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Establishing a Europe-wide foundation for high quality midwifery education: the role of the European Midwives Association (EMA).

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Abstract

A cornerstone of European policy involves freedom of movement of individuals between member countries, which applies equally to those who use and provide maternity care. To promote and support safe, high quality maternity care, minimum standards for midwifery education and practice have been published, including Directives EEC/80/154 and EEC/80/155 which support the recognition of professional qualifications. These Directives established a minimum standard for midwifery education, including the duration and content of theoretical and practical education. Annex V of the Directives established a framework of professional activities to define and guide the scope of midwifery practice in EU member countries. The Directives were updated in 2013, with the European Midwives' Association (EMA) an important partner in this process.

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While the degree of implementation of the Directives at individual country level varies, EMA has an ongoing role in ensuring, promoting and advancing high quality midwifery education and practice throughout the EU.

Keywords

European Union; European Midwives Association; Midwives; Midwifery education; Midwifery practice

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Introduction

The European Union (EU) is a geo-political entity currently including 28 member countries. It is governed by (1) the EU parliament, elected by its citizens, (2) an EU council, consisting of the government heads of the countries, (3) an EU council of ministers, which includes one cabinet member from each member country and (4) an EU commission, voted on by the EU parliament. The EU operates an internal single market strategy, facilitating the free movement of goods, services and individuals between its member countries. Its legislative framework applies across industry, law, agriculture and healthcare.

For most of the 1970s and 1980s the European Commission focused on the preparation of separate Directives for different healthcare professions, known as the Sectoral Directives. Each Directive was derived following a process of harmonisation of healthcare education, and subsequently healthcare practice, supported by relevant healthcare professions represented on advisory committees (Keighley, 2009). The European Midwives Association (EMA) played an essential role in the process of harmonising midwifery education and worked closely with the respective advisory committee.

Originally founded in 1968 as the European Midwives Liaison Committee (EMLA), the organisation became the European Midwives Association (EMA) in 2004 and continues to link with other European and global health professional organisations (Emons and Luiten, 2001; WHO, 2003; Mead et al., 2007). With the support of EMA, the advisory committee for the education of midwives agreed minimum standards regarding the nature, content and duration of programmes required to award qualifications mutually recognized by all EU member countries. After the EU advisory committees ceased functioning in 1999, EMA focused on the future of the Directives (EEC/80/154 and EEC/80/155), recognising that an

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ongoing strong political focus on midwives' competencies, education and legislation was needed.

An important aspect of EMA's role involves support to facilitate freedom of movement, such as automatic recognition of basic healthcare professional qualifications and harmonisation of minimal training requirements in line with the implementation of the Directives. For over a decade, EMA expanded to represent the growing European community and currently incorporates professional midwifery organisations not only from each EU member country, but the European Economic Area and the Council of Europe. Today, EMA represents 34 midwifery organisations from 29 countries. Members of EMA are from the EU member countries (25 members from the 28 EU countries), the European Economic Area (two members; Iceland and Norway) and the Council of Europe (two members; Switzerland and Turkey).

EMA recognised early on that the challenges of EU expansion would impact on the midwifery community. To meet these challenges, it adopted the following aims;

(1) to influence legal mechanisms at national and international levels to ensure and maintain the minimum standard of education and practice as stated in the EU Directives

(2) to adopt similar standards of practice as those already applied across the EU

(3) to reduce variation in midwifery competencies within the EU and EU candidate countries

(4) to guarantee optimal midwifery care for women throughout Europe (Mead, 2003).

A joint basis for quality education: the EU Directives for midwives

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Sectoral Directives for healthcare professions in the EU were introduced to promote patient safety and protect the public. The freedom of movement of regulated professions required the reciprocal recognition of education programmes to enable individuals to register and practice in other EU member countries. Host countries were required to ensure that the level of education and practice of migrating healthcare professionals at least reached the EU standard.

Sectoral Directives for midwives which were first adopted in 1980, were later incorporated as part of 2007 General Directive 2005/36/EC on the recognition of professional qualifications. As member countries adopted the Directives, the freedom of movement of midwives within the EU was guaranteed (Mead, 2003). In 2011, the Directive was due for review by the European Commission and EMA actively participated in the consultation and evaluation process. In collaboration with the Network of European Midwifery Regulators (NEMIR), EMA proposed several changes including that full-time midwifery education should include at least 5,000 hours, with at least half of these hours working in direct clinical practice. Some changes proposed by EMA were not adopted; the new Directive 2013/55/EU states that a midwife should be educated in a full-time programme consisting of at least *4,600* hours of theory and practice, with at least *one third* of the minimum duration based in clinical practice. In addition, the minimum requirements for an individual to be able to apply for midwifery training were revised from 9 to 12 years of previous general education.

Over the last decade, degree level midwifery courses have been developed in universities in many EU member countries which previously offered diploma or certificate level qualifications. However, concerns have been raised about whether all of the programmes offered are fit for purpose (Fleming et al., 2011). On behalf of its member organisations, EMA takes every opportunity to address identified problems such as:

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- Who provides the midwife education programmes?
- Have countries got the capacity to develop midwifery educators?
- Is there legislation and regulation to recognise the role of midwife within the health care system?

Although the new Directive provided a European framework for midwifery education and practice, implementation of this remains a challenge, as some member countries continue to interpret the Directives differently.

From joint education to joint practice: Activities of the midwife

Annex V of the Directive outlined the theoretical and practice content of the education programme for midwives, and competencies required (so-called 'activities' of midwives). When the Directive was updated in 2013, Annex V from Directive 2005/36/EC remained valid and largely reflected the content of the original 1980 Directive. While the EU, through its Directive, tries to ensure that midwifery education programmes attain certain minimum standards, Annex V focused solely on a quantitative description of tasks the midwife should carry out (Fleming et al., 2011). It enumerated the number of women a student midwife should care for in the antenatal and postnatal period, and number of births the student midwife should facilitate prior to completion of a midwife education programme.

EMA mapped how Annex V was implemented in each member country with two Europe-wide surveys in 2014 and 2016, which explored the content of midwifery education (Table 1) and competencies of a midwife (Table 2). The 2016 survey concluded that all responding countries (13 from 29) had implemented the requirements of Annex V in their national regulation on midwifery education and midwifery students in these countries should achieve the defined competencies during their programme. It was noted however that active

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participation in vaginal breech births and assessment and management of perineal trauma were difficult competencies to acquire in practice. To reflect survey findings, EMA is now preparing to update the content of midwifery education in Annex V to reflect advancements in clinical training, for example use of simulation training for the development of competencies in assessment and management of perineal trauma and vaginal breech birth, as well as provision of respectful maternity care. Recently a working group including educators from eight EU countries met to develop a concrete proposal for a new Annex V. The consensus of the group was that the language of Annex V needed updating, utilising language reflective of the recent ICM definition of the midwife (ICM, 2017) and the Lancet series on Midwifery (Renfrew et al., 2014).

Working on the future: EMA supporting midwifery education in various EU countries

The current vision and objectives of EMA are broader than a sole focus on pre-registration education standards linked to professional qualifications. The plethora of policies and Directives informing contemporary health and social care across the EU, have impacted on midwives' practice environment, continuing professional development and legislation of their role. EMA provides a voice for midwives in Europe and works in collaboration with other European professional organisations and non-governmental organisations (NGOs) to ensure midwives are visible and their voices heard.

Through EMA meetings and activities, midwifery research and evidence-based practice are more readily agreed upon and disseminated. A recent study on continuous professional development and lifelong learning which included five health professions (midwives, nurses, doctors, dentists and pharmacists) across European level organisations found that midwives, in each EU member country had more Continuous Professional Development (CPD) topics in common than other professional groups (EAHC 2015). .

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Nevertheless, it is an ongoing challenge to ensure midwives are invited to the table when relevant national policies are debated and developed. EMA support remains crucial. As an umbrella organisation, EMA has a strong role in providing information, knowledge and evidence by lobbying and direct communication with national and European level policy makers. Only together we can advocate for better care for women, babies and their families and impact on safe, quality midwifery care.

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Tables

Table 1: Overview of midwifery education in Europe (EMA survey, 2014). 27 responding European countries

		Countries
Structure	Direct entry only	21
	After nursing education only	4
	Both direct entry and after nursing education	2
Qualification	Master/Bachelor only	22
	Diploma/Certificate only	3
	Both Master/Bachelor and Diploma/Certificate	2
Organisation	University/University College only	19
	College only	4
	Hospital only	1
	Both University/University College and College	2
	Both University/University College and Hospital	1
Eduction standards developed at	National level only	13
	University/University College only	4
	Association only	0
	Both National level and University/University College	6

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	Both National level and Association	2
	At all levels (National University/University College and Association)	2

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Table 2: Achievement of the defined competences in Annex V by midwifery students during their practical and clinical training (EMA survey; 2016). 13 responding European countries

Defined competences in Annex V from the Directive 2005/36/EC	Can all midwifery students achieve the defined competence during their practical and clinical training (Countries)		
	In full, completely	In part	Not at all
Advising of pregnant women, involving at least 100 pre-natal examinations	11	2	0
Supervision and care of at least 40 pregnant women	11	2	0
Conduct by the student of at least 40 deliveries; where this number cannot be reached owing to the lack of available women in labour, it may be reduced to a minimum of 30, provided that the student assists with 20 further deliveries	11	2	0
Active participation with breech deliveries. Where this is not possible because of lack of breech deliveries, practice may be in a simulated situation	6	7	0

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Performance of episiotomy and initiation into suturing. Initiation shall include theoretical instruction and clinical practice. The practice of suturing includes suturing of the wound following an episiotomy and a simple perineal laceration. This may be in a simulated situation if absolutely necessary	7	5	1
Supervision and care of 40 women at risk in pregnancy, or labour or post-natal period	12	1	0
Care of women with pathological conditions in the fields of gynaecology and obstetrics	12	1	0
Initiation into care in the field of medicine and surgery. Initiation shall include theoretical instruction and clinical practice	12	1	0
Supervision and care (including examination) of at least 100 post-natal women and healthy new-born infants	11	2	0
Observation and care of the new-born requiring special care, including those born pre-term, post-term, underweight or ill	12	1	0

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