



# European Union Standards for Nursing and Midwifery: Information for Accession Countries

**Second edition**

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## ABSTRACT

This document has been prepared to support the implementation of the Munich Declaration, which urges all relevant authorities to strengthen nursing and midwifery by improving initial education and access to higher education. It also calls for the establishment of the necessary legislative and regulatory framework. The role and function of the various bodies relevant to health care in the European Union are described, as are the various types of European Union legislation, as revised in 2005. It reflects the experience of those countries that have joined the European Union since 2004, and of those currently engaged in the accession process.

### Keywords

NURSING – standards  
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## **Introduction**

The Munich Declaration (1) urged all relevant authorities “to strengthen nursing and midwifery by improving initial education and access to higher education” and called for “the establishment of the necessary legislative and regulatory framework”. One way of getting there is achieving compliance with European Union (EU) requirements for nursing and midwifery education. The focus in this document is on Directive 2005/36/EC (2) and the key elements of the negotiation and development processes that were involved in implementing the Directive. It further reflects the experience of those countries that have joined the EU since 2004 as well as those currently engaged in the accession process.

Compliance with Directive 2005/36/EC is for the most part achieved as part of a nursing and midwifery development package which incorporates a number of WHO Regional Office for Europe strategies, including those for nursing and midwifery education (3), guidance on the utilization of human resources, recommendations for strengthening nursing and midwifery practice, and use of WHO global standards for professional nursing and midwifery education.

Further information on the WHO Regional Office for Europe and the EU is available on their web sites (<http://www.who.int/about/regions/euro/en/index.html> and <http://europa.eu>, respectively).

## **Recognition of professional qualifications**

### **How the current situation arose**

Although the Treaty of Rome was intended to provide for the free movement of individuals, EU Member States were not obliged to recognize professional qualifications acquired in other Member States, and often did not. This represented a major obstacle to the freedom of movement of professionals in general, and resulted in the development of processes to facilitate the acceptance of education, training and qualifications acquired in another EU country, as well as any subsequent cross-border movement. This, in turn, gave way to two significantly different approaches – both applied by means of EU directives – concerning the ways in which professional qualifications could be accepted within the Union. These two routes (known as: the sectoral directives route, and the general systems directives route) are explained in more detail below. Exceptionally, for some professions such as nursing, both approaches are used, depending on the initial education and training of the practitioner concerned.

### **Sectoral directives**

For most of the 1970s and 1980s the European Commission focused on the preparation of separate directives for the professions, known as the sectoral directives. Each directive was derived from a process of “harmonization” that was achieved through the work of the relevant professions in advisory committee meetings that were held in Brussels. The advisory committee agreed the minimum standards for the profession concerned, with regard to the nature, minimum content and length of education and training programmes required to obtain qualifications that were to be mutually recognized by all Member States. Once agreement had been reached, a directive was put into place. The aim was to enable the freedom of movement within the EU, for EU nationals who were members of the relevant profession on the basis of their qualifications,

education, and training. Application for recognition of such qualifications, education and training in another EU country needed to be made through the “competent authority” (the body recognized by law to administer the sectoral directives) in the country concerned.

Midwives, nurses responsible for general care only, medical doctors in all their specialties, dentists, pharmacists, veterinary surgeons and architects, all had specific sectoral directives. The directives for nurses dating from 1977 were:

- Directive 77/452/EEC concerning the mutual recognition of diplomas, certificates and other evidence of the formal qualifications of nurses responsible for general care, including measures to facilitate the effective exercise of this right of establishment and freedom to provide services (4); and
- Directive 77/453/EEC concerning the coordination of provisions laid down by Law, Regulation or Administrative Action in respect of the activities of nurses responsible for general care (5).

The directives for midwifery were passed in 1980:

- Directive 80/154/EEC concerning the mutual recognition of diplomas, certificates and other evidence of formal qualifications in midwifery and including measures to facilitate the effective exercise of the right of establishment and freedom to provide services (6); and
- Directive 80/155/EEC concerning the coordination of provisions laid down by Law, Regulation or Administrative Action relating to the taking up and pursuit of the activities of midwives (7).

Over time, the process of creating and maintaining the sectoral directives through harmonization proved to be slow, cumbersome, and expensive, both in human and financial terms. In practice, the sectoral directives were unwieldy, particularly in making modifications to reflect the changing nature of health care and professional practice. As the demand by other professions for similar harmonization processes was high, the need for an alternative system that was more responsive to change was acknowledged.

## **General systems directives**

The general systems directives were based on a process of recognition, rather than harmonization. This approach meant that an individual recognized as a professional in one Member State could also be recognized as such in another, providing the profession concerned was a regulated one in both Member States. Directive 89/48/EEC concerned diplomas awarded on completion of a higher education course of at least three years duration, following education to the equivalent of A-level/baccalaureate (8).

Directive 92/51/EEC covered diplomas gained on completion of professional education and education and training of less than three years higher education duration (9).

This approach was designed to be easier and more flexible to apply, while endeavouring to maintain professional standards of education and practice. However, the definition of a regulated profession is not necessarily straightforward and can, in practice, be a source of difficulty for individuals seeking to migrate. No conditions for education and training were stipulated in the directives, but the applicants’ qualifications were assessed by the “designated authority” (the body designated by law in the Member State to administer the general system directives). It was

permitted to require a period of adaptation if there were doubts about the comparability of an individual's training, or the individual could be required to sit an examination. In the health field this was the route used by all those professions without sectoral directives.

This was also the route used by nurses and midwives who had undertaken specialist training, either as initial education and training, or as post-qualification specialization. In either case it was outside the remit of the general care nursing and midwifery directives. Such individuals were required to apply to the relevant designated authority for assessment in order to seek recognition of their qualifications. It was permissible for countries to require an examination or a period of supervised practice for recognition/registration in the country concerned to be granted.

Arising from the experience of implementing these sectoral and general directives, as well as the wish to develop more efficient mechanisms for enabling the free movement of the regulated professions in the enlarged EU, a new directive was developed which combined the previous directives and included the amendments agreed over the years.

## **Directive 2005/36/EC on the recognition of professional qualifications**

This Directive came into force on 20 October 2007 and replaced 15 sectoral directives, including the four which applied to nursing and midwifery. Its purpose was to strengthen the four freedoms described earlier and simplify the processes of mutuality, both harmonization and recognition. Mutuality is the process by which decisions reached in one Member State are honoured in another, unless there are clear grounds for doubt. Three areas of improvement were identified (2).

A regime is required for the temporary provision of services.

In view of the different systems established for the cross-border provision of services on a temporary and occasional basis on the one hand, and for establishment on the other, the criteria for distinguishing between these two concepts in the event of the movement of the service provider to the territory of the host Member State should be clarified. [paragraph 5]

Common platforms should lead to an extension of automatic recognition within the General System.

A common platform is a set of criteria which make it possible to compensate for the widest range of substantial differences which have been identified between the training requirements in at least two thirds of the Member States including all the Member States which regulate that profession. These criteria could, for example, include requirements such as additional training, an adaptation period under supervised practice, an aptitude test, or a prescribed minimum level of professional practice, or combinations thereof. [paragraph 16]

Administrative cooperation is required.

The competent authorities of the host Member State and of the home Member State shall work in close collaboration and shall provide mutual assistance in order to facilitate

application of this Directive. They shall ensure the confidentiality of the information which they exchange. [Article 56, paragraph 1]

This is to be achieved through the establishment of:

- competent authorities (Article 56)
- contact points (Article 57)
- a committee on the recognition of professional qualifications (Article 58)
- consultation (Article 59).

## General nurse training

Article 31 of 2005/36/EC lays out the principle requirements for the training of general nurses (2).

1. Admission to training for nurses responsible for general care shall be contingent upon completion of general education of 10 years, as attested by a diploma, certificate or other evidence issued by the competent authorities or bodies in a Member State or by a certificate attesting success in an examination, of an equivalent level, for admission to a school of nursing.
2. Training of nurses responsible for general care shall be given on a full-time basis and shall include at least the programme described in Annex V, point 5.2.1.
3. The training of nurses responsible for general care shall comprise at least three years of study or 4600 hours of theoretical and clinical training, the duration of the theoretical training representing at least one-third and the duration of the clinical training at least one half of the minimum duration of the training. Member States may grant partial exemptions to persons who have received part of their training on courses which are of at least an equivalent level.

The Member States shall ensure that institutions providing nursing training are responsible for the coordination of theoretical and clinical training throughout the entire study programme.

4. Theoretical training is that part of nurse training from which trainee nurses acquire the professional knowledge, insights and skills necessary for organizing, dispensing and evaluating overall health care. The training shall be given by teachers of nursing care and by other competent persons, in nursing schools and other training establishments selected by the training institution.
5. Clinical training is that part of nurse training in which trainee nurses learn, as part of a team and in direct contact with a healthy or sick individual and/or community, to organize, dispense and evaluate the required comprehensive nursing care, on the basis of the knowledge and skills which they have acquired. The trainee nurse shall learn not only how to work in a team, but also how to lead a team and organise overall nursing care, including health education for individuals and small groups, within the health institute or in the community.

This training shall take place in hospitals and other health institutions and in the community, under the responsibility of nursing teachers, in cooperation with and assisted by other qualified nurses. Other qualified personnel may also take part in the teaching process.

Trainee nurses shall participate in the activities of the department in question insofar as those activities are appropriate to their training, enabling them to learn to assume the responsibilities involved in nursing care.

6. Training for nurses responsible for general care shall provide an assurance that the person in question has acquired the following knowledge and skills:
  - (a) adequate knowledge of the sciences on which general nursing is based, including sufficient understanding of the structure, physiological functions and behaviour of healthy and sick persons, and of the relationship between the state of health and the physical and social environment of the human being;
  - (b) sufficient knowledge of the nature and ethics of the profession and of the general principles of health and nursing;
  - (c) adequate clinical experience; such experience, which should be selected for its training value, should be gained under the supervision of qualified nursing staff and in places where the number of qualified staff and equipment are appropriate for the nursing care of the patient;
  - (d) the ability to participate in the practical training of health personnel and experience of working with such personnel;
  - (e) experience of working with members of other professions in the health sector.

The content of training is laid out in Annex V.2. (2)

#### 5.2.1. *Training programme for nurses responsible for general care*

The training leading to the award of a formal qualification of nurses responsible for general care shall consist of the following two parts.

##### A. Theoretical instruction

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>a. Nursing:</p> <ul style="list-style-type: none"><li>– Nature and ethics of the profession</li><li>– General principles of health and nursing</li><li>– Nursing principles in relation to:<ul style="list-style-type: none"><li>– general and specialist medicine</li><li>– general and specialist surgery</li><li>– child care and paediatrics</li><li>– maternity care</li><li>– mental health and psychiatry</li><li>– care of the old and geriatrics</li></ul></li></ul> | <p>b. Basic sciences:</p> <ul style="list-style-type: none"><li>– Anatomy and physiology</li><li>– Pathology</li><li>– Bacteriology, virology and parasitology</li><li>– Biophysics, biochemistry and radiology</li><li>– Dietetics</li><li>– Hygiene:<ul style="list-style-type: none"><li>– preventive medicine</li><li>– health education</li></ul></li><li>– Pharmacology</li></ul> | <p>c. Social sciences:</p> <ul style="list-style-type: none"><li>– Sociology</li><li>– Psychology</li><li>– Principles of administration</li><li>– Principles of teaching</li><li>– Social and health legislation</li><li>– Legal aspects of nursing</li></ul> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

##### B. Clinical instruction

- a. Nursing in relation to:

- general and specialist medicine
- general and specialist surgery
- child care and paediatrics
- maternity care
- mental health and psychiatry
- care of the old and geriatrics
- home nursing

One or more of these subjects may be taught in the context of the other disciplines or in conjunction therewith.

The theoretical instruction must be weighted and coordinated with the clinical instruction in such a way that the knowledge and skills referred to in this Annex can be acquired in an adequate fashion.

## Midwifery training

Articles 40–42 of 2005/36/EC lays out the principle requirements for the training of midwives (2).

Article 40. The training of midwives

1. The training of midwives shall comprise a total of at least:
  - (a) specific full-time training as a midwife comprising at least three years of theoretical and practical study (route I) comprising at least the programme described in Annex V, point 5.5.1, or
  - (b) specific full-time training as a midwife of 18 months' duration (route II), comprising at least the study programme described in Annex V, point 5.5.1, which was not the subject of equivalent training of nurses responsible for general care.

The Member States shall ensure that institutions providing midwife training are responsible for coordinating theory and practice throughout the programme of study.

The content listed in Annex V, point 5.5.1 may be amended in accordance with the procedure referred to in Article 58(2) with a view to adapting it to scientific and technical progress.

Such updates must not entail, for any Member State, any amendment of existing legislative principles relating to the structure of professions as regards training and the conditions of access by natural persons.

2. Access to training as a midwife shall be contingent upon one of the following conditions:
  - (a) completion of at least the first 10 years of general school education for route I, or
  - (b) possession of evidence of formal qualifications as a nurse responsible for general care referred to in Annex V, point 5.2.2 for route II.
3. Training as a midwife shall provide an assurance that the person in question has acquired the following knowledge and skills:

- (c) adequate knowledge of the sciences on which the activities of midwives are based, particularly obstetrics and gynaecology;
- (d) adequate knowledge of the ethics of the profession and the professional legislation;
- (e) detailed knowledge of biological functions, anatomy and physiology in the field of obstetrics and of the newly born, and also a knowledge of the relationship between the state of health and the physical and social environment of the human being, and of his behaviour;
- (f) adequate clinical experience gained in approved institutions under the supervision of staff qualified in midwifery and obstetrics;
- (g) adequate understanding of the training of health personnel and experience of working with such.

Article 41. Procedures for the recognition of evidence of formal qualifications as a midwife

1. The evidence of formal qualifications as a midwife referred to in Annex V, point 5.5.2 shall be subject to automatic recognition pursuant to Article 21 in so far as they satisfy one of the following criteria:
  - (a) full-time training of at least three years as a midwife:
    - (i) either made contingent upon possession of a diploma, certificate or other evidence of qualification giving access to universities or higher education institutes, or otherwise guaranteeing an equivalent level of knowledge; or
    - (ii) followed by two years of professional practice for which a certificate has been issued in accordance with paragraph 2;
  - (b) full-time training as a midwife of at least two years or 3600 hours, contingent upon possession of evidence of formal qualifications as a nurse responsible for general care referred to in Annex V, point 5.2.2;
  - (c) full-time training as a midwife of at least 18 months or 3000 hours, contingent upon possession of evidence of formal qualifications as a nurse responsible for general care referred to in Annex V, point 5.2.2 and followed by one year's professional practice for which a certificate has been issued in accordance with paragraph 2.
2. The certificate referred to in paragraph 1 shall be issued by the competent authorities in the home Member State. It shall certify that the holder, after obtaining evidence of formal qualifications as a midwife, has satisfactorily pursued all the activities of a midwife for a corresponding period in a hospital or a health care establishment approved for that purpose.

Article 42. Pursuit of the professional activities of a midwife

1. The provisions of this section shall apply to the activities of midwives as defined by each Member State, without prejudice to paragraph 2, and pursued under the professional titles set out in Annex V, point 5.5.2.
2. The Member States shall ensure that midwives are able to gain access to and pursue at least the following activities:
  - (a) provision of sound family planning information and advice;
  - (b) diagnosis of pregnancies and monitoring normal pregnancies; carrying out the examinations necessary for the monitoring of the development of normal pregnancies;

- (c) prescribing or advising on the examinations necessary for the earliest possible diagnosis of pregnancies at risk;
- (d) provision of programmes of parenthood preparation and complete preparation for childbirth including advice on hygiene and nutrition;
- (e) caring for and assisting the mother during labour and monitoring the condition of the foetus in utero by the appropriate clinical and technical means;
- (f) conducting spontaneous deliveries including where required episiotomies and in urgent cases breech deliveries;
- (g) recognizing the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and assisting the latter where appropriate; taking the necessary emergency measures in the doctor's absence, in particular the manual removal of the placenta, possibly followed by manual examination of the uterus;
- (h) examining and caring for the new-born infant; taking all initiatives which are necessary in case of need and carrying out where necessary immediate resuscitation;
- (i) caring for and monitoring the progress of the mother in the post-natal period and giving all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the new-born infant;
- (j) carrying out treatment prescribed by doctors;
- (k) drawing up the necessary written reports.

The content of training is laid out in Annex V.5 (2).

#### 5.5.1. *Training programme for midwives (Training types I and II)*

The training programme for obtaining evidence of formal qualifications in midwifery consists of the following two parts:

##### A. Theoretical and technical instruction

###### a. General subjects

- Basic anatomy and physiology
- Basic pathology
- Basic bacteriology, virology and parasitology
- Basic biophysics, biochemistry and radiology
- Paediatrics, with particular reference to new-born infants
- Hygiene, health education, preventive medicine, early diagnosis of diseases
- Nutrition and dietetics, with particular reference to women, new-born and young babies

###### b. Subjects specific to the activities of midwives

- Anatomy and physiology
- Embryology and development of the foetus
- Pregnancy, childbirth and puerperium
- Gynaecological and obstetrical pathology
- Preparation for childbirth and parenthood, including psychological aspects
- Preparation for delivery (including knowledge and use of technical equipment in obstetrics)

- Basic sociology and socio-medical questions
- Basic pharmacology
- Psychology
- Principles and methods of teaching
- Health and social legislation and health organization
- Professional ethics and professional legislation
- Sex education and family planning
- Legal protection of mother and infant
- Analgesia, anaesthesia and resuscitation
- Physiology and pathology of the new-born infant
- Care and supervision of the new-born infant
- Psychological and social factors

#### B. Practical and clinical training

This training is to be dispensed under appropriate supervision:

- Advising of pregnant women, involving at least 100 pre-natal examinations.
- Supervision and care of at least 40 pregnant women.
- 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.
- Active participation with breech deliveries. Where this is not possible because of lack of breech deliveries, practice may be in a simulated situation.
- 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.
- Supervision and care of 40 women at risk in pregnancy, or labour or post-natal period.
- Supervision and care (including examination) of at least 100 post-natal women and healthy new-born infants.
- Observation and care of the new-born requiring special care, including those born pre-term, post-term, underweight or ill.
- Care of women with pathological conditions in the fields of gynaecology and obstetrics.
- Initiation into care in the field of medicine and surgery. Initiation shall include theoretical instruction and clinical practice.

The theoretical and technical training (Part A of the training programme) shall be balanced and coordinated with the clinical training (Part B of the same programme) in such a way that the knowledge and experience listed in this Annex may be acquired in an adequate manner.

Clinical instruction shall take the form of supervised in-service training in hospital departments or other health services approved by the competent authorities or bodies. As part of this training, student midwives shall participate in the activities of the departments concerned in so far as those activities contribute to their training. They shall be taught the responsibilities involved in the activities of midwives.

While other sections of the Directive are also important, the above sections are the basis of mutual recognition based on the process of harmonization. (See Annex 1 for case study).

## **General system for the recognition of evidence of training**

While basic training in nursing and midwifery operates on the principle of harmonization between Member States, it was clear that free movement was being hindered because of the lack of strong systems to permit recognition of other categories of regulated professions. The professions covered by this provision vary widely, both in and out of health care, but specific applications to nursing and midwifery exist – e.g. a mechanism is provided for two categories of practitioner:

- those nurses who entered the profession via a field of practice that was not general nursing;
- where nurses or midwives have taken a specialist training and wish to be recognized in that specialist field in another Member State.

It does not provide a mechanism for compelling recognition, especially if a Member State does not have that particular field of practice. However, it does introduce greater flexibility to the recognition process. It works on a case-by-case basis, and can result in either immediate recognition or the need for the individual to undertake a period of compensatory training and supervised practice, or they may choose to take an examination. Articles 12–15 explain the *modus operandi* in detail. Annex III lists the types of education and training regulated (2).

## **Future trends**

Inevitably, the future emerges from the past, and there are some significant developments in Europe as a whole which have been in progress for some time, and their continued development will have a significant impact on the EU and subsequently on nurses and midwives. Some of the key developments are addressed in summary here.

## **EU accession**

Since its inception, the then European Economic Community (now EU), has continuously pursued deeper integration while exploring the possibility of new memberships. The current focus is on south-eastern Europe and Turkey. The Treaty on European Union sets out the conditions for entry in articles 6 and 49 (10).

The EU Council meeting in Copenhagen in 1993 established the so-called Copenhagen criteria. They are:

- stable institutions that guarantee democracy, the rule of law, human rights and respect for and protection of minorities;
- a functioning market economy, as well as the ability to cope with the pressure of competition and the market forces at work inside the Union; and
- the ability to assume the obligations of membership, in particular adherence to the objectives of political, economic and monetary union.

In 1995 the Council further clarified that a candidate country must also be able to put the EU rules and procedures into effect.

The procedure has three stages. First is the mandate and framework. The mandate is a unanimous vote in the EU Council. The framework is 35 chapters of work in which the country demonstrates its compliance with the EU *acquis*, a French term meaning “that which has been agreed”. Chapter 2, which covers the freedom of movement for workers, is the section that most affects nursing and midwifery, though others apply to a lesser degree. There follows a screening stage and the production of a national plan to demonstrate how compliance with the *acquis* will be achieved. The third stage is one of negotiation and signing of the accession treaty. This includes a date for final access to the EU.

It is in this final phase that the country is able to contribute to consultations in the EU and receives support from the different agencies and directorates general (DGs) in order to achieve compliance. This often takes the form of technical assistance (11). The two best known to nurses and midwives are the Technical Assistance and Information Exchange Instrument (TAIEX) and twinning (see Annex 2).

TAIEX provides seminars, workshops, expert and study visits; training, peer review, and assessment type assistance. This has to be requested from within country. Occasionally TAIEX initiates its own exercises in order to ensure the delivery of strategic objectives (11).

Twinning projects link a Member State with an acceding or potentially acceding country. It involves the secondment of EU experts, known as Resident Twinning Advisers (RTA) to the acceding candidate, and potential candidate, countries on specific projects. These projects are usually ministry to ministry exercises lasting for about a year and focused on a particular part of the *acquis* (11).

There is a variant on this known as Twinning Light which combines elements of twinning and TAIEX missions (11).

## **Bologna process**

The Bologna Declaration of June 1999 has put in motion a series of reforms needed to make European Higher Education more compatible and comparable, more competitive and more attractive for our own citizens and for citizens and scholars from other continents (Berlin Conference of European Higher Education Ministers 18–19 September 2003). The intention was to achieve:

- a progressive convergence of the overall framework of degrees and cycles in an open European area for higher education;
- a common degree level system for undergraduates (Bachelor’s degree) and graduates (Master’s and doctoral degree);
- enhancement and facilitation of student and teacher mobility and improved recognition of degrees and academic qualification;
- the creation of a European Credit Transfer and Accumulation System (ECTS); and
- the development of EU-wide quality assurance frameworks in higher education (12).

The Bologna process comprises 46 countries. One of its shared aims (mobility), is facilitated by the existence of national centres for the recognition of qualifications. The European Network of Information Centres, ENIC, and the National Academic Recognition Information Centres, NARIC, combine in this work (13).

The European Credit Transfer and Accumulation System (ECTS) is a student-centred system based on student workload required to achieve the objectives of a programme and is of particular interest to nurses and midwives in the Bologna process. The objectives of ECTS are specified in terms of the learning outcomes and competences to be acquired. It has established parameters for recognizing the duration of studies, and mark scoring and together with the Diploma Supplement attached to qualifications, provides standardization and transparency. These are important factors in view of the desire to have comparative academic awards of comparative standards, and to make it possible for academic institutions and students to demonstrate what work has been done and at what level. This generates mutuality and trust and thereby facilitates free movement (14).

### **Life-long learning and vocational qualifications**

One area that affects the nursing and midwifery workforce is the process for recognition of professional development and vocational studies. In 2008, the Commission made the following Recommendation (15):

...to create a common reference framework which should serve as a translation device between different qualifications systems and their levels, whether for general and higher education or for vocational education and training. This will improve the transparency, comparability and portability of citizens' qualifications issued in accordance with the practice in the different Member States. Each level of qualification should, in principle, be attainable by way of a variety of educational and career paths. The European Qualifications Framework should, moreover, enable international sectoral organisations to relate their qualifications systems to a common European reference point and thus show the relationship between international sectoral qualifications and national qualifications systems. This Recommendation therefore contributes to the wider objectives of promoting lifelong learning and increasing the employability, mobility and social integration of workers and learners. Transparent quality assurance principles and information exchange will support its implementation, by helping to build mutual trust.

This will supplement the current legislative framework for nursing and midwifery, and enable countries to work towards shared platforms of study. It will help create explicit links between employment and education. While the Framework is non-binding, governments are asked to relate their national qualification framework to it by 2010.

### **Cross-border health care**

In recent years the European Court of Justice has on several occasions ruled on the subject of cross-border health care and in almost every instance in favour of the patient. This has resulted in countries having to pay for health care provided by another country. The obvious cases where there is usually little challenge are when there is an emergency, or an individual lives adjacent to a national border. However, there has been a number of cases where services have been sought because the home Member State could not provide the service, or could not provide it in a reasonable timescale. This is therefore a highly contentious issue and governments are concerned

about possible unplanned costs, while health service providers see market opportunities. This will have an effect on the provision of nursing and midwifery services in the coming years (16).

## Working in the EU

Up to now this document has dealt with the legal processes and powers within the EU that make freedom of movement of professionals possible within the EU. It is important to understand, however, that the relevant EU legislation deals only with the acceptance and/or recognition of qualifications and training, and not with securing employment within a Member State – a fact that is frequently misunderstood by migrating professionals.

The acceptance/recognition of qualifications/education and training is, of course, the essential first step in terms of practising a profession outside the individual's own country. Those who seek to move within the EU must first apply to have their qualifications accepted by the designated authority in the country in which they wish to work. Acceptance may be immediate, or may follow the satisfactory completion of any additional requirements set by the competent or designated authority. Practising without such recognition is illegal. Separate processes are then necessary to secure work permits and employment. It is not the responsibility of the competent or designated authority to advise on employment prospects or related issues.

Interested individuals are strongly recommended to seek as much information as possible from the relevant authorities before moving in search of work. This information is available from the relevant competent or designated authority or professional organization in the country concerned and through the ENIC/NARIC web sites identified earlier.

## The Munich Declaration

Although not an EU initiative, an important step was taken in June 2000 to improve the position of nursing and midwifery within Europe. Forty-eight health ministers or their representatives from across the WHO European Region signed the Munich Declaration, a statement of intent to which the signatories are now committed (1).

By signing the Declaration, governments are committed to:

- ensuring a nursing and midwifery contribution to decision-making at all levels of health care policy development and implementation;
- addressing the obstacles to health care delivery; recruitment policies, gender and status issues, and medical dominance;
- providing financial incentives and opportunities for career advancement of nurses and midwives;
- improving initial and continuing education and access to higher nursing and midwifery education;
- creating opportunities for nurses, midwives and physicians to learn together at undergraduate and postgraduate levels, to ensure more cooperative and interdisciplinary working in the interests of better patient care;

- supporting research and dissemination of information to develop the knowledge and evidence base for practice in nursing and midwifery;
- seeking opportunities to establish and support family-focused community nursing and midwifery programmes and services, including, where appropriate, the family health nurse; and
- enhancing the roles of nurses and midwives in public health, health promotion and community development.

The Declaration also commits governments to developing comprehensive workforce planning strategies and proper regulatory frameworks. The ministers promised to enable nurses and midwives to work to their full potential “both as independent and as interdependent professionals” (1).

Its implementation was reviewed in 2004 (17). A further review of the implementation of the Declaration is planned for 2009.

## Conclusion

The first decade of the 21st century has been the decade of accession for the EU. It is a trend that looks as if it will continue for at least the next decade. The European Commission is no longer keen on the idea of a group of countries acceding in the way that occurred in 2004, due to the problems associated with ensuring compliance and appropriate implementation of the *acquis*. The accessions that are likely to occur from 2011 onwards will most likely be one or two countries at a time, in order to ensure that the necessary developments have occurred.

In response to this more graduated response, the EU has extended its programmes of assistance in its neighbourhood scheme. This is allowing a wide range of countries to seek assistance in developing compliance schemes for different parts of the *acquis*. This programme of assistance often includes nursing and midwifery professions and is a clear way of helping a country to develop its infrastructure in ways that stabilize the society and decrease the likelihood of emigration in order to achieve a standard of living not attainable at home.

For nursing and midwifery, the development of the peer reviews (now assessments) has provided an opportunity to build the professional international community. The linkages between nurse associations, academic centres, and even individual health care institutions, is creating a framework of communication, exchange and mutual growth and development, which is breaking down barriers and ignorance. The major nursing and midwifery organizations in Europe have played a large part in this. Such development bodes well for the future, irrespective of how economies may falter, or political directions change. It is the era of mutual recognition and shared development.

## Sources of information

Much of the information provided in this document can be accessed on the web sites provided. Two more are worth noting.

1. All publications with decision-making power are published in the *Official Journal of the European Union* ([http://publications.europa.eu/official/index\\_en.htm](http://publications.europa.eu/official/index_en.htm)).
2. To help people cope with EU terminology, which changes because of new Treaty agreements, the EU has created a helpful glossary ([http://europa.eu/scadplus/glossary/index\\_en.htm](http://europa.eu/scadplus/glossary/index_en.htm)).

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## *Annex 1*

### HARMONIZATION CASE STUDY

Every country has great pride in the way that it trains its professionals, including its nurses and midwives. Often, this pride is stoked by statements from national politicians. These assure the population that the process of joining the EU will be comparatively straight-forward. Consequently, people come to believe that their country is well advanced and only minor changes will be needed. What follows draws on the experience of intimate involvement with many of the countries that joined the EU in recent years.

A minister of health might ask what was wrong with the country's system of nursing/midwifery education, with a look of astonishment that the training system could be questioned. The answer was quite plain:

- the duration of the course was wrong
- elements of the necessary content were missing
- the balance of theory and practice was wrong
- the practice of nursing was being taught by doctors, not nurses
- nurses were not nurses but medical assistants.

At this point, there was a distinct tension in the air. That was when the worst news was given: the minister was unaware that the Directive required a minimum of 10 years of certificated education before starting training, and that in most western European countries, it was now 12. His concern was how to avoid political embarrassment when he tried to give the bad news to the Prime Minister. His nurse and midwifery colleagues knew that this was the real problem.

Over the next two years, the necessary legislation was passed, including the creation of a chamber to act as the competent authority. However, the stumbling blocks were how to change the basic education programmes to comply with the requirements of the Directive, as this would mean reshaping the national education system. Further, it had become apparent that midwifery was little more than obstetric nursing, with no responsibility for care.

To assist in all of this a twinning exercise had been started (see Annex 2). This had illuminated the wide opposition among medical staff to allowing the development of midwives, and the resistance of nurses to change, as they felt that it would diminish their standing when the "new" nurses were trained. Thirdly, many of the training institutions felt threatened because they would have to change, and might lose their status as centres of training.

In the final year before accession, politicians realized that all of these issues had to be addressed, no matter how politically unpopular it might seem in the short term, because of the benefits of joining the EU in the long-term. Three years post-accession, some of the struggles to comply remain as the changes are implemented. However, for those nurses and midwives who have been involved in the work there is real pride:

- they see themselves as having raised the standards of training and therefore the standards of care for patients;

- they relish being part of the international community of nurses and midwives; and
- they are working to establish themselves in higher education.

Harmonization is never complete, but it brings opportunities for change when the professions of nursing and midwifery have previously had little power to enable such change.

## *Annex 2*

### TECHNICAL ASSISTANCE

Every country that has joined the EU since 2004 has used the resources of the Technical Assistance and Information Exchange Instrument (TAIEX) to some degree. For nursing and midwifery, the main resources drawn on have been:

- preliminary workshops to establish the requirements for accession;
- peer reviews/assessments to determine the degree of compliance achieved, in which a team of experts visits the country, determines the accuracy of information given prior to the visit and reports its findings, which forms part of the material submitted to justify the closure of the “Chapter”, i.e. demonstrates compliance with the *acquis*;
- twinning agreements to provide in country and long-term support for the development process.

Twinning has often proved to be most valuable.

In this instance, the twinning arrangement was facilitated by a western European Member State, but had been initiated by the country’s ministry of health. Between them, they identified financial resources and technical staff who could deliver on the year-long project. It was all coordinated by the Resident Twinning Adviser (RTA) who managed the following process: a near standard approach in this setting.

At the “kick-off” meeting, as many of the stakeholders as possible met to debate what was needed. This included the health care professions, the government ministries concerned with health care and education, the institutions responsible for training, and nurse and midwifery associations and trade unions. This helped to clarify the agenda and set the targets for the project.

The methodology was quite simple. It consisted of a number of seminars and workshops in the capital and the regional centres to help the different groups build up sufficient knowledge of what needed to be changed as part of the accession process and then to develop action plans. Built into the project was the opportunity to visit the Member State with which the country was twinned. This proved invaluable as it established relationships that were to last as they visited the competent authority, the nurse and midwifery associations, the universities and the government ministries.

However, during some of the workshops and seminars, great anger was expressed about the need to change training systems that groups had great pride in. This naturally drew in the politicians who had to act in order to ensure that changes were implemented.

Hidden in this process were challenges to the implicit status of nurses and midwives, but also of women generally in that society. It became clear that while the agenda was to change nursing and midwifery training, the deeper and more resistant agenda was to preserve gender divides that gave greater power to men. Some empowerment training was given at some of the workshops, and this seemed to move things on as individuals in the country concerned found the resources to challenge long-held views about the subservience of women and therefore of nurses and midwives.

At the end of the project, the necessary changes had been planned, and training for their implementation was underway. Links had been built to institutions other Member States and even more importantly to the European Commission itself. While problems remain, the country has chosen to address the necessary changes and to begin to live not just with professionalized nurses and midwives, but with the increasingly assertive women that the professions train.