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 opens 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 1 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...
that will make a difference.

limit access of women and babies to care

midwifery’s development hardly seems

practice outside the constraints imposed.

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 preg-
nancy, birth, postpartum and the early
weeks of life (1).

Lessons learned from
current health systems

The experience of several European coun-
tries indicates that midwifery can indeed
make a real difference to the lives of
women and infants. However, the poten-
tial of midwifery in Europe is constrained
by barriers that include limitations on
the scope of practice, weak professional
regulation, over-medicalized health sys-
tems, commercialization, unsupportive
environments, fragmented health ser-
tices, not implementing evidence-based
policy and practice and the low status of
women. These barriers limit develop-
ment 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 avail-
able 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 solv-
ing, reflexivity, and critical thinking
  skills. This will require improved
  education programmes for mid-
  wifery educators.

• Support for qualified midwives to
  practice within a health system

• Where they are integrated into
  multi-professional teams with
  strong multi-professional leader-
  ship, working in partnership with
  other professionals including
  obstetricians, paediatricians and
  family physicians, as well as matern-
  ity 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 prac-
tice.

• 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 under-
  stand 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 mid-
  wifery’s leadership skills and ability
  to challenge positively.

• Involving women and advocacy
groups in the planning and monitor-
ing of services to keep the core focus
on the needs of women, infants and
families.

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formed framework for maternal and
newborn care. Lancet 2014; 384:1129-
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2. Homer CSE, Friberg IK, Bastos Dias
MA et al. The projected effect of
scaling up midwifery. Lancet 2014;
384:1146-1157.
Table 2: Case studies of key factors in care by midwives* in three European countries: Italy, the Russian Federation and the United Kingdom.

<table>
<thead>
<tr>
<th></th>
<th>ITALY</th>
<th>RUSSIAN FEDERATION</th>
<th>UNITED KINGDOM</th>
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<tbody>
<tr>
<td><strong>Midwifery education</strong></td>
<td>University level: 3-year BSc - direct entry or post nursing</td>
<td>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.</td>
<td>University level: 3-year degree or 18 months post-nursing.</td>
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<td></td>
<td>Regulation of education Medical personnel regulate curricula. No moderation from outside midwifery or medical lecturers of theory, assessment or practice.</td>
<td>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.</td>
<td>Regulation of education Education standards set and monitored by Nursing and Midwifery Council (NMC) meet international (ICM) standards.</td>
</tr>
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<td></td>
<td>Access MCQ exam - nothing specific about pregnancy and childbirth. No interview.</td>
<td>Access No external moderation; for example, no external monitoring of theory, assessment or practice.</td>
<td>Access Strong admissions procedures, appropriate academic and personal qualifications required.</td>
</tr>
<tr>
<td></td>
<td>Currículum: 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.</td>
<td>Currículum: 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.</td>
<td>Currículum: theory Student centred learning approach. Students taught predominantly by experienced midwives with educational qualifications.</td>
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<td></td>
<td>Currículum: 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.</td>
<td>Currículum: 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.</td>
<td>Currículum: 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.</td>
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<td>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.</td>
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<td>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.</td>
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<td></td>
<td>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.</td>
<td>Professional status, regulation and scope of practice No role as an autonomous practitioner. Officially only permitted to work in state Polyclinics (antenatal care) or Roddoms (intrapartum care), under medical instruction.</td>
<td>Professional status, regulation and scope of practice 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.</td>
</tr>
<tr>
<td></td>
<td>Antenatal care delivered by obstetricians: midwives only assist. Obstetrician the lead clinician for all women during labour and birth.</td>
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*Note: ICM = International Confederation of Midwives. NMC = Midwifery Council of England.
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<td><strong>Women’s advocacy and engagement</strong></td>
<td>Currently there is no evidence that women are actively engaged in activities or initiatives to alter the status quo in maternity care provision.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Evidence-based policy and practice</strong></td>
<td>Midwives not educated to be intellectually confident or competent to promote an evidence based approach. Care is ritualized, being based on custom and practice.</td>
<td>Midwives not educated to be intellectually confident or competent to promote an evidence based approach. Care is highly ritualized.</td>
</tr>
<tr>
<td><strong>Sequelae for women and their families</strong></td>
<td>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.</td>
<td>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.</td>
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<td><strong>Opportunities</strong></td>
<td>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.</td>
<td>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.</td>
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**Acknowledgements**
Our profound thanks to Elisa Mauri and Ekaterina Khotlubey for assistance with the case studies.