

# Current Changes to Midwifery Education Programmes in Japan : a Comparison with Thailand

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## Abstract

The rules governing educational content for public health nurses, midwives, and nurses are scheduled to be revised in 2022 to correct an overcrowded curriculum and reflect issues facing the perinatal field in Japan. This paper identifies societal factors as well as professional needs that are driving such necessary changes. In addition, it also compares Japan's midwifery education programme with that of Thailand, which has achieved remarkable development in the Asian region. Midwifery students should be exposed to new subjects given the changes in the Japanese society. Moreover, midwifery competences must be developed to allow them to practise autonomously as professionals. To develop midwifery in Japan, midwifery programmes should be moved to the postgraduate level, and as a result, the contents of the midwifery curriculum should also be revised.

**Key Words** : basic midwifery education, curriculum, the rules governing educational content for public health nurses, midwives and nurses

## Introduction

In Japan, the context of the health care system is drastically changing due to the declining birth rate and aging population. Regarding the growing elderly population, it is estimated that Japan will be a super-aged society, in which one in four people will be over the age of 75 by 2025<sup>1)</sup>. As a result, there will be an increased need for at-home medical care for the elderly. Therefore, Japan must plan for this need for home nurses to ensure that the elderly can age safely and comfortably at home. In this regard, the Ministry of Health, Labour and Welfare (MHLW) announced a plan to train approximately 100,000 nurses with 38 advanced specific medical competences by 2025. The plan provides that nurse practitioners (NPs) can be trained as alternative medical doctors, allowing NPs with specific medical competences to treat patients according to a procedure manual (previously un-

acceptable medical care for nurses). These NPs, as well as doctors, are required to complete 250 hours of specialized training (195 hours of lectures and 55 hours of clinical practice). The training system for nurses with specific competences began in October 2015<sup>2)</sup>.

In addition, the birth rate is declining in Japan. In 2018, according to demographic statistics released by the MHLW<sup>3)</sup>, Japan experienced the lowest number of births in its history, 918,973 births; 2018 was the third consecutive year that Japan had less than one million births. The average fertility rate, defined as the average number of children that a woman has in her lifetime, was 1.42 in 2018, which was a decrease of 0.01 points from 2017. One reason for this trend is that the number of unmarried people has been increasing significantly. In addition to the decline in the average fertility rate, the age of mothers at the time of their first delivery has been rising as well as the number of people seeking

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treatment for infertility. More women are seeking to postpone having children until their 30s or 40s<sup>4</sup>), which increases high-risk pregnancies. Moreover, the number of mothers with parenting anxiety is increasing and approximately 10\_15% of mothers experience postpartum depression<sup>5,6</sup>). It is mentioned that these issues are impacted by the age of the mothers<sup>7</sup>). The National Centre for Child Health and Development reported 357 cases in Japan's Maternal Mortality Ratio, with 102 cases of suicide attributed to postpartum depression<sup>8</sup>). Hence, some maternity hospitals have instituted postpartum examinations two weeks after delivery. In addition, in many maternity hospitals, mothers who experience parenting anxiety after discharge after the birth of their baby can be hospitalized for up to four months. As an issue of perinatal care, it is important to take efforts to reduce maternal mortality due to suicide and to prevent infant abuse and neglect. The issues identified above can significantly impact the next generation. As a complicating factor, the number of people with challenging medical issues is also increasing.

Interestingly, under such difficult circumstances, the number of obstetricians has been declining in Japan in recent years<sup>9</sup>). This may be due to the heavy workload with which obstetricians are burdened compared to other medical doctors. For instance, working hours can span day and night, and parents and their families are likely to take legal action if babies or mothers are injured or die during birth. Additionally, the rate of Caesarean sections has increased in Japanese hospitals<sup>10</sup>). The number of natural births is dwindling due to the increase in high-risk pregnancies. As a result, the number of facilities for delivery as well as the number of obstetricians have decreased dramatically. In light of this context, midwives have moved into an essential role in the perinatal field.

In the Act on Public Health Nurses Article 3, Midwives, and Nurses (Act No. 203 of 1948), 'Midwife' is defined as 'a woman under licensure from MHLW to practice midwifery or provide health guidance for pregnant women, puerperal women, or newborn babies, as a profession'. In Japan, midwives have accountability for midwifery for normal deliveries and autonomously provide health care to pregnant women, women in the postpartum period, and newborns. By contrast, obstetricians have responsibility for not only normal deliveries but also abnormal pregnancies and deliveries. After World War II, with the transition to hospital delivery, the main healthcare provider for normal deliveries shifted from midwives to obstetricians<sup>11,12</sup>). Since then, many artificial

interventions (such as perineal incision and suture) have been introduced into labour and delivery. The percentage of births in hospitals and clinics has increased from 18% in 1955 to 84% in 1965. According to vital statistics in Japan (2017)<sup>13</sup>), the total number of births in 2017 was 946,065, of which 54.4% (514,590) occurred in a hospital, 44.9% (424,728) in a clinic, 0.6% (5,410) at a birth house, and 0.1% (1,337) at home or elsewhere. In terms of healthcare providers, 92.9% of hospital deliveries were assisted by obstetricians (477,978) and 7.1% were assisted by midwives (36,612); 99.0% (407,553) of clinic deliveries were assisted by obstetricians and 1.0% (3,975) by midwives; 16.2% (878) of birth house deliveries were assisted by obstetricians and 83.8% (4,532) by midwives; and 40.3% (539) of home births (or births in other places) were assisted by obstetricians and 38.5% (515) by midwives<sup>13</sup>). As shown above, most hospital and clinic deliveries were assisted by a medical doctor, which may indicate that the number of abnormal deliveries is increasing; even at birth houses, the percentage of delivery assistance by obstetricians was 16.2%<sup>13</sup>). The statistics indicate that the main assistance provided for deliveries has shifted from midwife to obstetrician. Consequently, it has become difficult for midwives to practise autonomously at hospitals and clinics, and the practical competences of midwives who work at hospitals and clinics have declined.

Currently, Japan seeks to clarify the division of roles between obstetricians and midwives in the perinatal field. Midwives need to improve their skills for midwifery and early detection of abnormalities in high-risk pregnant women. In October 2015, the midwifery certification system (CLOCMiP® level III) was started by the Japan Institute of Midwifery Evaluations in order to ensure a certain level of knowledge and competences as well as to continuously improve such knowledge and competences<sup>14,15</sup>). To become certified as an 'Advanced Midwife' (CLOCMiP® level III), for instance, a midwife needs to have delivered over 100 babies, conducted health examinations for 100 newborns as well as 200 pregnant and postpartum women, provided primary perinatal for 20 babies, provided health guidance for pregnant women and puerperal women (group or personal) as a profession as well as know how to perform cardio pulmonary resuscitation (CPR) and bleeding control<sup>14,15</sup>). The 'Advanced Midwife' certification system guarantees the quality of perinatal care for midwives who autonomously practise midwifery in hospitals, and it requires that knowledge and skills be updated every five years to maintain the certification. By contrast, the

national qualifications for midwives do not need to be renewed; midwives can continue to work under a lifetime license without continuing education or certification. The 'Advanced Midwife' designation indicates that a midwife is capable of autonomous delivery support and maternal management, and can ensure that normal pregnant women are safe and satisfied during pregnancy and afterwards. Amid recent changes, the rules governing educational content for public health nurses, midwives, and nurses are scheduled to be revised in 2022<sup>16)</sup>.

This paper aims to discuss changes to the content of the midwifery education programme and future directions in Japan by conducting a literature review. In addition, it will also compare Japan's midwifery education programme with that of Thailand, which has achieved remarkable development in the Asian region.

### The current trends in Japan's midwifery education programmes

In Japan, as of April 2018, 263 of the 1064 (24.7%) higher education institutes (including junior colleges, etc.) offer nursing education<sup>17)</sup>. Of those, 208 universities have a midwifery education programme that allows students to sit for the national qualification exam<sup>17)</sup>. Specifically, 39 institutes offer the programme as a postgraduate course (a two-year, full-time programme), 83 institutes offer the programme as a four-year undergraduate course, and 39 institutes offer a one-year programme as a post-undergraduate course<sup>17)</sup>. Of all of the programmes, 18.8% are postgraduate courses, 18.8% are post-undergraduate courses, and 39.9% are undergraduate courses<sup>17)</sup>. Many four-year Japanese nursing universities offer combined dual programmes that qualify graduates to sit for two qualification exams: nurse and public health nurse, or nurse and midwife; thus, it is possible for students to select the exam for a public health nurse or midwife. The curriculum in dual programmes is quite extensive, making it difficult for students to digest universities' unique curriculum within four years<sup>18)</sup>. As a result, the Japanese Nursing Association recommends that all public health nurses and midwives are educated in a postgraduate programme.

To develop midwifery in Japan, it is expected that all midwifery programmes will be offered as a postgraduate course (a two-year, full-time programme). The first midwifery programmes at the postgraduate level began in 2004, and currently, 39 institutes offer such programmes<sup>17)</sup>. According to a survey<sup>17)</sup>, the average number of required credits to graduate from a four-year

nursing university is 126.8, whereas the average number of credits to graduate from a dual four-year programme (nurses and midwives) is 146.8. The average number of credits for a two-year, full-time midwifery postgraduate programme is 58.7, whereas it is 30 for a one-year programme<sup>17)</sup>.

The postgraduate programme in Japan aims to provide profound academic knowledge from broad perspectives and develop research skills in a specific field, as well as build specific professional capacity to perform occupations based on the specialization<sup>19)</sup>. Normally, the requirements to earn a master's degree, regardless of the programme, are more than two years of study, at least 30 credits, academic supervision of a written dissertation, and the passage of the relevant examination<sup>19)</sup>. The Japanese midwifery education programme requires at least 28 credits, according to current rules. Therefore, to earn a master's degree for midwifery, a student must earn at least 30 credits for a master's degree plus an additional 28 credits for midwifery education<sup>17)</sup>. Hence, to resolve the issue of an overcrowded curriculum, the most ideal education programme might be 'professional graduate school', without a mandatory research dissertation. However, given the declining birth rate and a decreasing number of mothers willing to allow students to practise midwifery on them, it will likely be difficult for students to obtain the large number of deliveries required for graduation, no matter the length of the training programme.

Regarding the transition of midwifery education in Japan, before World War II, there were 61 training schools for midwives in Japan<sup>20)</sup>. In the early Showa era (approximately 90 years ago), midwifery education was a two-year, direct-entry programme, requiring students to practise 50 deliveries before graduating from the midwifery training school<sup>20)</sup>. Therefore, midwives were able to conduct normal deliveries autonomously without instructions by an obstetrician<sup>21)</sup>. After the War, the number of midwives with their own birth houses decreased dramatically, and now deliveries have moved from home or birth houses to hospitals or clinics<sup>13)</sup>. The main reason for the transition to hospital delivery may be an imitation of the style of delivery that is most popular in the US. In addition, after the national qualification system changed in 1952, the number of midwives gradually decreased<sup>20)</sup>. Additionally, the demand for public health nurses responsible for improving the health environment of the Japanese people was also increasing after the war. Under such circumstances, a school was established that not only compensated for the shortage of

midwives but also provided training for the required public health nurses. Kagawa Prefecture Nursing School was the first institute in Japan to initiate training through a joint curriculum for public health nursing and midwifery. It began training public health nurses and midwives in 1964 in a one-year combined dual programme<sup>22</sup>. After that, the joint courses (public health nurses and midwives) spread to municipal schools within Japan, increasing to 20 institutions nationwide by 1979<sup>20</sup>.

However, the literature has criticized midwifery competences, specifically that they are underdeveloped due to insufficient clinical practice hours<sup>20, 23</sup>. In 1967, the nursing curriculum was significantly revised, halving the time for clinical practice (from 3,727 hours to 1,770 hours)<sup>20</sup>. Since then, many concerns have been raised that midwives lack confidence about midwifery. Moreover, as stated previously, given the declining birth rate since the 1980s, it has become difficult for students to practise over 10 deliveries during the clinical training period for midwifery education programmes; thus, in 1996, in a partial revision of the rules setting forth the requirements to sit for the national midwifery exam, the number of deliveries was revised to approximately 10<sup>23</sup>. However, there is no evidence to support a need to practise 10 deliveries before graduating from the programme; indeed, 10 deliveries are an insufficient number to develop autonomous midwifery competences. Hence, a discussion of the minimum required competences must be at the centre of any discussion of the number of practice deliveries required to graduate from a midwifery programme.

In 2012, the Japan Society of Midwifery Education (JSME), which is organized by midwifery institutions, proposed 'the minimum requirements for midwives' in an attempt to clarify the curriculum for midwifery programmes<sup>24</sup>. The curriculum for midwifery programmes is stipulated by Japanese law within the Act on Public Health Nurses, Midwives, and Nurses (Act No. 203 of July 30, 1948) and the Act on Assurance of Work Forces of Nurses and Other Medical Experts (Act No. 86 of 1992). In April 2010, a revision to the Act on Public Health Nurses, Midwives, and Nurses was enacted that extended the academic period of study for public health nurses and midwives from '6 months or more' to '1 year or more'<sup>23</sup>. As noted previously, many universities offered midwifery in a combined curriculum with nursing. However, after the law was revised, it was thought that a separate programme after graduating from a nursing university was required to improve the quality of mid-

wifery. As a result, the midwifery programme as a one-year, full-time course was born in 2008<sup>17</sup>. A ministerial ordinance promulgated on the Act on Public Health Nurses, Midwives and Nurses revised the curriculum for training schools in 2010<sup>23</sup>. Consequently, the total number of credits required to qualify to sit for the midwifery exam increased from 23 to 28<sup>23</sup>. MHLW also examined appropriate educational content for midwifery, and MEXT established a study group of university professors and teachers in nursing schools to develop nursing human resources in universities. The study group issued a suggestion to increase the number of credits in the midwifery curriculum as follows: from 6 to 8 credits for 'Midwifery Diagnosis/Technology', from 1 to 2 credits for 'Midwifery Management', and 9 to 11 credits for 'Clinical Practice for Midwifery'<sup>23</sup>. As a result, those suggested were implemented. Overall, the total number of units has increased from '23 credits or more' to '28 credits or more'. In the near future, the number of credits is expected to increase even more.

As stated previously, the rules governing educational content for public health nurses, midwives, and nurses will be revised again in 2022<sup>16</sup>. According to the nursing education related review meeting organized by MHLW in January 2019<sup>16</sup>, the next revision will include the following changes: 'Midwifery Diagnosis/Technology' will increase from 8 to 10 credits; 'Maternal and Child Health in Community' will increase from 1 to 2 credits. The stated purposes for increasing the credits for midwifery programmes are to enhance the educational contents to strengthen the competences of midwifery students; enhance interdisciplinary (or multidisciplinary) approaches and communication skills needed for midwives to assess the needs of patients (or health care receivers); strengthen knowledge of women's health and health support for women, their children, and families throughout their lives; develop practical abilities to provide emergency care and assist high-risk pregnant women; obtain skills to provide mental health support during the perinatal period; and obtain knowledge to support parenting (for up to four months after delivery). Although it may be possible to finish these credits in a one-year curriculum, the appropriate midwifery programme should be a two-year postgraduate educational course. Currently, 39 institutions have midwifery postgraduate programmes and that number is expected to rise as a result of these anticipated changes.

According to the Japan Institute of Midwifery Evaluation (2009)<sup>25</sup>, midwifery postgraduate students should possess the following characteristics: a theoretical and

exploratory attitude; an awareness of professionalism for midwifery; The ability to clarify clinical issues; and improved communication skills. As for communication skills, medical staff, including midwives and nurses, must have strong communication skills to provide safe and comfortable clinical care to patients. However, there is a concern that midwifery students' communication skills are lacking. With strong communication skills, midwives can obtain the necessary information to provide proper health care to patients based on their needs. It is also important for midwives to communicate with other professionals to find better solutions to patients' problems and to interact with other professionals to support patients with complicated medical issues. To improve midwives' communication with other professions, a class should be added to midwifery programmes on multidisciplinary or interdisciplinary approaches, such as Inter-Professional Education (IPE). Spending two years in a postgraduate programme may be ideal for developing students' personality and competences necessary for the profession.

Although Japan had direct entry, two-year midwifery programmes before World War I, the direct entry system is no longer used at any university in Japan. Thus, the current midwifery qualification is premised on also being qualified as a nurse. According to a survey by Japan Medical Association<sup>26)</sup>, nurses have several problems related to their practical training: 'must use a large number of practical training facilities', 'employment of part-time teachers for clinical practice', 'practical training facility is far away', 'there are few practical training facilities available', 'management of practical training time and schedule', and 'few suitable subjects for practical training'. Midwifery education, too, struggles to find the right clinical practice facilities. Additionally, if midwifery students are practising in the same facility throughout the year, there will be fewer opportunities for newly certified midwives to perform maternity care at that facility, and the improvement of clinical competences after obtaining a license will be delayed. In the future, the manner in which clinical training for midwifery is conducted must also be reviewed.

### The rapid development of nursing midwifery programmes in Thailand

In Thailand, midwifery is a sub-field of nursing that provides professional healthcare to pregnant women, puerperal women, and their infants<sup>27)</sup>. Regarding the differences between Japanese nursing universities and Thailand's, all nursing universities in Thailand offer nursing

and midwifery, although not all universities in Japan offer midwifery. In addition, midwifery students must practise 10 deliveries to sit for the national examination in Japan, whereas nursing university students practise approximately five deliveries to earn a midwifery certificate in Thailand. Interestingly, students caring for 30 to 40 pregnant women can become an autonomous professional immediately following graduation in New Zealand, Canada, and the United Kingdom, which adopt direct entry systems for a midwifery certificate. Nonetheless, in Thailand, despite the small number of midwives practicing at hospitals, midwifery education provides advantages for all nursing students<sup>28)</sup>.

Nursing courses in Thailand began in the 1800s<sup>27, 28)</sup>. The first nursing school was opened in 1896, and in 1950, the Ministry of Public Health established the Nursing Division. A four-year nursing education programme was first offered in 1956, and a four-year nursing course began in 1971<sup>27, 28)</sup>. Additionally, a nursing master's degree has been offered since 1973, and a doctoral degree has been offered since 1984 as a postgraduate course<sup>28)</sup>. To ensure a certain quality of education, since 1973, nursing university applicants must have completed 12 years of education<sup>28)</sup>. Moreover, Thailand places emphasis on improving the quality of university faculty, to foster the quality of educational competences. In 1999, faculty of Chiang Mai University were first awarded scholarships by the Thailand royal family to earn overseas' doctoral degrees<sup>27)</sup>. In Japan, 37.7% of nursing teachers (including non-university teachers) had a master's degree and 9.5% had a doctorate<sup>29)</sup>. In terms of ensuring the quality of nurses, a Thailand law that guarantees the quality of nurses was established in 1997, and a national examination was initiated by the Thai Nursing Association (TNA) in 1998<sup>27)</sup>. Although nurse qualifications are guaranteed for life in Japan, nurses must renew their qualifications every five years in Thailand. To maintain the quality of nursing education programmes, educational institutions in Thailand must be evaluated by TNA once every five years<sup>27)</sup>.

The countries even differ by gender; midwives can be male in Thailand, whereas Japanese law requires that midwives are female. In Japan, there would likely be strong opposition to male midwives due to Japanese cultural views, such as that women are suitable caregivers for women during childbirth. In addition, Japanese women generally do not feel comfortable entering the delivery room with men present, except for their medical doctors and husbands; indeed, it is difficult for men to enter the delivery room or engage with maternity and

postpartum care, even for practicing nursing students. However, midwife is a profession, regardless of gender.

As part of my research, I visited Mahasarakham University in Thailand in March, 2019. Many of its nursing faculty have studied abroad in the UK or US to earn a Ph. D. They are fluent in English, and there are many nursing classes taught in English at Mahasarakham University. Thailand's nursing education institutes are expected to develop as international research institutions, where faculty development is strongly supported and evaluations of higher education programmes are strictly performed. Thailand's nursing education institutes can accept foreign students from overseas, whereas few Japanese universities accept foreign students due to language difficulties. However, Japan must prepare to accept foreign students due to its declining youth population.

The faculty of nursing at Mahasarakham University was established in 1995 to grow the demand for qualified nurses and to improve the quality of health care in the northeast area in Thailand<sup>30</sup>. As a nursing education institution representative of the northeast region, Mahasarakham University has the following four goals: 'To create nursing graduates who have high quality, leadership attributes'; 'To develop a knowledge base that contributes to innovations in health'; 'To promote a strong, healthy community in the northeast region'; and 'To conserve and nurture our local wisdom and cultural heritage'<sup>30</sup>. Additionally, its faculty have the following aims: 'To educate qualified nursing graduates who meet all levels of the national standards'; 'To conduct research, disseminate knowledge and develop nursing innovations including other health related innovations, which may be conducted in collaboration with other organizations in Thailand and overseas'; 'To provide academic services in health which are useful to local people, neighbouring communities and both governmental and non-governmental organizations'; and 'To maintain, support and promote cultural heritage as being integral to professional nurses'<sup>30</sup>. To obtain a Bachelor of Nursing Science (B.N.S.), nursing and midwifery students must earn 144 credits, consisting of 30 credits in general education, 76 credits in main subjects (51 credits in nursing theory and 25 credits in practice), 32 credits in other main subjects, and 6 credits in elective subjects; the number of credits does not differ much from the requirements for the combined dual programme in Japan. The credit requirement for a Master of Nursing Science (M.N.S.) is 42 credits<sup>30</sup>. I observed the nursing practice room at Mahasarakham University, and it was a fully

equipped facility. In the adult nursing training room, there was a simulation programme that is conducted by using a high-function simulator (Fig.1 A and B). I also observed the midwifery students' practice at a teaching hospital (Roi Et Hospital, located in northeast Thailand). In the outpatient department, a pregnant woman was interviewed by a midwifery student. Although there was a nursing teacher present, the student was talking independently with the pregnant woman (Fig.2 A and B).

In Thailand, 54.7% of women (aged 15\_49 years) have completed primary school and lower secondary school, and only 11.2% of women enter university<sup>31</sup>. By contrast, 45.1% of high-school female students attend university in Japan<sup>32</sup>. Therefore, the nursing students in universities in Thailand may be considered an elite group. The admission policy for nursing universities in Thailand requires that candidates possess high aspirations. These high aspirations required for admissions to nursing and midwifery programmes, to develop students' autonomy and promote pride within the learning process.

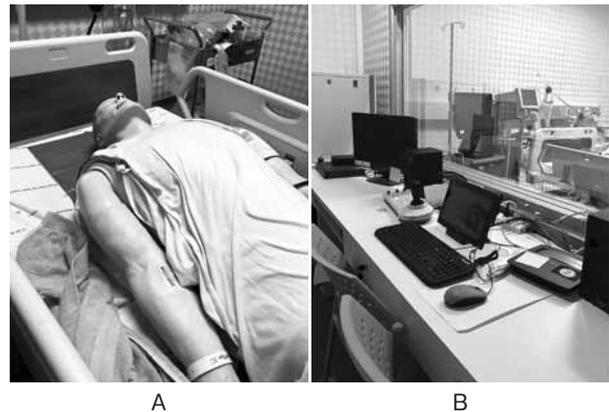


Fig.1  
There was a simulation programme that is conducted by using a high-function simulator.  
A: SimMan 3 G<sup>®</sup> is advanced patient simulation system that can train for basic and advanced nursing care.  
B: The simulation training for nursing students is guided by nursing teachers in this room.

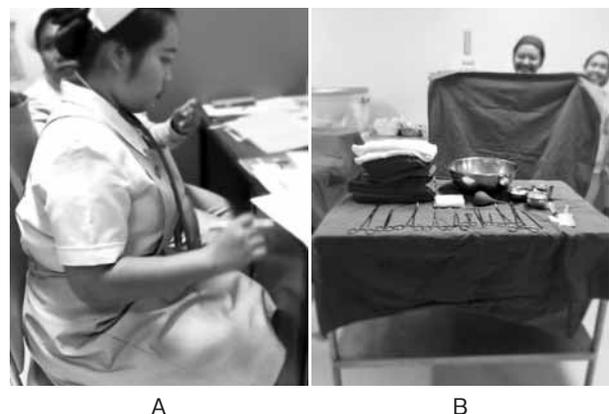


Fig.2  
A: A midwifery student interviewed a pregnant woman in the outpatient department.  
B: The instruments for delivery were prepared by a midwifery student (such as the umbilical cutter)

## Another issue for future midwifery education in Japan

In Japan, the birth rate will continue to decline, which will ultimately lead to a shortage of prospective students for universities. It is predicted that the 18-year-old population will remain flat from 2009 to 2020, and begin to decline in 2021<sup>32)</sup>. Currently, the universities' admission capacity already exceeds the 18-year-old population. As of 2017, about 40% of private universities failed to meet their enrolment capacity<sup>32)</sup>.

Not surprisingly, the number of students who will seek admission to a postgraduate institution after graduation is also expected to decrease. In fact, the number of students enrolled in postgraduate programmes increased 2.5 times from 1991 to 2016, but it has been decreasing since 2011<sup>33)</sup>. Having a large number of applicants to maintain competitiveness may be necessary to guarantee the quality of educational institutions. However, given the current situation in Japan, the number of applicants for postgraduate programmes will likely decline in the future. Therefore, it is important to promote a recurrent education system in which anyone can learn at any age, as well as to increase the number of international students in postgraduate programmes in Japan. Although the number of nursing universities with a global perspective is speculated to increase in Japan, most lectures are conducted only in Japanese. Additionally, although admission of international students into postgraduate programmes in Japan increased 1.5 times from 2003 to 2016, admission has remained flat since 2011<sup>33)</sup>.

For the future development of nursing and midwifery education, Japan must appeal to students from around the world who are interested in learning nursing and midwifery in advanced medical settings in Japan. In addition, including foreign students in the programme can contribute to the other students' development of global perspectives and recognition of diverse values. Thus, Japanese nursing universities must work toward conducting nursing and midwifery classes in English like Mahasarakham University and prepare to diversify various learning options (such as introduction of a part-time programme in addition to the full-time programme).

### Conclusion

Until now, the practical training time for students in a basic nursing programme has gradually been reduced in Japan, and many are concerned that there is not enough time for practical training to ensure safe nursing care

upon graduation from a nursing programme. Therefore, it is necessary to train nurses in high-quality nursing programmes in universities. Moreover, it is necessary to add the subjects of clinical judgment and integrated nursing education for home settings. The Japan Nursing Association is promoting a four-year basic university programme for nurses, with training for public health nurses and midwives in postgraduate programmes.

Current challenges in Japan's midwifery education programme include insufficient training hours for clinical practice and an overcrowded curriculum. JSME has raised concerns about the current quality of midwifery programmes, continued to request assistance from the Japanese government regarding the need to expand the midwifery education period, and sought to move all education programmes to the postgraduate level. As stated above, in the near future, the rules governing educational content for public health nurses, midwives, and nurses are expected to be revised in 2022, and the number of credits is expected to increase to around 31. To develop midwifery in Japan, it is recommended that all education programmes be moved to the postgraduate level (two-year, full-time course). Although the nursing midwifery programme in Thailand developed rapidly, the university's educational structure is well established, with a global perspective that has reached other local universities. Japan should attempt to adopt certain aspects of Mahasarakham University's programme to improve the quality of its own midwifery programmes.

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# 日本における助産師教育の変遷

## —タイ王国との比較から—

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### 要旨

保健師助産師看護師養成所指定規則が改正され2022年から新しいカリキュラムによる助産師教育が始まる。新助産師教育課程における単位数の増加が見込まれる中、助産師教育の大学院教育化が促進することが予測される。現在の周産期医療をめぐる様々な課題を背景として、助産師の自律性を高めるための教育が求められている。本論文では、アジア圏内で大学における看護師助産師教育の著しく発展したタイ王国における看護師助産師教育を参考にしながら、日本の助産師養成の将来展望について考察している。日本における助産学の発展のためにも、助産師教育の大学院教育化は必然であり、その新しい教育課程では助産専門職として自律的に実践できるようにその能力を高められるようなカリキュラムにする必要がある。

**Key Words** : 助産師教育、カリキュラム、保健師助産師看護師学校養成所指定規則

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