throughout the Scope without mentioning all the specific areas. Further clarification of what these areas involved was requested. It was not considered that providing this care to whānau was the role of the midwife. There were suggestions that these areas extend the scope and skills of a midwife should be developed post-graduation. As mentioned in previous sections it was considered there was a risk of being sent to other areas such as gynaecology if midwives had these skills. As with other areas extending the scope, questions were asked about additional education and renumeration.

OTHER AREAS NOTED

- Others areas noted to be missing:
    - Protection of breastfeeding
    - Add evidence based
    - Continuity of care
    - Emergency care
    - Supporting students
    - Wellbeing of midwife
    - Early loss
    - Working for equity
    - Consumer rights and informed decision making
- Healthcare safe systems has no understood definition
- Prescribing included, a medical practice, when other areas removed
- A request to make it easier for nurses to become midwives and vice versa
- Appears communication skills all that is required
- Increased number of sections
- Include need for MC accredited programmes

- Agree with ICM feedback

SUGGESTIONS FOR CHANGE

Several of the organisations, that provided feedback, also proposed suggestions for rewording aspects of the Scope. Other edits suggested include the following:

- Change ‘enabling’
- Reflective instead of reflexive. It was suggested that reflexive is a known more in the research arena
- 'Preconceptional' rather than ‘preconceptual'
- Number paragraphs

ORGANISATIONS PROVIDING FEEDBACK

The following organisations provided feedback on the draft Scope.

- Ara Institute of Canterbury
- Canadian Association of Midwives
- Canterbury and West Coast DHB
- Home Birth Aotearoa
- Hutt Valley and Capital & Coast DHB
- General Practice New Zealand
- International Confederation of Midwives
- La Leche League New Zealand
- Maternity Services Consumer Council
- MERAS
- Midwifery Leaders - DHB
- Ministry of Health – Maternity Team
- National Council of Women of New Zealand
- Nga Maia Trust – Māori Midwives ki Aotearoa
- New Zealand Breastfeeding Alliance
- New Zealand College of Midwives – National
- New Zealand College of Midwives - Legal
- New Zealand College of Midwives – Te Taitokerau
- New Zealand College of Midwives – Wellington region
- Northland DHB – Midwifery Leadership Team
- Perinatal Anxiety and Depression Aotearoa
- RANZCOG
- Royal New Zealand College of General Practitioners
- Tōpūtanga Tapuhi Kaitiaki Aotearoa - New Zealand Nursing Organisation
- Waitemata DHB
- Women’s Health Action

DEVELOPMENT OF SCOPE AND CONSULTATION PROCESS – MIDWIFERY COUNCIL

There were many comments relating to the process of developing and subsequent communication and feedback around the Scope. These are summarised below.

- Development process
    - Not aware of reality
    - Opinions of a few, does not represent all views
    - Rational for changes not provided
    - Little engagement during 18 months of development
    - Design in partnership with actively practising midwives (LMC & Core)

    - Concern about the MC's intentions
    - Concern about cost
    - Who is the 'we' referred to as the wider profession only just joined the journey

- Consultation process
    - Little time, more time needed, particularly in a pandemic
    - Poor communication
    - Too quick
    - Causing unrest in already difficult times
    - Resources presented in academic way
    - Provide current Scope alongside draft
    - Not a good time with current stressors
    - Concern whether consumers, other professions been consulted

- Webinars
    - Felt unable to have fair say in webinars without seeming culturally insensitive
    - Unenlightening
    - Occurred too late
    - Delays created unnecessary speculation
    - Avoidance of addressing challenging debate
    - Concern about the removal of the chat function

- Concern that feedback will not be considered
    - Comments were made such as 'wonder if this will be read", "feel done to", "done deal", "must listen this time", "feel suspicious", "don't think will listen"
    - Any Intention to change as a result of feedback
    - Concerns will not have any impact
    - Need to be open to constructive feedback
    - Already working on competencies
    - Need more consensus before going ahead
    - Needs to be transparent, honest, robust process
- Group who wrote report appear to have been left with little support and work not given due recognition

LIMITATIONS

The members of the Midwifery Council, or the Aotearoa Reference group were not excluded from providing feedback. It is recommended that they be asked not to provide feedback in future feedback rounds.