PATHWAYS TO STRENGTHENING MIDWIFERY IN EUROPE

Introduction

A re-examination of midwifery in Europe is timely. Recent evidence demonstrates that midwifery is key to the survival, health and well-being of women, infants and families in all countries and settings (1, 2). Improved outcomes include reduced maternal and neonatal morbidity and mortality, stillbirth, low birth weight, fewer adverse clinical outcomes and fewer inappropriate clinical interventions. Other benefits of midwifery include increased breastfeeding, improved psycho-social outcomes and more efficient use of health services. Having universally available midwifery services offers scope to reduce health inequalities. An evidence-based framework for quality maternal and newborn care has recently been published to guide health system and education planning and provision (1).

Examining ways to strengthen midwifery and thereby improve outcomes for women and infants is of particular relevance in the light of changes in the childbearing population in Europe. These include growing poverty and social inequalities, increased migration, more older mothers and more women using artificial reproductive technologies, all of which result in more complex disease profiles. High-quality midwifery care has much to contribute to this challenging picture.

Variations in midwifery across Europe

The International Confederation of Midwives (ICM) has established international standards for midwifery education. However, midwifery across the 58 European countries, with their diverse history, culture and health systems, is very varied and these standards are often not met (3, 4). Prior to the 2005 Bologna declaration obliging European Union (EU) countries to offer degree-level midwifery education, a vocational-based education was common across much of central Europe. In some countries outside of the EU this remains the case and in countries with degree-level education standards vary considerably.

The Nordic countries provide positive examples of strong midwifery practice. Midwives are the primary care providers and woman-centred care is characterized by a reciprocal relationship within a positive birthing atmosphere (5). Lower caesarean section rates are one important outcome; Finland, Sweden, Norway and Iceland all have rates below 18%. However, even where midwifery is strongly integrated into the health system in both community and hospital settings, midwifery can struggle to withstand over-medicalization. The Netherlands has a well-established community midwifery system, but a greater focus on hospital-based care has seen home birth rates fall. Geographical variation within countries and inter-institutional variations in caesarean section rates indicate barriers to midwifery that result in a limited scope of midwifery practice. Midwifery is perhaps especially weak in parts of central and eastern Europe. In Hungary and the Czech Republic, for example, some midwives have received prison sentences despite conforming to the international scope of midwifery practice.

As a consequence of this variation, data on workforce and outcomes can present a confusing picture. For example, there is an inconsistent relationship between the number of midwives per 1000 live births (range 4.5 [Slovenia] to 60.9 [Sweden]) and outcomes such as maternal and neonatal mortality, or caesarean section rates.

Case studies

The Russian Federation, Italy and the United Kingdom (UK) have similar numbers of midwives per 1000 live births and the great majority of women in all three countries are cared for in the state-run health system. We examined the health system environment in which midwives work in these countries to illuminate the different ways in which midwifery is implemented and to identify strategies needed to strengthen midwifery and improve care. Table 1 shows some of these countries' key indicators. Table 2 (on pages 14-15) presents brief national profiles, describing some key factors including education, regulation and scope of practice. The information has been drawn from published material and from first-hand experience of working in these countries.

Table 2 demonstrates a wide interpretation of the scope of a midwife's practice. In the UK, a strong regulatory and education framework is in place. This enables midwives to work as autonomous practitioners in a range of settings, although many still work in settings where traditional hierarchies persist and limit midwives' full potential. In Italy midwifery could perhaps be best described as a

Table 1: Key indicators for three case study countries.

Country	Live births (2013)[1]	MMR (2013)[2]	NMR (2011)[2]	Caesarean Section (%)[2]	Mother's Index Rank (of 178 countries) [where 1=best][3]	Midwives per 1000 live births[4]
Italy	514 308	4	2	37.8	11	30.3
Russian Federation	1 901 182	24	6	18.0	62	40.1
UK	782 089	8	3	23.7	26	44.2

Sources: (1) UN Statistics Division, (2) WHO Global Health Observatory, (3) Save the Children 2014 State of the World's Mothers, (4) UN Population Prospects 2010 Revision.

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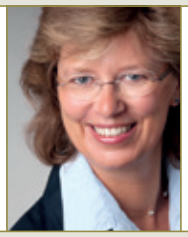

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semi-profession, while in Russia midwifery lacks a strong educational or regulatory system. In all three settings there are challenges to be addressed from over-medicalized approaches to care, which results in risk-based assessment systems and the routine use of unnecessary interventions. Most importantly, these case studies show that women, infants and families in countries with weak midwifery systems lack the skilled and compassionate care of a health professional who works in partnership with women and who is able to promote the normal processes of pregnancy, birth, postpartum and the early weeks of life (1).

Lessons learned from current health systems

The experience of several European countries indicates that midwifery can indeed make a real difference to the lives of women and infants. However, the potential of midwifery in Europe is constrained by barriers that include limitations on the scope of practice, weak professional regulation, over-medicalized health systems, commercialization, unsupportive environments, fragmented health services, not implementing evidence-based policy and practice and the low status of women. These barriers limit development of the whole health system and expose individual midwives to risk if they practice outside the constraints imposed. Professional territorialism that blocks midwifery's development hardly seems defensible when the consequences are to limit access of women and babies to care that will make a difference.

Strategies to strengthen midwifery in Europe

National and international leadership by policy makers, health system planners and health professionals is needed to ensure that high quality midwifery care is available to all women and infants.

Essential strategies to overcome barriers include:

- **Implementing appropriate standards of education**
  - to be able to provide women and infants with skilled, compassionate care during pregnancy, childbirth and the early weeks after birth, midwives need to be educated to international (ICM) standards. This includes a student-centred approach to learning which values the development of problem solving, reflexivity, and critical thinking skills. This will require improved education programmes for midwifery educators.
- **Support for qualified midwives to practice within a health system**
  - where they are integrated into multi-professional teams with strong multi-professional leadership, working in partnership with other professionals including obstetricians, paediatricians and family physicians, as well as maternity support workers.
- **A strong system of professional regulation to monitor standards of education and practice**
  - both to protect the public from inappropriate care and to enable the full scope of midwifery practice.
- **Strong professional leadership to support midwifery and a strong professional association to safeguard standards.**
- **Tackling the predominant over-medicalized, risk-based approach through implementing evidence-based practice across maternal and newborn health services**
  - this should include educating the multi-professional team to understand and optimize the normal processes of pregnancy and birth.
- **Clearly describing any limitations to midwives' scope of practice when examining comparative data on outcomes**
  - definitions of the type of midwifery practice (e.g. meeting international standards or not) and the type of maternal and newborn care system in place (e.g. woman-centred, evidence-based, over-medicalized) would help to interpret data on outcomes.
- **Educating and engaging midwives in research**
  - this will both increase the relevant evidence base and strengthen midwives' leadership skills and ability to challenge positively.
- **Involving women and advocacy groups in the planning and monitoring of services to keep the core focus on the needs of women, infants and families.**

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Table 2: Case studies of key factors in care by midwives* in three European countries: Italy, the Russian Federation and the United Kingdom.

	ITALY	RUSSIAN FEDERATION	UNITED KINGDOM
Midwifery education	University level: 3-year BSc - direct entry or post nursing *Regulation of education* Medical personnel regulate curricula. No moderation from outside midwifery or medical lecturers of theory, assessment or practice. *Access* MCQ exam - nothing specific about pregnancy and childbirth. No interview. Curricula: theory Didactic education model. Obstetricians and allied medical clinicians deliver much of the taught material. Midwifery lecturers exist but teach within a didactic model and assess students using MCQs and exams. *Curricula: practice* No formal mentorship arrangement in placements. However, practice is assessed by a midwife who has worked some hours with student using an assessment grid to evaluate and document the student's knowledge, skills, or attitudes. Practice may include a placement within the community - although in the community midwives mainly do paperwork, cervical screening, sometimes antenatal classes, they usually run a breastfeeding clinic once a week. They assist gynaecologists during antenatal visits. No homebirth service is available. No home visit after birth.	Two routes: 4-year course for those who have completed 9 classes (equivalent to UK GCSE): 3-year course for those who have completed 11 classes (equivalent to UK A level). Exit with a Diploma in Midwifery. *Regulation of education* No external moderation; for example, no external monitoring of theory, assessment or practice from outside midwifery or medical lecturers. Medical personnel regulate curricula. *Access* Apply to medical schools where a set number of places are available without fee per year. Students additional to the quota can be accepted for a fee ($2,000-4,000/yr.). Every year the subject for the entry test is defined by the Department of Education. For example, in 2014, the topic was chemistry. For 2015, it will be biology. The same exam is used for every healthcare profession, including medical students. Applicants are also required to undertake a literacy test in Russian. *Curricula: theory* Didactic education model. Obstetricians and allied medical clinicians deliver much of the taught material. Midwifery lecturers teach within a didactic model and assess students using an annual exam and regular MCQ tests following lectures. Curricula: practice No mentorship arrangement in placements: students observe practice in large groups led by obstetricians. They cannot deliver a baby. No clinical competency model. No formal practice assessment. No documentation to demonstrate knowledge, skills, or attitudes.	University level: 3-year degree or 18 months post-nursing. *Regulation of education* Education standards set and monitored by Nursing and Midwifery Council (NMC) meet international (ICM) standards. *Access* Strong admissions procedures, appropriate academic and personal qualifications required. *Curricula: theory* Student centred learning approach. Students taught predominantly by experienced midwives with educational qualifications. *Practice* Structured clinical experience in hospital and community settings with identified clinical mentors, close monitoring and regular clinical and academic assessment. Documentation required to assess competence. Final year students are assessed on their ability to caseload a selected group of women through pregnancy, birth and postpartum.
Professional status, regulation and scope of practice	By law, the midwife is an autonomous practitioner (in line with ICM scope of practice). In practice however, this is only in name in the state system. Can practice independently, but without insurance. Antenatal care delivered by obstetricians: midwives only assist. Obstetrician the lead clinician for all women during labour and birth. Midwives have no medicine prescribing rights and are not allowed to make key decisions (i.e. to admit or discharge a woman from hospital).	No role as an autonomous practitioner. Officially only permitted to work in state Polyclinics (antenatal care) or Roddoms (intrapartum care), under medical instruction. Homebirth is now outlawed. Antenatal care delivered by obstetricians: midwives only assist. Postpartum care managed by obstetrician and nurse who does baby check. Some illegally attend women at homebirth.	The lead named healthcare professional for healthy women during pregnancy and childbirth. Strong statutory role as autonomous practitioner, protected by legislation and by regulation by Nursing and Midwifery Council. Midwifery practice in hospitals, community and home settings, including home birth, and in midwifery-led settings including alongside units (inside hospital) and freestanding units (separate from hospital). However scope of practice limited for those practicing in some hospitals where traditional hierarchies persist. Midwifery is practiced almost exclusively in the state-run (NHS) system. All women have free access to midwifery care in this system. Small numbers of midwives offer private independent midwifery care. Understaffing is a problem, aggravated by the increased birth rate and more complex caseload.

	ITALY	RUSSIAN FEDERATION	UNITED KINGDOM
Women's advocacy and engagement	Currently there is no evidence that women are actively engaged in activities or initiatives to alter the status quo in maternity care provision.	Currently there is no evidence that women are actively engaged in activities or initiatives to alter the status quo in maternity care provision. Cultural norms are very difficult to challenge as a result of the hierarchical system and strict controls.	From the 1970s onwards, improvements in women's status and growth of organized advocacy groups challenged over-medicalized care and lack of evidence in policy and practice. Active lay involvement in professional regulation, education, policy and practice.
Evidence-based policy and practice	Midwives not educated to be intellectually confident or competent to promote an evidence based approach. Care is ritualized, being based on custom and practice.	Midwives not educated to be intellectually confident or competent to promote an evidence based approach. Care is highly ritualized.	Research findings that challenged the over-use of interventions, along with midwives themselves being educated in research and the increasing use of evidence to inform policy and practice, helped to raise the profile of midwifery from the 1980s. Evidence-based policy and practice strong theme in midwifery and in maternity services. National evidence-based standards currently promote midwife-led care and choice of place of birth.
Sequelae for women ‡ and their families	Midwives are ill-equipped to be a woman's advocate. Not taught how to develop a professional relationship with, or to involve women in decision-making about their care. Not clinically confident or competent to facilitate normal processes during pregnancy and childbirth. No experience with a continuity model. Childbearing women expect to have decisions made for them, be cared for by doctors, to give birth in an obstetric unit and to see different doctors during pregnancy, labour and birth and postpartum.	Midwives cannot psychologically or legally conceive themselves to be a woman's advocate. Not taught how to develop a professional relationship with, or to involve women in decision-making about their care. Not clinically competent to facilitate normality during childbirth. No experience with a continuity model. Childbearing women expect to have decisions made for them, be cared for by doctors, to give birth in an obstetric unit and to see different doctors during pregnancy, labour and birth and postpartum.	All women and infants have access to midwifery care, increasingly on a continuity model. Midwives educated to be advocates for women and families though not always enabled to be so. Limitations on the scope of practice limit full potential. Higher-than-expected maternal and neonatal mortality rates and the use of unnecessary interventions remain challenging.
Opportunities	Mentors are now being introduced although as yet there is no mentor training or supervision programme. There are a few midwifery led units (MLUs) in Italy (for example, Genoa, Florence, Milan, Reggio Emilia), run by the Association of Independent Midwives. Women have to pay to receive care in them. There is one public MLU in Florence (La Margherita) although women see an obstetrician on admission and a paediatrician at discharge. MLU-based midwives can accompany women who they transfer to hospital but this is not regulated: it is up to them to build a good relationship with the nearest hospital's managers, midwives and doctors. For a fee, some MLUs provide "training programmes" for qualified midwives. These programmes are not recognized by the Italian NHS equivalent.	A few Roddoms (number unknown) provide antenatal consulting and birth rooms where women can be cared for by a midwife of their choice. Typically this is a state qualified midwife who is working as an independent midwife, in collaboration with an obstetrician and paediatrician. This currently small-scale fee paying service has arisen in response to an increasing request expressed by women who want to be active participants in shaping the care they receive and for that care to be skilled and compassionate. Pregnant women and their partners/family members can attend private antenatal education sessions and postnatal care provided by a mix of state qualified and lay midwives. These sessions are delivered in a user-friendly style, and the facilitators refer to evidence-based practice.	Drawing on best evidence, national multi-professional standards currently promote midwife-led care and choice of place of birth. This involves promoting out of hospital birth for healthy pregnant women. Strong professional leadership and active and engaged advocacy groups ensure political engagement and support.

**Midwives who are educated and work within the state system (UK, NHS equivalent). ‡Women who are cared for during pregnancy and childbirth by the state system.*

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